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Informational Letter

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				Working Together: Health Services for Children in Foster Care	The New York State Care Coordination Pilot Project: Process & Impact Evaluation Study

I. Purpose

The purpose of this Informational Letter is to transmit to social services districts and voluntary authorized agencies a practice guidance paper, “Health Care Coordination for Children in Foster Care: Approaches and Benefits.” This paper, developed by the Office of Children & Family Services (OCFS) in conjunction with Welfare Research Incorporated (WRI), describes the lessons learned during a four-year pilot project and provides social services districts and voluntary authorized agencies with useful information regarding health care coordination for children in foster care. The pilot and its evaluation were supported with Child Welfare Quality Enhancement Funds.

II. Background

Children who enter foster care are more likely than other children to have a wide array of health care needs and issues. With changes in placement, the use of numerous medical providers and emergency rooms, occasionally incomplete information on health care prior to placement, and multiple demands on foster care caseworkers, meeting the health care needs of these children can become a serious challenge. To address these issues, the American Academy of Pediatrics and The Child Welfare League of America recommend that child welfare agencies adopt a care coordination approach to the health assessment, treatment, and follow-up of children residing in foster care.

In an effort to enhance the child welfare system’s capacity to identify and address the health-related needs of children in foster care, OCFS developed a pilot project to support the creation of health care coordination programs in eight service providers around the state. Funded sites were selected to reflect the various geographical areas, levels of care, health service delivery models, and authorized agencies that make up the foster care system in New York. The participating agencies determined how to implement care coordination within their existing structures. The attached paper describes their experiences, the benefits and challenges they addressed, and includes recommendations for putting care coordination into practice.

The New York State Care Coordination Pilot Project – Process & Impact Evaluation Study Findings is available at: <http://www.ocfs.state.ny.us/main/reports/>

III. Program Implications

The attached guidance document discusses staffing and service delivery considerations, and key elements to a successful care coordination program. It also provides suggestions for initiating implementation of care coordination on a limited scale.

OCFS is sharing this for local districts' and authorized agencies' information and use as you review current processes for coordination and oversight of health services for children in foster care.

/s/ Nancy W. Martinez

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Health Care
Coordination for
Children in Foster
Care: Approaches
and Benefits

A White Paper

New York State Office
of Children and Family Services

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Health Care Coordination for Children in Foster Care

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Abbott House

Catholic Guardian Society and Home Bureau

Child and Adolescent Treatment Services, Inc.

Episcopal Social Services

Erie County Department of Social Services

Green Chimneys Children's Services

The House of the Good Shepherd

Kinship Family and Children's Services

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Health Care Coordination for Children in Foster Care

In this White Paper, the Office of Children and Family Services (OCFS) provides guidance to agencies in the creation and implementation of a health care coordination approach for children in foster care. Health includes all aspects of the child’s well-being—physical, dental, developmental, and mental health. The paper defines health care coordination and briefly describes models used in other states and in specific agency programs in New York State. In accordance with standards adopted by New York State and widely accepted in the child welfare field, OCFS recommends that all agencies incorporate a health care coordination approach in their provision of health services to children in foster care.

“Since implementing our enhanced health care coordination project, we have experienced a marked improvement in communication with mental health, developmental, and educational services, and better responsiveness of these service providers to the needs of the children. The health care coordinators are very knowledgeable about these systems, and how to access services that optimally match the particular needs of each child.”

Abbott House

1. Introduction

Overview

Coordination of health care is a valuable service for everyone. Given the segmented system of care currently prevalent in the United States, coordinating the services provided by more than one doctor or other health care professional can present a significant challenge. In the child welfare system, however, health care coordination is not only critical but also attainable. Built into the system of agency and court oversight are opportunities for care coordination not available in the general population. Along with case management, service planning, and permanency planning, health care coordination can and should be provided.

In child welfare, the overall purpose of health care coordination is to coordinate children’s health care needs and services within the context of foster care placement and agency efforts to enhance the safety and well-being of children and plan for their permanency. As such, health care coordination plays a supportive role in service planning and permanency planning for children—a role that is increasingly valued as children come into placement with multiple physical, emotional, and developmental needs. This role is emphasized by the American Academy of Pediatrics (AAP) in *Fostering Health: Health Care for Children and Adolescents in Foster Care* (2005).

Children who are removed from their homes often enter the foster care system with multiple and sometimes complex health-related needs. Because of their experiences, they may have serious emotional, mental health, and behavioral problems. They generally have higher rates of developmental delays and physical disabilities than children not placed outside their homes.

Given the diversity and range of their medical needs, children in foster care may receive assessment and treatment from a number of health care providers, or their needs may be overlooked, and they may not receive necessary services. The function of health care coordination is to manage all of the child’s

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health-related needs and issues including mental health, developmental, and substance abuse issues. This paper provides suggestions on how agencies may wish to integrate this function into their program.

What is health care coordination?

To promote optimal health of children in foster care, health care professionals, casework staff, agency staff, caregivers, birth parents, and service providers should work collaboratively toward implementing an integrated plan of care. To make this happen effectively, the function of health care coordination is crucial. Health care coordination is a series of activities that support oversight and responsibility for all aspects of health services for children in foster care.

The role of health care coordination is important so that: each child receives all necessary medical, developmental, mental health, dental, and substance abuse assessments in the specified time frames while in foster care; the foster family / caregiver supports the medical plan for the child; and information is shared appropriately among professionals involved in the child's care. Key health care coordinator activities include: collecting and updating health information, accessing and coordinating health services, health education, discharge planning, and facilitating communication between families and health care professionals.

