

**New Jersey
Department of Children and Families**

**Coordinated Health Care Plan for
Children in Out-of-Home Placement**

May 22, 2007

Executive Summary

After extensive study, DCF proposes in this report a model of coordinated health care for children in out-of-home placement which emphasizes:

- Care should be provided in a manner sensitive to the child.
- Continuity of care is critical and will be managed by child health units providing health care case coordination in each of the Division of Youth and Families Services (“DYFS”) local offices.
- Children’s access to care requires expansion of existing providers statewide and flexibility in the service delivery model which will be addressed through contracting via a public Request for Qualifications Process (RFQ) in June 2007.
- Health care planning must be integrated into permanency planning for children in out-of-home care.
- Success requires real partnership between state agencies, with and among providers, and with the child and family team.

Introduction

The well-being of foster children requires timely access to quality health care. Over the past year, the Department of Children and Families (“DCF”) has assessed the provision of health care services for children in placement to construct a statewide plan for better meeting the health care needs of children in custody. This report details the assessment and DCF’s plans for implementing improvements in its health care delivery system for children in out-of-home placement.

The assessment, described below in more detail, revealed that foster parents are doing a far better job than had previously been known in ensuring that children in placement receive routine medical care. But the critical issues remain the negotiation of a statewide health care system which one report described as “fragmented” (Glied 2005) and which struggles with the full range of access challenges to pediatric and adolescent primary care, including the location and access of care sites, long appointment and office waiting times, insufficient provider time and other signs that the outpatient delivery system is stressed (Vali 2001).

The heart of DCF’s plan for health care reform for children in out-of-home placement is a commitment to build the capacity to provide strong coordination of children’s health care needs and services within the 47 DYFS local offices. Beginning in July, with implementation rolling out over the next year, each local office will begin to build its own child health unit, led by nurses charged with ensuring continuity of care for children in DYFS custody. Concurrently, DCF is expanding access to health care by committing to issuance of a Request for Qualifications next month which will broaden the array of medical providers

available to offer services to DYFS children. Throughout, DCF is working closely with the existing range of providers to improve access to critically needed services.

DCF is working closely with its primary state partners – the Department of Health and Senior Services and the Department of Human Services – to address the systemic issues which affect both access to and quality of care for children in placement – and indeed all children, especially all poor children, in the State of New Jersey. Together, these agencies are working to tackle such challenges as enrollment for foster children in health insurance programs, designing and making easily accessible updated health care forms, coordinating lead case management for children, auditing the quality of existing services, and exploring opportunities to broaden access. New Jersey Governor Jon S. Corzine has provided critical leadership across the board, including addressing the need to increase support for pediatric sub-specialty services by proposing a targeted increase in pediatric Medicaid rates in his FY 08 budget.

While in 2006 and early 2007, DCF has focused on the fundamental building blocks of change to the child welfare system, the hardest work remains ahead. In the health care arena, the instinctive aspiration is to have achieved perfect implementation yesterday. But implementation of such significant system changes will take time and require resolve. Demanding too much change too fast is, as shown by previous experience, a clear recipe for failure. This plan represents the commitment to move significantly forward in delivering on the promise of ensuring access to quality health care for children in DYFS custody.

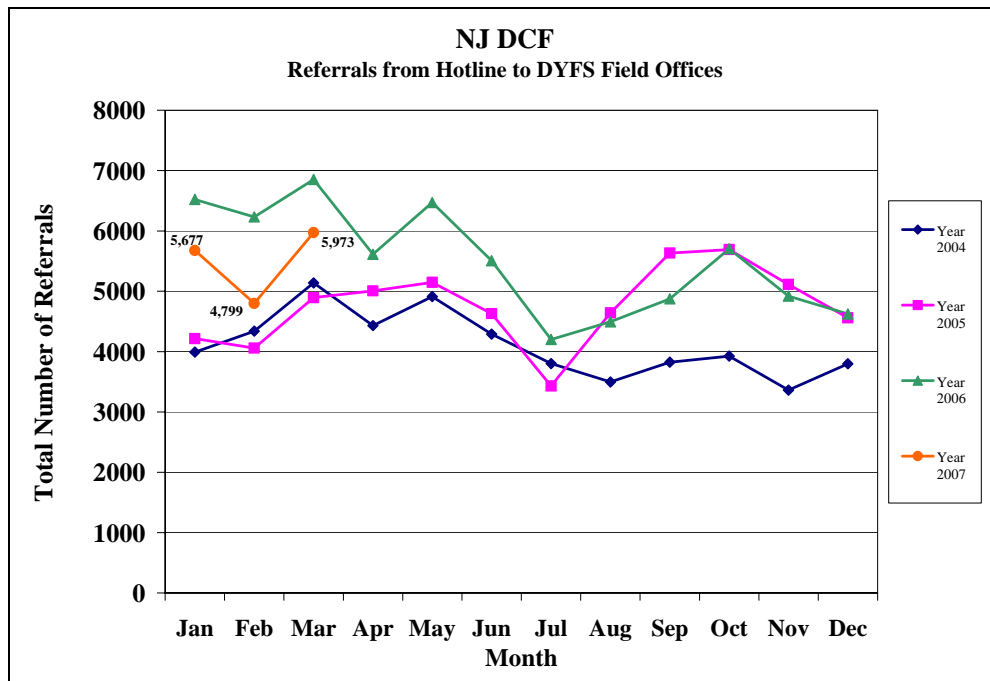
Setting the Stage: Delivering on the Fundamentals

