Social Work **Policy** Institute

CHILDREN AT RISK:
OPTIMIZING HEALTH IN AN ERA OF REFORM

MARCH 2012

> REPORT FROM NOVEMBER 2011 SYMPOSIUM

- > Hosted by the Social Work Policy Institute of the NASW Foundation
- > In collaboration with the School of Social Work, University of Southern California, and PolicyLab of The Children's Hospital of Philadelphia

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CHILDREN AT RISK:
OPTIMIZING HEALTH IN AN ERA OF REFORM

This report is a product from the symposium, *Children at Risk: Optimizing Health in an Era of Reform*, hosted by the NASW Foundation's Social Work Policy Institute in collaboration with supporting partner, the University of Southern California School of Social Work, and PolicyLab of The Children's Hospital of Philadelphia, on November 17, 2011 in Washington, DC.

NASW and the NASW Foundation thank the University of Southern California School of Social Work for providing partial financial support for the symposium.

Additional copies of the report can be downloaded from the Social Work Policy Institute's website, www.socialworkpolicy.org. The PowerPoint presentations can also be viewed at that site.

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PREFACE

Each day, *Child Welfare in the News*, distributed by the Child Welfare Information Gateway (www.childwelfare.gov), includes reports of children who have died due to child abuse and neglect; reports of agencies that are under fire to improve their services; and reports of increasing concerns about the well-being of children served by the public health and social service systems.

Of particular concern in recent years have been the poor physical and behavioral health statuses of children receiving child welfare services, especially those who are in foster care. Increased attention is being paid to these children through research, policy improvements and implementation of new models of service delivery. Yet more attention is needed to truly improve children's outcomes. Building on this momentum, it seemed that the Social Work Policy Institute (SWPI) of the NASW Foundation could be a powerful convener of stakeholders across child welfare and health to catalyze greater action to enhance children's health and well-being. We were pleased that the School of Social Work at the University of Southern California (USC), with leading child maltreatment researchers, was well positioned to be a collaborator for this symposium and we appreciate Dean Marilyn Flynn's promotion of a SWPI/USC collaboration and the provision of financial resources to partially support the symposium. Based on her extensive research and practice expertise at the intersection of child welfare and health, Janet Schneiderman, RN, PhD, Research Associate Professor at the USC School of Social Work, served as the symposium's Academic Chair. To further undertake this interdisciplinary endeavor, we reached out to PolicyLab of The Children's Hospital of Philadelphia, a leader in research to practice/policy initiatives at the intersection of child welfare and health care, which also agreed to serve as a collaborator. Thank you to David Rubin, Director of PolicyLab for his visionary work, and to Sarah Zlotnik, MSW, MSPH, PolicyLab's Senior Strategist who was a key part of our planning team. Additional thanks to Megan Finno of USC and Cara Curtis of PolicyLab who assisted in the planning and implementation of the symposium. Thanks also to my NASW colleagues who helped to make the symposium a success by providing logistic support and serving as facilitators during the working groups. Finally, thank you to Alice Cahill, whose graphic recording helped to capture the symposium's process and content.

In addition to Janet and Sarah who were panelists at the symposium, I also want to thank Joan Alker, MPP, *Center for Children and Families, Georgetown University*; Kamala Allen, MHS, *Center for Health Care Strategies*; David Berns, MSW, *District of Columbia Department of Human Services*; Rachel Dodge, MD, MPH, FAAP, *MATCH* Program at Baltimore City Department of Social Services; Deirdra Robinson, ABD, MSW, *Morehead State University*; Suzanne Theberge, MPH, *National Quality Forum* and Rita Vandivort-Warren, MSW, *Substance Abuse & Mental Health Services Administration,* who all provided thoughtful and informative presentations. The 50 participants, representing many disciplines and broad experience at the local, state and national levels, contributed their expertise and perspective in helping to create this important agenda for action.

As you read this report and the accompanying action brief, we hope that you will consider what steps you can take to optimize the health and well-being of children at risk. Based on the strategies identified by participants, collaboration will be key. Collaboration across disciplines, collaboration across systems, collaboration between researchers and practitioners and policy makers, collaboration between universities and communities, and collaboration with youth and their families are all critical if we are to achieve better outcomes for children and families.

Joan Levy Zlotnik, PhD, ACSW
Director, Social Work Policy Institute
March 2012

EXECUTIVE SUMMARY

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> OVERVIEW

The health profiles of children in the child welfare system indicate high rates of physical and mental health disorders and developmental risk factors. These are exacerbated by concerns about access to health care, high rates of use of psychotropic medication for children in foster care, and insufficient attention to prevention and early intervention. The National Study of Child and Adolescent Well-being (NSCAW) and other recent research have provided more comprehensive data on these poor health and mental health outcomes, demanding attention by practitioners, administrators and policy-makers.

To further explore these issues and to set an agenda to improve children's health outcomes, the Social Work Policy Institute (SWPI) of the NASW Foundation with contributing partner, the University of Southern California School of Social Work (USC), and with PolicyLab of The Children's Hospital of Philadelphia, convened key stakeholders for a think tank symposium, *Children at Risk: Optimizing Health in an Era of Reform*, on November 17, 2011. The symposium brought together an interdisciplinary group, working in policy, practice, research and education, including representatives of state and federal government agencies, community-based agencies, national professional and provider organizations, universities and policy entities. The symposium participants explored:

- Findings from research on health care delivery and the health characteristics of children in the child welfare system.
- Research to policy implementation strategies to improve physical and behavioral health outcomes, access and coverage for children served by the child welfare system.
- Implications of recent legislative provisions and their implementation including directives to ensure that behavioral health needs are more adequately met.
- Initiatives to develop measures for quality children's health care delivery.
- Innovative practice models to guide improved outcomes for children, including perspectives from community-based prevention, health promotion, care coordination and service delivery models.