Specific activities of health care coordinators may include the following:

- Collect information on a child/family's health history.
- Establish and maintain a comprehensive and up-to-date medical file.
- Obtain medical consent(s) as needed.
- Establish a medical home for the child (i.e., an established, ongoing relationship with a primary health care provider).
- Schedule and oversee the completion of medical, dental, developmental, mental health, and substance abuse assessments at foster care intake.
- Obtain any necessary and appropriate follow-up evaluations and services.
- Obtain documentation from health service providers for the child's medical file.
- Record current and ongoing health status and activities.
- Establish service relationships with health care providers.
- Coordinate and monitor ongoing health-related services.
- Communicate the results of initial assessments and ongoing health care treatment with the child's primary care provider, case manager, and other relevant service professionals, as authorized.
- Educate the child, birth parent / guardian, and foster family / caregiver about a child's health needs and issues, as authorized.

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- Coordinate treatment team meetings with caseworker, supervisors, agency health staff, childcare staff, and caregivers as appropriate.
- Facilitate the development and incorporation of health-related goals in the child's Family Assessment and Service Plan (FASP).
- Compile health, mental health, developmental, and substance abuse information for the court.
- Communicate with schools regarding the health and developmental needs of the child, as authorized.
- Develop a discharge plan and establish a medical home (*see above*) for children preparing to exit foster care.

Care coordinators accomplish many of these functions by working closely with child welfare staff, specifically case managers (caseworkers) and the child's medical home and other providers. Communication with case managers is integral to providing information and guidance on health-related matters to reach the goals of safety, well-being, and permanency for children in foster care. Although health care coordination may be conducted by a variety of individuals, it is recommended that a lead person with a health background be identified to provide or assist with health care coordination (*see section 4, Guidance for Agencies Implementing Health Care Coordination*).

What Does Health Care Coordination Look Like?

What health care coordination looks like depends on the agency and its characteristics: its mission, purpose, structure, resources, and community. Although health care coordination encompasses certain common activities, the way it is implemented can vary tremendously. The "what" is generally the same; the "how" differs depending on particular circumstances. This is good news in terms of implementing health care coordination statewide: agencies have the flexibility of designing a model that meets their needs.

Section 2 of this paper briefly describes models of health care coordination that have been used in other states.

Section 3 addresses the implementation of a four-year health care coordination pilot in eight sites supported by OCFS from 2003 to 2007. As will be apparent, each agency funded by the project designed a different model depending on the agency's foster care programs, staffing, and ages and characteristics of children in care.

Section 4 provides guidance to agencies in implementing health care coordination.

2. Health Care Coordination Models in Other States

Health care coordination has also been implemented in other states, including California, Colorado, Connecticut, Massachusetts, Michigan, New Hampshire, New Jersey, and Wyoming. This section summarizes the efforts in four of these states.

In California, a public health nurse provides care coordination, within county child welfare service agencies and probation departments, under the supervision of a public health nurse manager. The local Child Health and Disability Prevention (CHDP) program is responsible for the administration of the Health Care Program for Children in Foster Care. The public health nurse works to ensure that the medical, mental health, dental, and developmental needs of those in foster care are being met. In addition, the public health nurse also collaborates and consults with the foster care team, including social workers and probation officers, in order to provide specialty services as well as comprehensive care.

Through Colorado's Department of Public Health and Environment's Health Care Program for Children with Special Needs, health care coordination has been implemented in 41 local and 14 regional public health agencies. A multidisciplinary team of health care coordinators includes community health nurses, social workers, family advocates, speech pathologists, registered dietitians, and a variety of other specialties. The health care coordination team assesses the child's medical and educational needs and then works with the family to produce a plan for care coordination. As the plan is implemented, the team monitors and evaluates the effectiveness of the plan to determine if desired outcomes have been reached.

In New Hampshire, the Department of Health and Human Services district offices have nurse coordinators on staff to ensure that children in foster care and relative home placement are receiving appropriate medical, dental, and mental health care. The nurse coordinator acts as a liaison between those who are involved with the health care needs of the child. This includes all those who are concerned with the safety of the child, including the child's birth and foster family, the child protection service worker, the juvenile probation and parole officer, and the medical community. The nurse coordinator assesses the child's past and current health status in a health care planning meeting and determines the best way to implement the ongoing health care of the child by coordinating both immediate and long-term care.

New Jersey began implementation of mini-health units in each of the local Division of Youth and Family Services offices in 2007 for children in out-of-home placement. Run by nurses, these mini-health units are charged with coordinating medical scheduling, participating in visits and meetings with families and their children, and collecting health records. The health units schedule appointments for initial medical exams, coordinate medical and mental health assessments, and monitor follow-up appointments. Further, they work to ensure continuity of care, which includes continuing care with the child's provider prior to placement, if possible; maintaining a single medical home for the child throughout placement; and ensuring a smooth transition after permanency has been achieved.

3. Health Care Coordination Approaches in New York State

New York State Care Coordination Pilot Project

In an effort to enhance the child welfare system's capacity to identify and address the health-related needs of children in foster care, OCFS developed a pilot project to support the creation of health care coordination programs in eight service providers around the state. Initiated in 2003, these programs sought to improve the health, well-being, and permanency of children living in foster care by designating a particular individual (i.e., a care coordinator) or set of individuals to monitor, coordinate, and facilitate all aspects of a child's health care while in foster care.

Sites were selected to reflect the various geographic areas, levels of care, health service delivery models, and authorized agencies that make up the foster care system in New York State. OCFS provided a conceptual framework and mandatory outcomes for the project, but agencies were expected to work out the details of operationalizing health care coordination within their existing structures. In this way, pilot agencies have paved the road for the implementation of care coordination in other agencies.

Although specific models and operating procedures varied across the selected sites, each of the sponsored programs was designed to enhance the comprehensive identification of children's health problems, timely access to necessary programs and services, health education for staff and families, and communication among health professionals, service providers, and families. Long-term goals included reducing time to permanency and pregnancy prevention.