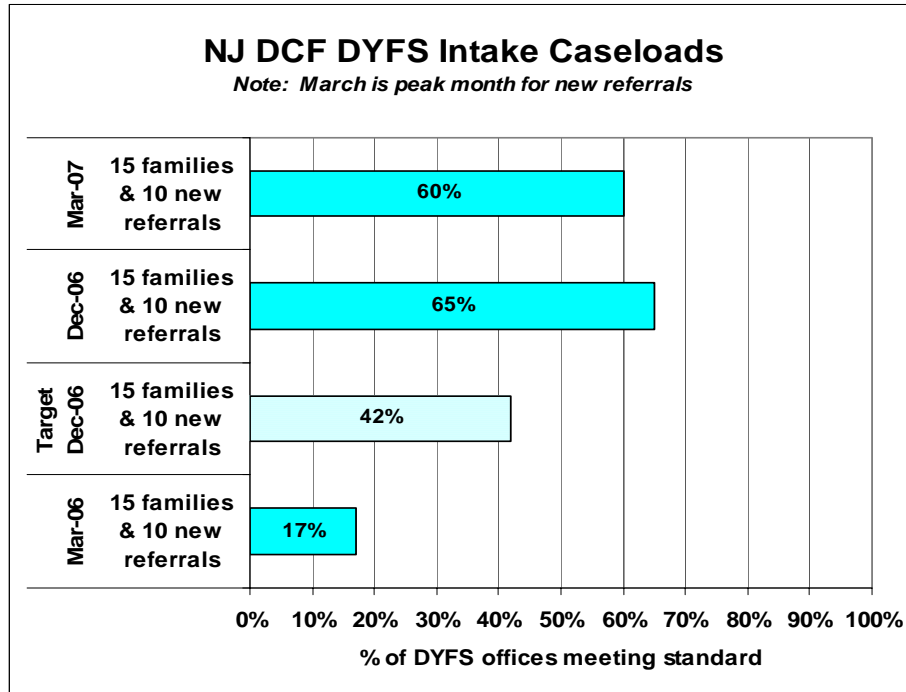
Some of the basics of child welfare reform – lowering DYFS caseloads, stabilizing the organization's direction and leadership, delivering tools and supplies to staff, expanding the pool of resource families – have to be tackled if health care reform for children in out-of-home placement is going to succeed.

In 2006, DCF focused on improving these fundamentals. For New Jersey, the challenges began at the start of our interaction with children, within the DYFS intake units. Intake caseworkers, partnering with permanency staff, play a pivotal role in the quality of health care delivery for children entering placement. They have the first contact with a child and so have a range of health care related responsibilities including collecting initial health information, accompanying the child to the pre-placement assessment, and often arranging for the child's first comprehensive medical exam. At the start of 2006, DYFS intake staff was operating under severe strains. Over 80% of them in March 2006 worked in offices that could not meet intake caseload standards. They were investigating referrals at historically high rates. Many lacked basic equipment such as operating cars and cell phones. So it was not surprising that these same staff were struggling to get medical records, struggling to schedule medical exams, and relying on

transportation staff or foster families to attend children’s comprehensive health exams.

Several studies, including one by the Office of the Child Advocate (December 2005) and another by Dr. Thomas Lind of the CARES Institute (May 2006) highlighted the fact that DYFS staff have not been participating at the desired level in health care delivery, but were instead too often having to rely on transportation aides to take children to appointments, too often sending those children to exams without medical records, and too often delayed in scheduling both the initial and follow-up exams. These studies, and internal reviews, tell the same story again and again, and make it clear that DCF has had to address the basic needs of DYFS caseworkers in 2006 as part of a plan to address health care for children in 2007 and beyond.





As of March 2007, even as DYFS intake staff tackled the third highest number of referrals in the agency’s history, caseloads have improved significantly. Indeed, DYFS caseloads have been halved and there has also been substantial caseload improvement for DYFS staff engaged in ongoing permanency work. Cars were ordered, mechanics made more available, and cell phones made operational. After two years of net negative losses in resource families, 2006 saw the first net increase. The first quarter of 2007 proved even more bountiful, exceeding in that first quarter all of the gains achieved in 2006. Much remains to be done, but these critical improvements help set the stage for DCF to support improvements in its health care delivery system for children and, consequently, improve childhood well-being outcomes. The reform is rooted in these values:

Values

Care should be provided in a manner sensitive to the child:

- Avoid compounding trauma.
- Minimize intrusion.
- Avoid repetitive and any unnecessary testing.
- Utilize familiar providers whenever possible.

Continuity of care for children is important:

- Children’s median length of stay in out-of-home placement is currently 11 months, so DCF needs a system of care that incorporates coordination across transitions - transitions coming into care, during care, and transitions to permanency.

- DCF prefers providers who can serve as a medical home for a child.
- DCF recognizes that some providers serve a critical consultative role, the best example of which are the state's hospital-affiliated Regional Diagnostic and Treatment Centers ("RDTCs"), and that consultative role is best fulfilled if the provider is committed to cooperating in the provision of follow-up care.

Access to care is important:

- Children, their families, and DCF staff should not have to travel for more than an hour to receive routine medical care, including comprehensive health exams. Recognized exceptions would include the need for a child to see a specialist or if such travel helped preserve a pre-existing relationship with the child's own medical provider.
- Whenever possible, a child should receive health care in his or her own community and from his or her own provider, if that provider can continue to provide the necessary quality care. In the event the child needs to see a new provider, that provider should be selected with an eye towards continuity of care, both during the child's stay in placement and upon achieving permanency.
- DCF favors providers who have the capacity to serve our children based on their needs. DCF values providers who can schedule emergency consultations immediately, who can conduct pre-placement health assessments in non-emergency room settings in the 24 hour window around a child's entry into care, who can schedule comprehensive medical exams within a thirty day timeframe, who can provide reports in the timeframes needed to inform decisions about the care and legal status of a child.
- DCF recognizes the need to develop strong internal coordination capacity. DCF must be able to ensure the prompt scheduling of necessary health care appointments, the coordination of transportation and the participation of key adults and provision of critical health information at exams (and so reduce "no shows"), tracking of the provision of follow-up care, and integration of health planning and information into the child's overall case plan.
- DCF recognizes that our DYFS caseload carrying staff cannot do this work alone. They need to have appropriate caseloads so they can pay sufficient attention and provide support.