Participating agencies were: Abbott House, Catholic Guardian Society and Home Bureau, Child and Adolescent Treatment Services, Episcopal Social Services, Green Chimneys Children's Services, The House of the Good Shepherd, St. Vincent's Services, and Kinship Family and Youth Services. The Jewish Board of Family and Children's Services participated for one year.

Funds for the NYS Care Coordination Pilot Project were drawn from the OCFS-administered Quality Enhancement Fund (QEF), which uses Temporary Assistance for Needy Families (TANF) dollars to support the development and evaluation of innovative child welfare services aimed at promoting a family's ability to safely care for children in their own homes and preventing teen pregnancy. Pilot agencies were required to track activities in a database for evaluation purposes.

Anticipated Benefits of Health Care Coordination

The thinking behind the pilot project was that the anticipated benefits from providing health care coordination would be both short-term and long-term. When care coordinators have the management of children's health-related needs and issues as their primary responsibility, they can devote the time needed to arrange and monitor health and health education services, with the goal of identifying and appropriately treating children's health-related issues. Regular, repeated contact with treatment providers may also facilitate the establishment of strong working relationships between a care coordinator and local health care professionals, potentially facilitating timely access to services. Thus, anticipated short-term benefits included:

- an increased likelihood that a child will receive a full array of comprehensive health-related assessments at foster care intake;
- better identification and documentation of health care needs;

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- more timely access to health care and service providers; and
- increased education of and communication among birth parents, caregivers, and service providers regarding a child's health needs and services.

It was felt that improvement of the overall health and well-being of children resulting from the short-term benefits may in the long run promote permanency. Potential long-term benefits included:

- decrease in changes in foster care placement due to fewer demands placed on caregivers;
- reduction in time in placement due to education of birth parents/caregivers about a child's health needs and involvement of family members in the child's health care, addressing a possible barrier to reunification; and
- reduction of risky behavior and teenage pregnancy due to increased access to health education, reproductive services (family planning, gynecological care, etc.), and mental health and/or substance abuse services.

Program Settings, Staffing, and Models

While each participating program served children placed into foster care as a result of child abuse and neglect, the level of foster care in the eight participating sites ranged from regular foster boarding homes to institutional settings. Other differences included: environment (rural, urban), location (upstate or NYC), size and staffing, facility resources, and health services delivery systems. The main characteristics of each program are displayed in the chart on the next page.

The qualifications of care coordinators also differed across sites. Requirements set by the individual agencies for their care coordination staff included: Registered Nurse (RN), Licensed Practical Nurse (LPN), Bachelor of Arts (BA), Master of Arts (MA), Master of Science in Education (MSED), Master of Social Work (MSW), and Master of Public Health (MPH). One agency used foreign-licensed physicians in the process of obtaining licensure in the United States.

To help promote the development of programs that were responsive to local needs and issues, OCFS encouraged the agencies to develop the service delivery model best suited to their target population, staffing resources, and existing operational structure. As a result, each of the eight models in the pilot project is unique. Each reflects the agency's characteristics as well as the creativity and energy of the agency's staff.

“The Care Coordinator has allowed for an additional layer of oversight, and central point of Health information. This has improved communication among the Treatment Team.... As the Care Coordinator has shared her experience with the Social Services department and other clinical and campus staff, there is an increased awareness among staff about medical issues present in our client population.”

Green Chimneys Children's Services

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Agency Settings & Staffing			
Agency	Setting	Health Services Delivery	Care Coordinator Qualifications & Caseloads
Abbott House	Bronx Regular agency-certified and kinship foster boarding homes Short-term diagnostic group homes	Neighborhood-based clinics and hospitals Halfway through project, agency opened an on-site clinic for primary care	Experienced caseworkers with bachelor's degrees Foster homes–1 FTE care coordinator for 35 children Group homes–1 FTE care coordinator for 15 children
Catholic Guardian Society and Home Bureau	Manhattan, Bronx, Staten Island Regular foster boarding homes–most children qualified for special or exceptional board rates Mother/baby group homes	Community health providers	Medical social workers for foster care Registered nurses for mother/baby homes Foster homes–1 FTE care coordinator for 40 children Mother/baby group homes–0.5 FTE care coordinator for 12 mothers and their babies
Child and Adolescent Treatment Services	Erie County–urban and suburban Regular foster boarding homes	Medicaid managed care. All foster children go to one medical home for primary care	Bachelor's or master's degree in social work or related field 1 FTE care coordinator for 30 to 45 children
Episcopal Social Services	Manhattan, Bronx Special needs (medically fragile) foster boarding homes	On-site medical clinic for primary care, dental, mental health	Physicians trained outside of U.S. 0.5 FTE care coordinator for 13 children
Green Chimneys Children's Services	Putnam County–rural, close to New York City Residential Treatment Center for young children	On-site medical clinic for primary care, developmental, dental, mental health	Master of Social Work 1 FTE care coordinator for 15–25 children
The House of the Good Shepherd	Oneida County–small city and rural Therapeutic foster boarding homes Residential Treatment Center	Foster boarding homes used community health providers Residential Treatment Center used on-site clinic for primary care	Master of Social Work Foster homes–1 FTE care coordinator for 30 children Residential Treatment Center–1 FTE care coordinator for 30 children
Kinship Family and Children's Services	Steuben County–rural with children from many counties Therapeutic foster boarding homes	Community health providers Contract psychologist conducts all mental health assessments	Registered nurse Master of Science in Education 2 FTE care coordinators for 30–40 children
St. Vincent's Services	Brooklyn Regular foster boarding homes	On-site medical clinic for primary care, agency mental health and chemical dependency clinics	Medical social worker, registered nurse 2 FTE care coordinators for 60 children

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Despite these differences in program setting and structure, which were evident in the applications for funding, the day-to-day functions of the care coordinator were expected to be similar across pilot sites. In all of the programs, care coordination staff were expected to work with the caseworker assigned to the child's family by the local social service agency, and to assume primary responsibility for managing all aspects of the child's health care.

Managing all aspects of the child's health care includes working with the child's primary care provider and any other health-related providers (mental health, developmental) as well as agency staff dealing with medical issues. Care coordinators were also expected to work closely with other providers such as the Early Intervention (EI) Services Coordinator for children up to three years old receiving EI services and the School Supportive Health Services Program for children with handicapping conditions receiving Committee on Special Education (CSE) services. As educational services and assessments are integral to other health issues, particularly for children with special needs, care coordinators became key liaisons between the agency and the child's school.

Challenges

As with any new approach involving staffing and organizational considerations, challenges will occur in getting the program off the ground and keeping it going smoothly. The agencies participating in the pilot faced several challenges, some of which they shared but dealt with differently. Their challenges are much the same as those that might be experienced by any agency seeking to implement health care coordination effectively. Learning how agencies dealt with these challenges may be helpful to agencies implementing health care coordination.

This section briefly describes each agency in the pilot, the challenges faced by the agency or program, and the solutions used to deal with the challenges.

Primary challenges included:

- Clarifying the roles of the care coordinator
- Handling staff turnover and retention
- Establishing relationships with casework and supervisory staff
- Meeting the needs of children
- Gaining trust and involvement of birth parents
- Obtaining health records from providers
- Accomplishing data collection and input for the pilot

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Agencies and Their Solutions

Abbott House

Abbott House provides several levels of foster care: foster boarding homes (FBH), including kinship and emergency; therapeutic foster boarding homes (TFBH), group homes, and a residential treatment center (RTC), as well as diagnostic reception centers. Abbott House serves metropolitan New York City and the surrounding counties. The main agency offices, located in Westchester County, have a medical department and dentist. However, it is not practical for foster parents in the Bronx to bring children there for care, so community health care services were used at the inception of the project.

Care coordinators were employed for the Bronx foster boarding home program initially, and later for the short-term, diagnostic group home program as well. Experienced, motivated foster care caseworkers were selected from existing staff for these positions. A nurse devoted part of her time to providing technical assistance to the care coordinators.

Even before participating in the pilot project, Abbott House had been providing health care coordination for children in its foster boarding homes, but there were challenges in fulfilling this function for children receiving health care services in the community. It was difficult for foster parents to access health care (e.g., for initial assessments) on a timely basis and there were problems from both sides (foster parents and providers) in obtaining medical documentation of appointments. Halfway through the project, it became apparent to the agency that there was a need for on-site services, and they opened a medical clinic in the Bronx office and contracted with a mobile dental van.

Some adjustments in staffing were made to fully integrate the health care coordination function into the programs at Abbott House. The care coordinators now took on the responsibilities for all medical, mental health, developmental, educational, and dental assessments and treatment. Since foster care caseworkers were previously responsible for these functions, they—along with foster parents and birth parents—were confused about the role of the care coordinator. “This adjustment within the organizational structure had an enormous impact on Abbott House and the children served within this project,” reported the medical director.

Solutions: The medical clinic and dental van provided the opportunity for a full health care coordination function to operate successfully and as a team (medical director, nurses, and health care coordinators). Establishing an on-site clinic addressed the two issues of access and documentation: the agency was now able to provide timely initial assessments and to schedule child/parent medical visits. Routine visitations between birth parents and their children were scheduled at the Bronx office for clinic days. This way, parents were able to attend the clinic appointments and learn about their child’s health needs without making an extra trip.

To clarify their roles, the care coordinators and caseworkers held weekly team meetings to update one another on their areas of responsibilities. Each child’s status was reviewed once a month. These team meetings became one of the most critical elements in the success of care coordination at Abbott House. To reduce any confusion among foster parents and birth parents, the care coordinators attended the 72-hour conference to introduce themselves and explain their role in the case. The care coordinator accompanied the caseworker on home visits to the foster parents and birth parents to speak about the health and educational needs of the children and support communication among the parents.

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As an agency that contracts with the New York City Administration for Children's Services (ACS), Abbott House must comply with ACS requirements. The health care coordinators identified and used community providers that were willing to follow the rules and regulations set forth by ACS and provide the agency with necessary documentation. Mandated contacts with foster and birth parents were increased as a result of the care coordinators' involvement.

Abbott House will continue to use the health care coordination, incorporating the position into ACS' new Improved Outcomes for Children (IOC) model.

Catholic Guardian Society and Home Bureau

In 2006, during the period of the pilot project, the former Catholic Guardian Society merged with Catholic Home Bureau, forming a large foster care agency offering foster family care and group homes along with supportive services primarily serving Manhattan and the Bronx through five community-based centers. The congregate care program serves youth in four boroughs.

Catholic Guardian's care coordination services were integrated into the agency's existing range of services, using such approaches as early engagement and intervention along with family involvement in services and planning. Most of the many tasks of care coordination were completed during interactions with birth parents, children, foster parents, child care staff, caseworkers/supervisors, and medical, mental health, and educational providers.

The care coordinators assigned to the mother-child group homes were experienced registered nurses who enjoyed the challenge of working with youth in foster care. The nurses conducted all initial assessments except mental health, which were completed by a psychologist.

The care coordinators assigned to the foster boarding home (FBH) program were medical social workers who worked closely with the nurse assigned to the cases on their caseload. This allowed for adequate monitoring and consultation on health and mental health issues with health care providers. Children selected for participation in the project were already in foster care, rather than new admissions. The care coordinators focused on working with the birth parents to increase their involvement with the children and capacity to bring them home.