Quality of care is important:

- DCF expects its children to receive high quality medical care.
- DCF expects its children to receive care in a culturally competent manner which is sensitive to the particular needs of a most vulnerable population.
- DCF will contract with its providers to ensure data is collected to monitor health care outcomes for children in out-of-home placement.
- The quality of the care provided to foster children should be monitored through the routine collection of data from providers, both quantitative and

qualitative; through health care audits conducted by DCF, Medicaid, and other qualified stakeholders.

Integration:

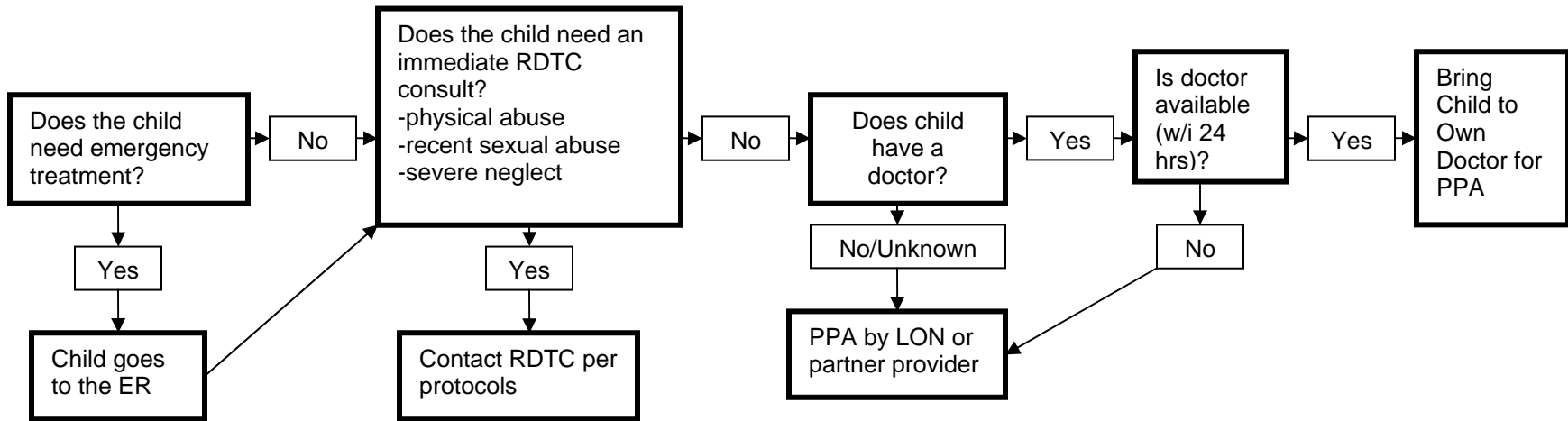
- Attention to health care needs to be integrated into services to the child as a whole.
- Collection of health care information should be integrated into existing opportunity moments, including family meetings.
- Reductions in caseloads and the creation of supports such as child health units in each office will take time but are critical if we are to build a robust health care delivery system for our children that is sustained.

Partnership:

- DCF cannot do this alone and previous attempts to solve this challenge solely with internal resources have not succeeded and cannot succeed.