Solutions: The establishment of a designated care coordinator supervisor at the Washington Heights site was instrumental in providing ongoing supervision of the care coordinators; monitoring so that all assessments were completed within the required time frame; and calling team meetings to discuss issues around case planning, problem-solving, and rectifying organizational problems such as staff shortages and turnover.

It took some time for staff and families in the Washington Heights site to understand the role of the care coordinator. Over time, the care coordinators were able to establish non-threatening relationships with birth parents: they advocated for birth parents, included them in decision-making, educated them on the health needs of their children, and helped them obtain medical and mental health services. The care coordinators complemented the caseworkers so that together they were effective in working with the children, foster parents, and birth parents. Foster parents were educated on the health needs of the children in their care, asked to attend all medical appointments, and encouraged to partner with the birth parents around medical care.

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The most important challenge for the care coordinator for the mother/child group homes was to establish a relationship with the teen mothers. The coordinators used a variety of ways to build this relationship, including group meetings focused on activities with infants, nutrition, and safety in the home. The care coordinator encouraged expression of feelings and provided emotional support while teaching healthy behaviors in a nonjudgmental fashion. Fathers were encouraged to be involved. During the project, sexual acting out and subsequent pregnancies were significantly reduced.

Catholic Guardian Society and Home Bureau will continue to use the health care coordination model by incorporating the costs into their Medicaid per diem.

Child and Adolescent Treatment Services

Unlike the other health care coordination contractors, Child and Adolescent Treatment Services (CATS) is not an authorized foster care agency. CATS is a community organization that provides counseling and treatment services in accessible, child-friendly offices throughout Erie County, as well as in schools and other community-based settings. The staff of multidisciplinary mental health professionals provides specialized programs for children with emotional disorders, victims of physical and sexual abuse, suicide prevention, and violence prevention, as well as guidance for parents. This care coordination model comprised an agreement between a Medicaid Managed Care Plan and a large urban county social services agency.

The care coordination program, known as Care4Kids, is a Medicaid Managed Care Plan under the auspices of CATS. Prior to this project, the Child Advocacy Center (CAC), also a part of CATS, conducted sexual abuse exams for chronically abused children, as well as pre-placement foster care physicals. Through Care4Kids, the CAC was established as the medical home for children in direct care with the Erie County Department of Social Services (DSS). Virtually all children entering foster care in Erie County receive comprehensive medical, dental, and behavioral health assessments through the CAC. With access to the agency's on-site medical and mental health professionals, the Care4Kids program could provide children in the pilot quality comprehensive medical care through 30-day follow-up examinations, improved recordkeeping, and a focus on the need for early mental health assessments.

Solutions: The most difficult challenge was clarifying the role between CATS and Erie County DSS. As an outside organization, CATS was providing services to children not directly in its care. At times, children were moved without notification to the care coordinator, contact information on birth parents was not available, and caseworkers did not understand the care coordinator's role in the service plan review. For this model of care coordination to succeed, a liaison is critical: Erie County DSS provided a liaison who helped implement the program and explained it to caseworkers and other DSS staff.

One staffing challenge involving delays in hiring a health care coordination supervisor was solved by reconfiguring the position from a nurse to a master's level human services candidate. Staff included two social workers (one a medical social worker), nurse manager, and a secretary.

Over time, as the care coordinators made connections with health care providers in the community, the children were more likely to be seen more quickly; as a result, foster parents overcame initial resistance to the "extra work" coming from the care coordinators and began to understand their role and see them as being supportive to them as well as to the children. Erie County caseworkers also began to be aware of and appreciate the work being done on behalf of the children in their caseload by care coordinators.

Health Care Coordination for Children in Foster Care

Another challenge was the delay in Medicaid coverage for some of the foster children in the pilot. The delay caused problems in accessing necessary referrals for mental health counseling and other specialty care services such as vision and eye glasses. This was addressed by notifying Erie County DSS caseworkers of the delay.

Upon completion of the pilot project, the medical component of Care4Kids will continue in that all children entering foster care will receive a pre-placement physical and 30-day recheck at the Child Advocacy Center. If possible, Erie County DSS will pick up the care coordination component.

Episcopal Social Services

Located in Manhattan and the Bronx, Episcopal Social Services offers foster care, adoption, and preventive services, group homes, Early Intervention services, and Early Head Start, among other programs. Two on-site medical clinics provide a comprehensive range of health services: pediatric medicine, child psychiatry, child psychology, dental services, and services for vision, hearing, sex education, and immunizations.

Because Episcopal Social Services made education of the caregivers and birth parents the overarching goal of their project, health care coordinators were called health educators. The children receiving care coordination services were medically fragile; some of the presenting problems included HIV infection, shaken baby syndrome, seizure disorder, diabetes, sickle-cell disease, autism, and cerebral palsy. Though primary pediatric care, including dental and mental health, was provided by agency clinics, these children needed care from medical specialists in the community. The health care coordinators served as liaisons between hospital staff and parents (birth and foster).

Solutions: To help prevent multiple transfers from one foster home to another, the families received close supervision and support. Birth parents and foster parents were given a thorough explanation of the children's conditions and provided the opportunity to ask questions and get answers. To increase health knowledge and engagement with the child, the health care coordinator insisted that foster parents go to all specialty appointments. The care coordinators worked closely with the social work staff, conducted monthly home visits, addressed language barriers, advocated for the children, and facilitated compliance with treatment recommendations.

The agency medical director, who is board certified in pediatrics and child psychiatry, occasionally called specialty physicians directly to break through bureaucratic barriers in obtaining necessary services for these children.

The most important challenge was to verify that each child was safe in an environment that allowed for personal growth and a healthy lifestyle. This challenge was addressed by providing education for caregivers and birth parents on the type of care needed for medically fragile children. When given a comprehensive understanding of the child's needs and the necessary skills to address those needs, foster parents have the confidence and support to maintain the placement, and birth parents can work toward the child's return home.

The care coordination model continued at the agency upon the pilot's end.

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Green Chimneys Children’s Services, Inc.

Green Chimneys operates residential treatment for children and a special education school on a 200-acre farm in Brewster, NY. The agency offers specialized treatment and educational and recreational services to children in New York City, upstate New York, and western Connecticut. Using animal-assisted therapy, the Farm & Wildlife Rehabilitation Center is an important component of the treatment program. Green Chimneys provides extensive structure and support to children aged 5-13 (upon admission) with diagnoses such as Attention Deficit Hyperactivity Disorder (ADHD), Asperger’s Syndrome, Pervasive Developmental Disorder, Anxiety and Social Phobia, Post Traumatic Stress Disorder, Reactive Attachment Disorder, and Oppositional Defiant Disorder.

Through the project, an MSW became the health care coordinator for a group of 25 children with a high level of medical, mental health, and developmental needs. A population of mostly girls (aged 5 to 14) was identified for care coordination. Health care needs of the children are addressed on campus. The Health Center provides medical, dental, developmental, and mental health services for residents, and children attend an on-campus school. The care coordinator focused on communication issues. She provided a central point of health information, increased communication among the treatment team members, increased awareness among casework staff about medical issues, helped train clinical staff to work more effectively with families, and bridged the gap between school staff and cottage staff.

Solutions: Prior to implementation of care coordination, a social work model of care was in place. Each child was assigned a social worker who provided therapy, worked with the family, and completed caseworker duties. The care coordinator took over some of the duties that would typically be done by a caseworker, such as oversight of all medical and health services, liaison with ACS/DSS case planners, and discharge planning. The result was a dual track approach that clarified and defined roles. Social workers now provide family and group therapy, and caseworkers attend case conferences and provide other common casework functions.

To address the fact that because the agency had a higher population of boys than girls its services were geared more toward the needs of boys, the project brought a focus on activities that would encourage girls’ self-esteem. While living at home, many of these girls were exposed to domestic violence, witnessed sexual activity, and/or were victims of sexual abuse. Targeted activities provided them with appropriate role models, information on healthy development, and self-esteem.

Having a health care coordinator has also allowed for a clear role—a person that others can go to regarding coordination and communication between clinical/health staff, education staff, and caseworkers, as well as parents. The health care coordinator successfully opened lines of communication between the agency and their outside contractor for substance and “children of abusers” services. She provided feedback to the agency from the birth parents around issues of health care management. She also assisted in identifying the need for a different level of care when appropriate, and developed discharge plans.

The health care coordination model has continued at Green Chimneys.

The House of the Good Shepherd

Located in Utica, The House of the Good Shepherd (HGS) provides residential care including a residential treatment center and group homes, as well as foster boarding homes and preventive services in the surrounding counties. The agency’s Health Department provides pediatric health services for children

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living on campus; a nurse coordinates health care with primary care providers in the community for children in foster boarding homes.

The care coordination project focused on the children who would be most likely to benefit from aggressive coordination of services. Children selected displayed evidence of serious mental health disorders or severe dysfunction. Two master's level social workers served as care coordinators—one for the therapeutic foster boarding home program and one for the Residential Treatment Center (RTC). These coordinators were responsible for a plan of care that ensured that services provided by a multi-disciplinary team of social work, educational, medical and residential staff or foster parents were delivered and communicated in a timely, organized, and coordinated fashion. Even though the youth in the RTC received health services on campus and the children in therapeutic foster care received care in the community, the care coordination functions were similar.

Like Green Chimneys, the House of the Good Shepherd used a “primary therapist” model, wherein one individual was responsible for all aspects of the child's treatment. Handing health concerns over to the new care coordinators was a significant change, but benefits to the therapist became quickly apparent.

Solutions: Although nursing and therapist staff had undertaken many of the care coordination tasks before the project began, the formalization of the care coordination roles resulted in a stronger program in delivering educational services such as pregnancy prevention (through a contract with Planned Parenthood) and substance abuse education. Weekly communication with service providers, attendance at treatment planning meetings, and supervision with staff were required so that service needs were met.

The RTC care coordinator initiated regular team meetings among the clinicians and residential supervisors that helped to address treatment challenges, increase communication and coordination, and provide greater opportunity for successfully maintaining stability in placement. As a result of the pilot project, treatment team supervisors now oversee the work of the therapists in the RTC.

While care coordination as described above did not continue after the pilot, it set the stage for more collaboration between clinical and social work aspects of treatment. The nurse practitioner now participates in treatment planning and is involved in many of the activities that had been completed by the care coordinator.

Kinship Family and Children's Services

Kinship Family and Children's Services offers residential care, preventive services, therapeutic foster care, child health care, and parenting skills education throughout the rural Finger Lakes and Western Regions of New York State. The agency is a division of Catholic Charities of Rochester, Inc. Except for mental health services, which are available through contract, health services are provided in the community.

This is a small agency and children come from several surrounding counties. All children placed in the therapeutic foster boarding home program received care coordination services. Due to the geography in this area of the state, transportation to medical appointments was a challenge.

With the goal of providing services to children with severe mental health and behavioral needs living in therapeutic foster care, the RN care coordinator shared responsibility with an education specialist with a master of science in education (MSED) degree. Responsibilities were differentiated: the RN became responsible for coordination of services, documentation, tracking, and oversight of health services, while

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the education specialist focused on areas of special need such as special education and birth parent involvement.

Solutions: After some organizational adjustments, it became apparent that it would be more effective to divide the responsibilities between the RN and MSED staff. Rather than maintaining their own caseload, the two care coordinators worked collaboratively with all children in the program. This division of roles worked well to facilitate continuity of health care and sharing of accurate information with all involved in the children's care.