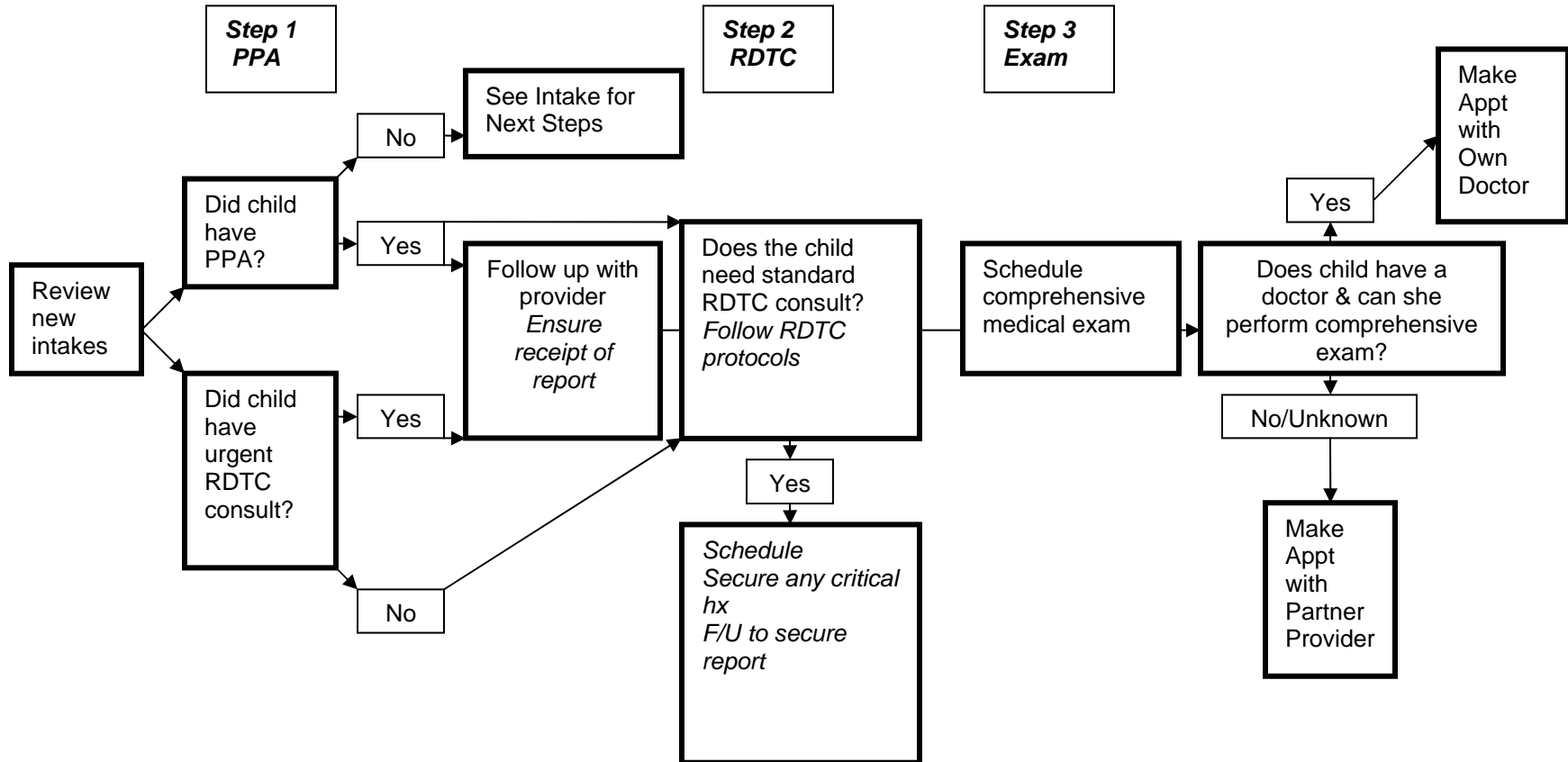
PLACEMENT

DYFS Staff Determines Child Unsafe at Home
If possible:
-packs
-gathers any medications
-asks parent/guardian for child's doctor contact info



CHILD HEALTH UNIT CHU

1-5 Nurses (depending on # of children in placement)
2-4 Admin Support (scheduling, medical record gathering, data collection, customer service)



DCF's Health Care Assessment

The process of planning this reform of the health care system for children in placement began with an assessment because surprisingly little was known about many elements of the existing health care delivery system. In addition to a review of previously published reports, described throughout, the assessment utilized three different tools:

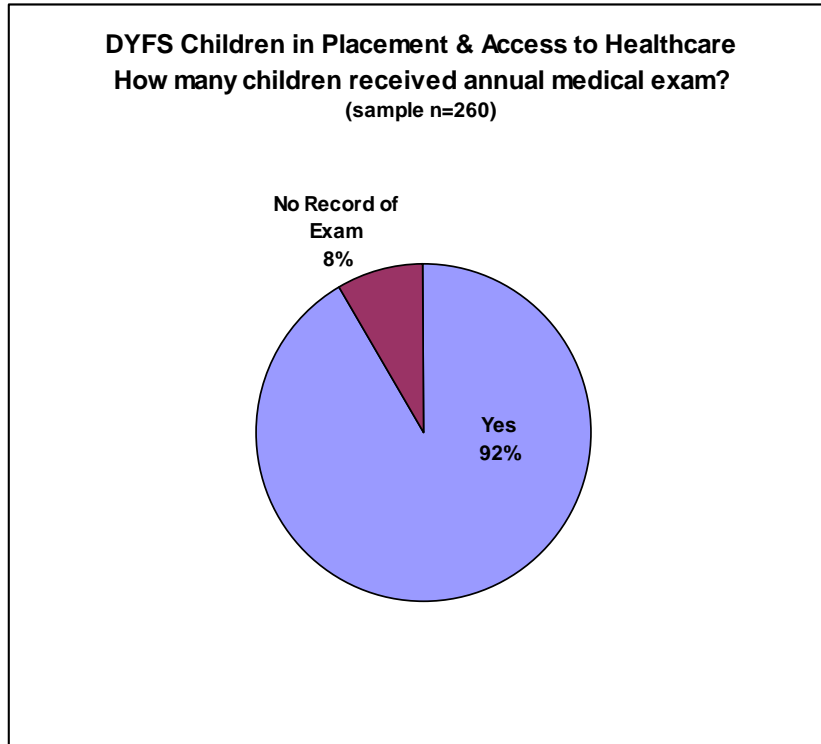
- Data collection and analysis
- System mapping
- Best practice review

Data collection and analysis: Experts report that while child welfare systems struggle with all forms of data collection, health care information proves particularly elusive. That observation holds for New Jersey. The data that has previously been developed concentrates only on fragments of the system without being an analysis of the whole system for all children in care. For example, there are reports available about issues related to RDTCs or children who received CHECs (Comprehensive Health Evaluations for Children) but these services represent only a portion of the system and these studies have missed the bulk of the medical and dental care received by DYFS children. Analysis of the RDTC exams, while useful, was limited because by definition they were provided to only a small percentage of the DYFS population. Similarly, at current levels, existing CHEC capacity has reached fewer than half of the children coming into care and, more fundamentally, was not designed to address the on-going health needs of children in care.

The majority of children in out-of-home placements receive their health care from hundreds of different providers, including doctors in New Jersey's Federally Qualified Health Centers (FQHCs). New Jersey is a large and diverse state – and health care availability varies tremendously from county to county. The wide range of providers currently serving DYFS children reflects that variety. Virtually all of DYFS children received their care through Medicaid, thanks to an earlier system reform which provides for automatic enrollment.

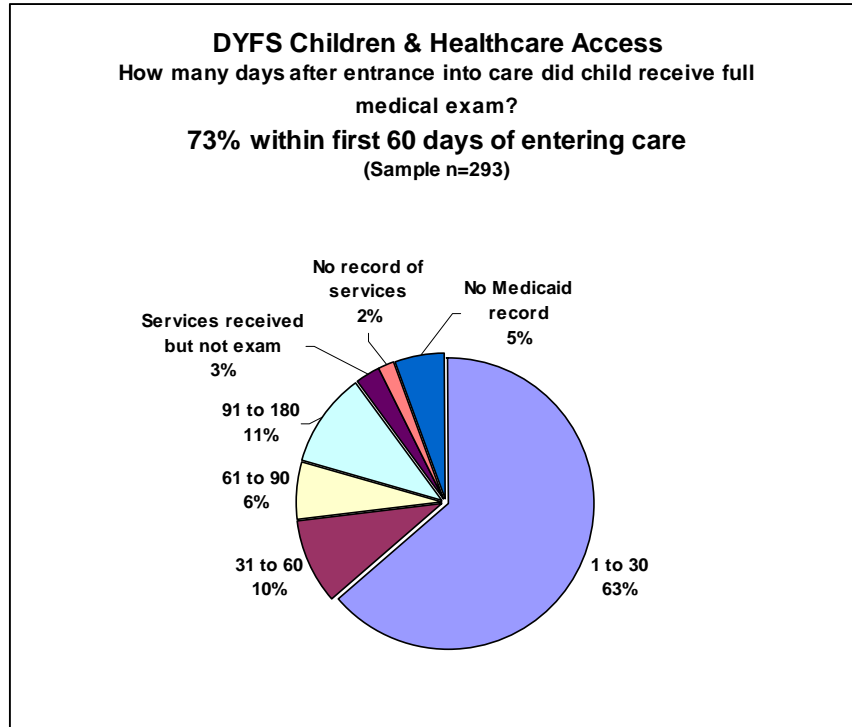
The wide range of providers presents challenges in conducting an analysis of health care for DYFS children. In order to address gaps in information, throughout 2006, DCF collected data and, beginning in December, began analysis of two statistically significant, random samples¹ of DYFS children to understand more about their health care needs and access to services. One of those studies revealed that 92% of the children in the sample (238 of 260) had documented evidence of having received an annual medical exam.

¹ A statistically significant sample is determined by looking at the demographics of the target population as a whole and choosing a random number from among that target group that matches the larger group to a degree of statistical certainty that the sample represents the experience of the entire group.



This finding proved heartening as it suggests that despite a fragmented delivery system, foster parents, providers and DYFS staff were working hard to ensure children received health care. The study also looked at a sub-sample of young children, who must receive more frequent physical check-ups according to the federally defined Early Periodic Screening, Diagnosis, and Treatment (EPSDT) schedule. In that sub-sample, 50% (18 of 36) were 100% compliant with all required exams and services, with almost 70% (25 of 36) at least 75% compliant with required exams and services. This level of EPSDT compliance proved higher than previously suspected, but still below what is acceptable.

A second sample of children which concentrated on timeliness of the medical exams found that 73% of DYFS children (214 of 294) had received their health care exam within the first 60 days of placement.



The first study also examined levels of dental care, about which nothing had previously been known. Even as New Jersey struggles with a shortage of dentists who are willing to accept Medicaid, 61% of the sample of DYFS children (128 of 221) had received at least one annual dental exam.

In short, these studies provided some good news – the overwhelming majority of New Jersey’s children in out-of-home placement are receiving medical care and are getting it in a timely manner, and the majority are getting some dental care. Nonetheless, these studies also highlighted where more work needs to be done. DCF wants to see the levels of EPSDT compliance, dental care, and timeliness of medical care and follow-up all improve.

System Mapping: The second part of the assessment required an examination of the existing health care delivery systems for New Jersey’s children in placement. The system findings are mixed. There are pockets of excellence and many promising practices – but those fragments are not yet composed into a system. Examples of excellence and promising practices include:

- Pre-placement health assessments: Some local DYFS offices have constructed strong relationships with local providers to ensure their children have pre-placement assessments in a timely and sensitive manner in non-emergency room settings.
- Health care supports in the local DYFS offices: Utilizing two different provider networks, virtually all 47 DYFS local offices have a nurse in the

office available for medical consultation with a specific charge to address the needs of medically fragile children.

- Availability of forensic abuse and neglect expertise: New Jersey has a network of RDTs – four in all with one additional satellite – with concentrated expertise diagnosing child abuse and neglect and developing plans of care.
- Piloting of comprehensive medical examinations: New Jersey also invested in a small group of providers – seven in all – who have been piloting the delivery of the comprehensive medical, neuro-developmental, and mental health assessment, known as the CHEC.
- Health care funding: New Jersey has put systems into place to ensure all children in DYFS care have medical insurance, most through a Medicaid Managed Care Organization (MCO).
- Children’s mental health: New Jersey has made significant investments in a children’s behavioral health system. The existence of this statewide system should offer opportunities for enhanced access to treatment for children in placement if the integration of child welfare and behavioral health services is accomplished successfully. DCF’s proposal to establish Innovation Zones in the Division of Child Behavioral Health Services, as described earlier this year, intends to launch this effort.

But the fragmentation of health care services and the lack of coordination remain the largest challenges. The positive elements described above are robust in some parts of the state and completely absent in others. There are competing models of care which can act at odds with one another – operating in some cases to provide multiple (and at times, unnecessarily repetitive) assessments of some children while missing other children altogether.

There are competing priorities which are challenging to resolve and require navigation of a health care system which can prove confusing to even the most educated consumer. Various elements of care do not communicate successfully. Indeed, there are elements of the existing system which invite miscommunication as each were built in isolation without providing for critical transitions, such as the need for follow up care, standardized information collection or transmittal of information from one element of the system to another. (See, for example, the OCA Report December 2005 critiquing the “stand alone” model of the CHEC.)

Best Practice Review of Care Coordination: The best practice standards (AAP and the Child Welfare League of America) and previous studies of New Jersey’s health care delivery system for children in placement (OCA 2005) highlight the fact that care coordination is not optional – it is the pivot for a successful system. Over the years, a variety of solutions have been proposed for New Jersey. Most often, the explicit recommendation or implicit assumption was that caseworkers should serve in this role. Earlier health care reform recommendations placed a large number of additional responsibilities on the shoulders of DYFS caseworkers including: securing the child’s medical records from all previous providers; inputting medical

information into comprehensive and extensive (one model required over 14 pages of input) medical and dental forms to be provided to doctors, foster parents, parents and others; scheduling initial and follow-up care; accompanying the child to the pre-placement assessment, RDTC exams, and CHEC exams; monitoring the child's medications, etc.

As documented at the start of this report, these additional expectations have fallen on a workforce that was already under strain. That workforce did not have the capacity to assume these additional responsibilities successfully. But as noted by the experts, such as the American Academy of Pediatrics ("AAP"), even if they were fully resourced, they lacked the right type of expertise to do this work on their own. In the words of the AAP: "Health care management is the responsibility of the child welfare agency, but it is a function that requires medical expertise."

Several previous attempts to add that expertise in New Jersey have not proven successful. A care coordination element was embedded in the original CHEC RFQ – but never came to fruition. The contracted MCO Medicaid providers have care coordinators specifically designated for DYFS children in out-of-home placement but those have had mixed success. Operating from outside of both the DYFS offices and far from the providers, they have struggled.