The challenge of documenting and tracking health services by agency staff, foster parents, and birth parents was addressed by frequent phone calls and reminder letters. Kinship developed a brief form that foster parents bring to medical appointments. The health provider fills it out and it becomes a record of the appointment. Samples of these forms can be found in the manual *Working Together: Health Services for Children in Foster Care* at http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp

Care coordinators were invited to attend weekly team meetings that reviewed placement referrals, new admissions, discharges, moves, and health-related issues. The care coordinators assisted in identifying appropriate placements for children coming into the agency. In one case, contact by the care coordinators resulted in a birth mother providing transportation to her daughter for health appointments while the child was in care. As a result, the mother was effectively engaged in family counseling and the child was discharged earlier. The project as a whole resulted in significant reductions in movement while in care and quicker discharges.

The care coordination team continued to serve the children at Kinship for another year after the pilot ended.

St. Vincent's Services

St. Vincent's Services offers a broad array of services including foster care, group homes, a program for children with AIDS and other medically fragile conditions, a licensed mental health and chemical dependency clinic, and services for the developmentally disabled. The agency is located in Brooklyn and serves all of New York City.

The medical caseworker (social worker) and RN worked as a care coordination team to serve large sibling groups, teen mothers with their children, and adolescents. As the program progressed, children with more intense medical needs were added to the group served. They described their service population as those "children who are falling through the cracks." The associate director of the Medical Department directly coordinated the project and held weekly team meetings, which included data entry staff, who were integral to the project. Identified needs were to involve more birth parents in their children's health care, increase discharge planning services, better engage the teen population to prepare them to address their own health needs, and educate birth parents and foster parents on health care issues.

Solutions: Initially uncertain of the project's impact, eventually casework staff welcomed the interventions of the medical caseworker in several areas: decreasing the caseloads of existing staff, providing comprehensive case management to families and better quality of service including specialty care, and meeting mandated requirements.

Data entry staff handled documentation requirements and also helped the care coordination team to assess the service provided and identify needs.

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To enhance training of youth and parents, the project obtained a portable DVD to facilitate educational activities. A system was put in place for rescheduling missed appointments and providing follow-up, including a reward system. To encourage going to the dentist, the care coordinators initiated “dental dates” in which children were rewarded by going out to lunch or receiving special attention from staff in conjunction with their dental appointment.

The more intense case management provided resulted in many children feeling comfortable enough to reveal past sexual abuse, which could then be addressed. As with many agencies, St. Vincent’s found that heightened awareness and communication resulted in more identification and quicker intervention for health issues. Some children were transferred to the specialized medical program to provide a higher level of service.

St. Vincent’s is unable to maintain the intensity of case management in the pilot project. However, second year MSW students will become a part of the medical department.

Benefits of Health Care Coordination in Pilot Programs

According to one pilot agency, “Overall, the significant benefit of enhanced health care coordination is a magnified focus on the health care issues of children in care, which has resulted in rapid identification of health needs and establishment of health services, improved communication among various entities (health and mental health providers, developmental and special education services, pediatric subspecialists), improved compliance of foster parents, and involvement of birth parents.”

The program evaluation of the pilot project documented the following program benefits:¹

- Higher rates of initial assessment completion and timeliness. Following establishment of their care coordination programs, sponsored agencies significantly increased the number of children under their care who received initial physical, dental, mental health, developmental, and substance abuse assessments within state recommended time frames.
- Better identification of health care needs. Children were more likely to have documentation of physical, mental health, developmental and educational problems diagnosed and/or identified by a health care professional.
- Improved documentation of access to health care professionals. Documentation of well child care, preventive dental exams, mental health therapy, Individual Education Plans, and Early Intervention service receipt was significantly higher for children in care coordination.
- Increased communication with service providers and caregivers. Care coordination staff had more contact with birth parents, foster parents, and service providers about a child’s health-related needs than foster care staff working without health care coordination.

In addition to the evaluation findings, the pilot sites reported that enhanced attention to health services resulted in benefits at the institutional level. Participants were motivated to shift their broader agency culture to a more integrated, health-oriented model of service delivery. As a result, some agencies designed new mechanisms for gathering and tracking health care information; developed assessment

1 NYS Office of Children & Family Services. *The New York State Care Coordination Pilot Project: Process & Impact Evaluation Study Findings* (March 2007). Available at <http://www.ocfs.state.ny.us/main/reports/>

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protocols for new admissions; enhanced parent education services; established agency-community provider partnerships; and established or improved on-site health facilities. Many agencies noted that the project was instrumental in identifying service gaps, preventing issues from falling through the cracks, and reducing duplication of effort. Care coordination staff also acted as a model for other agency staff, piloting and sharing new ways for addressing health issues.

Agencies found that health care coordinators served as an additional support to caseworkers and birth parents alike. Caseworkers became comfortable with care coordinators addressing all aspects of health care. Birth parents perceived the care coordinators as a nonthreatening resource within the agency. Trust was built between birth parents and care coordinators as both focused on the child's well-being and worked together to understand and support the child.

“Having a dedicated person (Care Coordinator) who can ‘shepherd’ and monitor the completion of evaluations and subsequent follow-ups has been particularly valuable in the physical health area. Our experience is that we have more timely completions of evaluations and a much tighter process of ensuring that follow-up treatments are provided. As an indirect result, we have also revised our physical health assessment form to be much more comprehensive and in line with the Working Together manual.”

The House of the Good Shepherd

4. Guidance for Agencies Implementing Health Care Coordination

Health care coordination will look different across New York State because of the variety of health service delivery models in our agencies and local departments of social services. In planning implementation, agencies should consider a variety of factors, including available resources. Two important factors to consider are how health services are delivered to children in foster care, and how the agency currently monitors or oversees the services.