The responsibility for coordinating health care services for children in placement is squarely DCF's, and the opportunity to do so with appropriate expertise arises from the fact that, over the years, New Jersey has invested in placing nurses in each of the DYFS local offices utilizing two different provider agencies. Throughout 2007, DCF leadership has worked closely with the nursing providers to establish greater clarity about their roles and negotiate prioritization among the variety of responsibilities, opting for a stronger partnership model.

DCF will build on its existing nursing staff in the local DYFS offices and construct mini-health units with the ability ensure the collection of medical records, coordinate medical scheduling, and participate in visits with children and their families and participate in family meetings. The size of the staff of each mini-health unit will depend on the number of children in out-of-home placement under the supervision of that office as well as the ages of those children. DCF anticipates working with existing provider(s) and beginning implementation in July 2007. Such implementation will start with the hiring of the required staff site by site. As the staff come on board, they will begin with a review of the health status of all children in out-of-home placement in that local office. They will build on the existing data collection efforts, currently focused only on the pre-placement assessment and will begin to take advantage of the development of electronic medical forms and databases that will be made available to them. The mini-health units will ultimately develop responsibility for:

- Either providing or arranging for the provision of the child's Pre-Placement Assessments (PPA) (with the child's pre-existing provider if appropriate)
- Retrieving the child's previous health history
- Meeting with intake staff to review medical issues for newly placed children
- Participating in family team meetings
- Making appointments for the initial medical exam and coordinating the provision of all medical, mental health and neuro-developmental assessments and follow-up care, including preventive and sub-specialty services
- Working to ensure continuity of care, including continuing care with the child's provider prior to placement (if appropriate), striving to ensure the child stays with a single medical home throughout placement, and ensuring a smooth transition of health care delivery with achievement of permanency
- Providing developmental monitoring
- Maintaining documentation for each child and collecting health care information to be utilized for both quantitative and qualitative reviews
- Maintaining systemic communication, contact and consultation with the child or adolescent, caregivers, family, and casework staff
- Conducting home visits as appropriate and necessary
- Ensuring that a child or adolescent's health care plan is integrated into the permanency plan
- Educating children, adolescents, caregivers, family, and DYFS staff about health care issues

It is expected that it will take 18 months to fully implement these mini-child health units in each local office. Implementation of the model will be monitored closely. It is expected that changes will need to be made in the basic model as it matures from conception to practice in order to ensure its effectiveness.

**Local Office
Child Health Unit
RESPONSIBILITIES**

Ensure PPA (Arrange or Deliver)

Participate in family meetings & home visits (focus on transitional events)

Identify previous providers & collect records

Ensure delivery (same site or coordinate all sites) comprehensive medical

**EPSDT PHYSICAL
EXAM**

**MENTAL HEALTH
SCREEN**

**DEVELOPMENTAL
SCREEN**

Coordinate Follow Up Care

Coordinate dental care

Provide health education & records interpretation

Data entry

Expansion of Access to Health Care Services

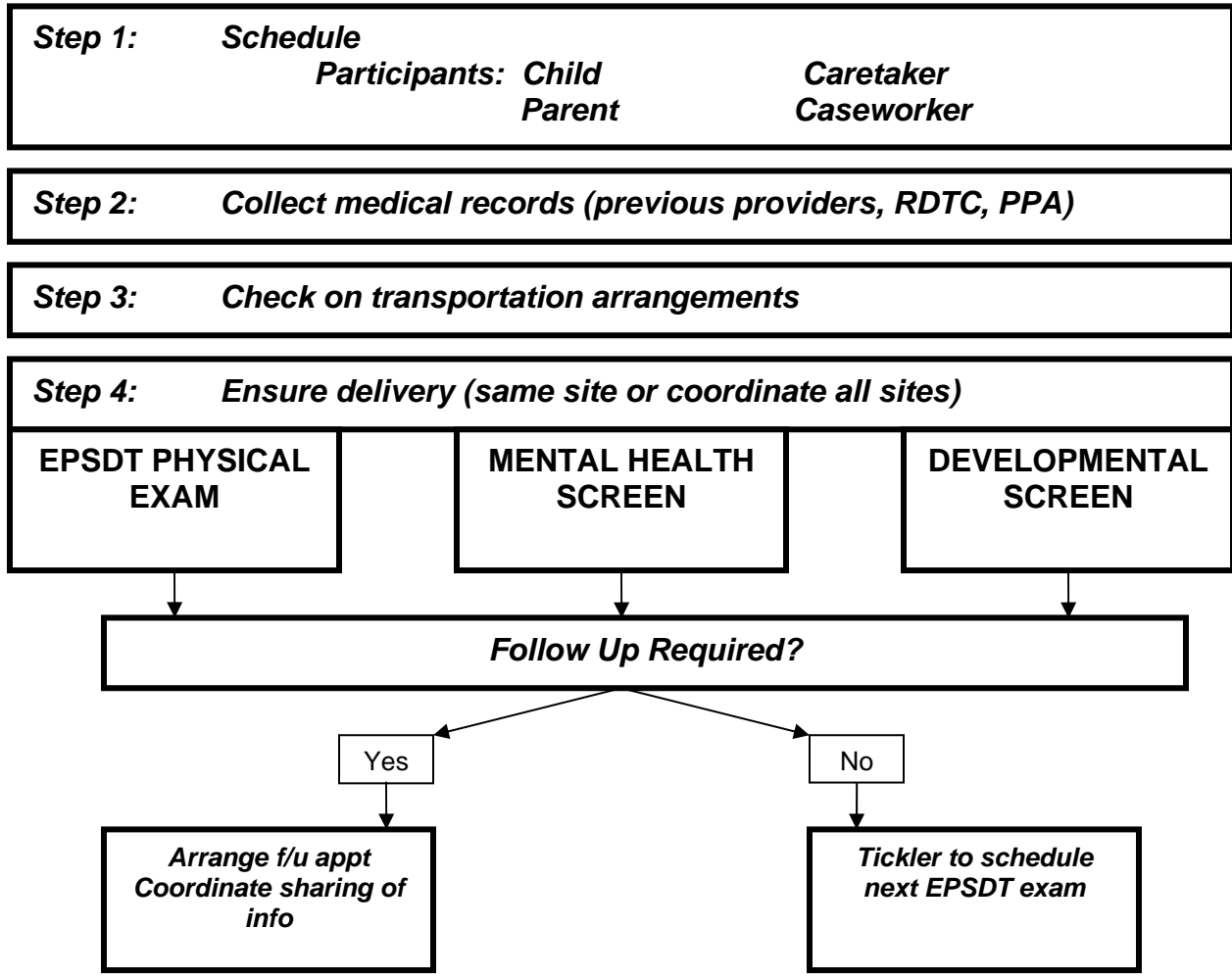
The 2004 plan for reforming health care delivery for children in out-of-home placement relied heavily on a single model of health care delivery, the CHEC, which was to be delivered to every child entering care within 30 days of placement. By the start of 2006, while progress had been made and over 2000 children had received the CHEC, it was clear that this progress had fallen far short of the expected return. More than one-third of the state had no access to CHEC exams and even among the 14 counties with some access, 13 of the 14 lacked the capacity to meet the full need. The CHEC model has been justly criticized because it did not successfully tackle the challenge of providing follow up care. (See OCA Report December 2005.) Providers who wanted to participate in delivering quality health care services to foster children found themselves shut out of the original CHEC RFQ process because the model mandated a strict service delivery system – with all services required to be delivered in the same site on the same day, a system which appeared ideal on paper but had the practical result of severely limiting access. Little was known about the majority of health care being received by DYFS children because in practice, most of it was delivered outside of the CHEC process – and the lack of data inhibited the state’s ability to diagnose the issues and construct solutions.

One year later with substantial input from stakeholders and with the advantage of some data analysis, DCF has a better idea about what the challenges are and about the need to allow for a range of potential solutions. New Jersey is a large, densely populated state. Health care access varies tremendously from county to county. There is no “one size fits all” solution that will ensure access across the state for all of DYFS’ children in placement. What is clear is that access must be expanded and follow up care must be built into the service delivery models. And services must be sequenced according to the need of the child, in order to avoid the child enduring too many repeat assessments or assessment ill-timed to match service provision. While the existing CHEC model could serve as a safety net for the range of assessments, too often it occurred too late for a child who was in mental health crisis – leading to the DYFS office arranging immediate mental health assessment and treatment only to be followed by the mandated CHEC mental health assessment – or the timing of the CHEC did not match the window required for early intervention services, resulting in repeated neuro-developmental assessments.

Next month, DCF will issue a RFQ to expand children’s access to comprehensive medical services, with an anticipated implementation to begin in Fall 2007. This RFQ will allow for a range of proposed models including the single site/single day model, but also the delivery of services in each component part, separating the medical from the mental health and the neuro-developmental. The creation of the new care coordination component within DYFS offices, detailed above, is critical to ensuring the success of the multi-part comprehensive health exam. This permissible model favors a thorough medical exam with a basic developmental

assessment and mental health screen. In the event the health provider indicates the child requires follow up, the provider will support referral to the appropriate specialist with the support of the nursing staff within DYFS. The RFQ will favor providers who have the ability and willingness to serve as medical homes for DYFS children; who can provide or at the very least, coordinate follow up care; and who either have existing electronic medical record systems which can be integrated into the required reporting or who have a commitment to develop such systems.

**COMPREHEHSIVE
MEDICAL
EXAM**



Timing

DCF's ultimate goal is to meet the best practice standards set forth by both the American Academy of Pediatrics (AAP) and Child Welfare League of America (CWLA) for delivering a comprehensive health assessment within 30 days of a child's placement. But the existing service delivery systems clearly lack the capacity to deliver the needed number of exams on that timeframe. Consequently, DCF intends to begin with a target of completing these exams within the first 60 days of placement and has been working with the federal court monitor to set staggered targets for improvement over time for the percentage of DYFS children who will be served within that timeframe. The creation of the care management system and the expansion of providers are both critical pre-requisites to meeting the targets. As a start, DCF wants to pay close attention to ensure it does not slip back from what the data suggests is a rate of 73% of children having an exam within the first 60 days of placement. The risk of such slippage is real as system changes can have the inadvertent effect of eliminating or reducing existing capacity through over-concentration on expansion.

Improving Service Delivery: Regional Diagnostic and Treatment Centers and Pre-Placement Assessments

Regional Diagnostic and Treatment Centers: The RDTCs were created by statute as centers of expertise in the diagnosis and treatment of child abuse and neglect. Four RDTCs had been funded, with an additional satellite, and are located in five different geographic areas of the state. Given the size of New Jersey, this means that there are parts of the state that are geographically remote from the existing RDTCs and so have difficulty accessing RDTC services. At the start of this assessment, there was general agreement that DCF needed to examine the capacity of the existing RDTCs and also study RDTC services as each of the existing RDTCs operated differently.

Throughout the past year, DCF staff conducted a series of interviews with the existing RDTC providers, examined RDTC reports, reviewed contracts and budgets, and interviewed DYFS staff and others utilizing RDTC information. The RDTC providers observed both that they have at times been asked to provide expert consultation inappropriately on cases which should not have been referred, and at times failed to be consulted on cases which should have been brought to their attention. DYFS staff and critical stakeholders, including prosecutors and judges, have expressed a strong desire to improve the timeframes in which services are provided and in prioritizing services. All agreed that there were different models of service delivery among the RDTCs, that each center has followed its own process, utilized its own forms, followed its own timelines, and has had differing, and at times, conflicting views about which services are essential. Protocols describing when children should be referred to an RDTC, which had been laboriously developed in past years by the RDTCs, had never been implemented. RDTC providers complained about under-funding, while DYFS

staff struggled to interpret RDTC budgets that varied radically in scope and funding levels.