Health Services Delivery

Children in foster care receive medical care in a variety of ways. Methods of communication and collaboration between the provider and care coordinator will differ across these models. Some typical health delivery models include:

- **Community providers.** Children in foster homes receive their care from providers within the community. These may include doctors and clinics that the foster parents or agency know to be reliable and familiar with the needs of children in foster care. Typically, the foster parent accompanies the child to the appointment, keeps track of appointments, and informs the caseworker about the outcome of the appointment.
- **Agreements with providers.** The LDSS or voluntary agency may have agreements or contracts with community or hospital-based providers to serve children in foster care. For example, a specific psychologist may contract with the agency to conduct all initial mental health assessments, or a mobile dental van may be engaged on a regular basis.

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- **Agency clinic.** The LDSS or agency may operate its own medical clinic for children in care. Children may still use community or hospital providers for specialty care.

Oversight

The coordination, monitoring, and oversight of health services are dependent on the staffing model at the agency or LDSS with whom the child is placed, as well as the level of care. Identifying individuals who are currently carrying out the care coordination activities is an important step in determining what changes, if any, will take place. Typical oversight models:

- Foster parents may play a major role by scheduling appointments, accompanying the child to appointments, and advocating for specialty services. The foster parents keep the agency informed of health-related activities.
- The case manager or caseworker may be responsible for arranging and reminding caregivers of appointments, assisting with transportation, and obtaining copies of records.
- The agency may employ health care coordinators and/or nursing staff that track attendance at appointments and review records to determine what additional services are needed. This model is often employed in congregate care settings.

Critical Elements

Although the models created varied, the pilot agencies agreed that certain activities were critical to the success of their health care coordination projects.

- **Designation of care coordinator.** The single most important factor in the success of health care coordination is the designation of an individual whose sole responsibility is care coordination. That person is freed from the many tasks, concerns, and responsibilities that foster care staff must address. The care coordinator can simply concentrate on the child's health and well-being.
- **Organizational support.** The decision to incorporate health care coordination for children in foster care must be supported by administrators and managers throughout the organization.
- **Clarification of roles.** Staff must understand which activities will now be performed by the care coordinator. Among other things, the care coordinator's role in service plan development and review, and working with foster and birth parents should be clearly defined.
- **Team meetings.** Pilot agencies found that regular team meetings with health care coordinators, caseworkers, supervisors, and in-house medical staff were instrumental in sharing information and fully integrating health issues into the child's service and permanency plans.

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Activities That Benefit the Agency

Depending on the size, capacity, and experience of the staff responsible for health care coordination, additional support may be provided to the agency in a variety of ways. These include:

- Coordination of training efforts around health topics. Both caseworkers and caregivers need information about the unique health care needs of children in foster care. Community health providers may also appreciate information on child welfare issues to help them understand the children they are serving. Health care coordination serves a central role in identifying, arranging, and tracking the provision of health training and education.
- Consultation and advocacy on special medical issues.
- Assistance and support for the caseworker around special services such as Early Intervention (EI), Bridges to Health (B2H), or the Committee on Special Education (CSE). More information on these services can be found in the manual *Working Together: Health Services for Children in Foster Care*. http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp
- Documentation and update of agency protocols and procedures. These may address topics such as confidentiality, maintenance of the child's medical record, billing procedures for providers and emergency rooms, protocols around the use of psychiatric medications, or the development of specialized forms or systems for tracking health activities.
- Monitoring and evaluation of the overall quality of health services provided to children in foster care. This information can prove valuable in overcoming barriers to optimal health services. It can also inform management and local government on the strengths and areas for improvement in the local health care delivery system. State, county, and voluntary agencies should cooperate in the development and implementation of Quality Improvement Programs for health services for children in foster care.

Getting Started

After consideration of the health services delivery model, current practice, and resources, your agency may choose to delegate some health care coordination activities to designated staff. It is recommended that a lead person with a health background be identified to provide or assist with health care coordination. This individual may be an RN, LPN, psychologist, LCSW, LMSW, or social worker with experience in addressing the physical and mental health needs of children in foster care. If the individual does not have training or experience in a health field, health practitioners should be identified to provide technical assistance.

A starting point allows for agencies to learn how this function would work in their environment and with their own model of health care delivery. Here are some suggestions for implementing care coordination on a limited scale:

- Start small. Have one care coordinator work with a couple of caseworkers in one unit with a supervisor that supports the concept.

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- Pilot agencies identified the population most likely to benefit from care coordination to be children in foster homes receiving health services in the community. Start with this group.
- Target only the neediest children. Identify children with the most complex health needs or those in a special program within your agency for care coordination.
- Target service gaps. If a specific issue has been identified, such as birth parents not understanding their children's health needs, focus care coordination on that issue.
- Limit the length of time that care coordination services are provided. Have the care coordinator be responsible for newly admitted children receiving timely assessments, identifying specialty providers, and verifying that a service plan is in place, then give oversight responsibility back to the caseworker.

Asked about the impacts of the health care coordination pilot, one agency noted, "This program has helped us ensure that families have access to the services needed as quickly as possible without unnecessary barriers or duplication." Such an outcome is desirable in all areas of our work to benefit the health, safety, and well-being of children in foster care. If care coordination can have this impact in the area of health, it is well worth the effort and time to set up and incorporate within our agencies.

"Oversight and implementation of care coordination provided higher standards and accountability for those involved in the health care needs of children in our program. Duplication of services decreased, accurate healthy history and information was obtained and shared with all persons involved in the care of the child. Positive relationships were established and maintained with service providers, which improved communication and quality of services which resulted in improvement of services our children received."

Kinship Family and Children's Services