Over the past year and with significant input, DCF has reviewed the draft protocols for RDTC and DYFS interaction and began implementation in May 2007. DCF's dissemination of the protocols went hand in hand with system changes designed to support more immediate referrals to the RDTCs. Nonetheless, this initiative remains in its infancy and it will take several months to determine whether and how this new process is successful and what additional supports will be needed to ensure sound implementation.

Pre-Placement Assessments: Pre-placement assessments (PPAs) are health assessments of children either just prior to coming into placement or within a very small window (generally 24 hours) of their entrance into placement. Each year, more than 5000 children enter placement. In some cases, DCF may have been working closely with the family to try and maintain the children in the home but the family could not stay together safely. In other cases, a safety crisis requires an immediate removal. In either scenario, the removal of a child from his or her own family is a difficult event which even as it aims to improve the safety, well-being, and outcomes for that child, in the immediate moment can be both confusing and emotionally painful.

Pre-placement health assessments are necessary in order to try and determine if the child has an immediate health need which must be addressed. The core components of such an assessment include: Does the child appear to have a contagious disease? Does the child have an identified pre-existing condition which requires immediate access to medical care, including prescription medication (e.g. asthma)? Does the child have bruises or other injuries which require immediate treatment or documentation or referral to an RDTC? The challenge is figuring out how best to conduct a pre-placement assessment while being sensitive to the needs of the child who is in a most difficult moment.

In reviewing existing PPA practice, DCF staff found two conflicting models of care and a lack of clarity about the timing of PPAs. One model focuses on the potential of a PPA to gather health information including taking blood and urine samples so those tests would be completed and available as part of the later scheduled comprehensive health exam, address routine health care needs (such as missed immunizations), and begin the construction of a comprehensive medical history. This model requires examination of the child by a doctor or APN and is fairly intrusive, including at least some activities which might be difficult for the child, such as shots and the taking of blood, at a moment when the child is particularly vulnerable.

The competing model emphasizes the contextual challenges of the moment – and so seeks to reduce intervention to a minimum until the child has weathered the moment of removal and can return for a thorough comprehensive medical exam.

This model focuses on the core elements and can be completed by a nurse. This model holds the promise of reduced trauma for the child by reducing the need to rely on emergency rooms and markedly reduces medical interventions which can be safely delayed for a better time. With the prevailing view favoring the first model over the recent past, DYFS children often could not receive their initial PPAs with the nurses in the office, and staff occasionally turned to emergency rooms for the required assessment. In some cases, DYFS staff were able to bridge the two models and achieve the ideal by having the child see his own doctor for the pre-placement assessment.

Furthermore, there was confusion about the timing of the PPA. While DYFS policy clearly allowed for a 24 hour window, practice mandated that PPAs be delivered prior to placement which led to an over-reliance on emergency rooms. DCF has committed to reducing reliance on emergency rooms because of the concern that visits to emergency rooms (unless needed for an immediate health crisis) had the potential to further traumatize the child in the course of the difficult removal process. But fulfillment of that commitment has required that DCF address the issues about both the model and the timing – and then tackle capacity.

Data collection and system mapping of the pre-placement assessments proved challenging. With regard to data collection, while a great deal of effort had gone into designing a new system that would be incorporated in New Jersey Spirit (NJS)², the existing legacy system which remained in effect throughout the assessment period informing this report, had no such capacity. Consequently, pre-placement health care data was collected through a laborious process requiring multiple iterative exchanges of information between central office data and health care staff and each field office with much of the information collected by hand.

Over the course of the past year, the data collection process was continuously refined in an attempt to improve the quality of the data collected and streamline the process. These efforts culminated in revisions to the Safe Measures data information system available in each DYFS local office which will allow the staff to more easily report on health care information. Those revisions went into effect in May 2007, building on a system-wide effort over the preceding months to train all DYFS staff in how to utilize Safe Measures. The ability to utilize Safe Measures in pre-placement assessment reporting represents improvement and should allow swifter reporting of data which previously required two months to process.

Analysis of the pre-placement assessment data proved enlightening. The good news was that there were DYFS offices which had great access to local health

² Increased knowledge about the pre-placement assessment process (and about other parts of the health care delivery system) may suggest the need to tweak the existing design of NJS. However, taking a conservative approach to proposing any changes in a system so close to implementation, DCF will defer any substantive changes to NJS related to health care delivery until after the system goes into operation so as to ensure any proposed changes operate in an already well-tested environment.

care providers with both the capacity and the willingness to swiftly see children coming into care. For example, one Monmouth County local office has constructed a very productive partnership with an FQHC located within two blocks of the office. That FQHC has extended evening hours which accommodated the timing of many late afternoon removals and DYFS staff and children were made very welcome in that practice. The Bergen County DYFS offices have invested in local providers with expanded hours specifically to address their needs for pre-placement assessments – and those contracts were working. These are just a few examples of local innovations, but challenges loom large. In some areas of the state, there is a shortage of providers altogether or a shortage of providers who either had extended office hours or are willing to negotiate extended office hours to accommodate DYFS needs.

After much review, DCF committed to the core model for the PPA. Unless a child needs immediate medical care (in which case, the child will go to their own doctor or to an emergency room or to an RDTC, as appropriate), the PPA will be delivered either by the child's own doctor (preferred), by the nurse in the local office or by one of the designated partner providers immediately, if at all possible, and if not, within the first 24 hours of placement. All partner providers will have received guidance on the needs of DYFS children, including focus on the context of the trauma associated with placement. The results of the PPA will be collected in an electronic medical form available on the Health website. Copies of that information will be provided to the caseworker, caretaker, and child (if age appropriate) and e-mailed to the CHU to be provided both for the child's DYFS medical record and to the primary provider and other providers, as appropriate.

Conclusion

Tackling the challenges of providing health care to children in out-of-home placement requires vigorous partnership among state agencies and with the provider community. Care coordination based in local offices allied with an expansion of access to services holds the promise of achieving the vision of continuity of quality health care. Implementation will be challenging but should result in a reformed health care delivery system over the next two years that improves childhood well-being – and that, of course, is the only real test of reform.

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