> FINDINGS FROM RESEARCH

Drawing from NSCAW data and other recent research, Janet Schneiderman of USC, who served as the symposium's Academic Chair, set the context, indicating that health profiles of children in the child welfare system are similar, whether or not they are living in an out-of-home care setting. Data reported on covered:

- Physical health status including chronic conditions and obesity.
- Risks of injury and fatalities.

- Behavioral and developmental risks.
- Health status differentials related to age.
- Health care utilization, including mental health and developmental service use.
- Caregiver issues.

> BRIDGING RESEARCH AND POLICY TO IMPROVE PRACTICE OUTCOMES

Recognizing that research findings can lead to implementation of evidence-based programs and policies, Sarah Zlotnik of PolicyLab provided information on several of its current initiatives, especially highlighting the Child Stability and Well-being (CSAW) study in Philadelphia and research related to use of psychotropic medications. Following on the finding that placement instability was associated with poor behavioral health outcomes, CSAW was launched.

Funded by foundation and government sources, CSAW is a multi-dimensional study aimed at promoting placement stability and child well-being. It is examining 1) the impact of placement stability on educational outcomes; 2) agency characteristics (including workforce) affecting placement stability; and 3) the relationship between kinship care, placement with siblings, placement stability and behavioral health. To strengthen the behavioral health system's capacity to support quality interventions that work, PolicyLab investigated evidence- based behavioral services and how these services could best be funded, operationalized and monitored and sustained beyond the research study period.

Another PolicyLab study is examining national Medicaid data and state policies related to the use of psychotropic medications for children in foster care. PolicyLab is a leader in efforts to bridge research and policy to improve the behavioral health of children in child welfare and serves as a catalyst to use policy-informed research to understand barriers to meeting the health needs of children in child welfare.

> POLICY CHANGES SET THE STAGE FOR BETTER HEALTH OUTCOMES

Several recent legislative provisions specifically address health outcomes and health care for foster children as well other children who are at high risk for poor health. The laws with relevant provisions include: *Fostering Connections to Success and Increasing Adoptions Act of 2009* (P.L. 110-351); *Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA) (P.L. 111-3); *Patient Protection and Affordable Care Act of 2010* (ACA) (P.L. 111-148); and the *Child and Family Services Improvement and Innovation Act* (P.L. 112-34).

Symposium speakers highlighted policy enhancements targeted to improving health care delivery and health outcomes. This included the development of children's health outcome measures by the National Quality Forum; provisions to move toward integration of health and behavioral health care and expand coverage due to the ACA, as highlighted by the Substance Abuse and Mental Health Services Administration (SAMHSA); the status of health care coverage for children, in the context of the ACA, Medicaid and managed care, addressed by the Center for Children and Families at Georgetown University's Health Policy Institute; and innovative Medicaid managed care pilots, quality improvement initiatives and Medicaid data analysis focused on understanding utilization and improving behavioral health outcomes for children in foster care, being implemented through the Center for Health Care Strategies.

> COMMUNITY-BASED STRATEGIES FOCUS ON PREVENTION AND COORDINATION OF CARE

Community-based, collaborative prevention and coordinated care models were highlighted. They included preventive health care education and screening efforts in a rural community in Kentucky; the implementation of a medical managed care unit for children in foster care, a collaboration between health, child welfare and mental health service systems in Baltimore; and efforts to promote more comprehensive, integrated coordinated and preventive care across public health and social service systems, that is family-centered and strengths-based and promotes wellness and safety, in the District of Columbia.

> OVERARCHING ISSUES IDENTIFIED

- Children transition in and out of foster care and in and out of the child welfare system, suggesting that there must be a more holistic approach to primary care and behavioral health services and consistent use of screening.
- There are a growing number of evidence-based practices and innovations at the individual and system level (e.g., early childhood home-visiting, parent-child interaction therapy) that can be adopted and adapted into routine service delivery, requiring attention to the implementation process.
- Cross-system and interdisciplinary collaboration and training are essential to improve outcomes, along with increased engagement with caregivers, including birth families.
- The changes occurring due to recent federal legislation will have impact on the health care of high risk children. As more adults have access to health care coverage in 2014, they may increase their use of health and behavioral health services, perhaps resulting in better child welfare outcomes as well.

> AGENDA FOR ACTION

The participants grappled with identifying what changes need to occur to enhance, policies, practices, partnerships and professional development to strengthen quality of care, access to care, and health care coverage to improve children’s health and well-being. This resulted in development of an agenda that calls for the following actions:

- *Promote access and continuity of care for children who have contact with the child welfare system.*
- *Create systems of communication to achieve better accountability and to improve communications between agencies, providers and managed care organizations.*
- *Create better focused and coordinated efforts to address health care needs of children served in the child welfare system at the highest levels within state and federal governments.*
- *Ensure that the voices of families, communities and foster care alumni are included in the development of models to address healthcare needs in the child welfare system.*

- *Clarify the authority to consent for healthcare, early intervention and other services for those who are in the foster care system and those who are served in their own home.*
- *Promote the establishment of cross-disciplinary initiatives in universities to serve as models for interdisciplinary community-based practice.*

This convening covered a great deal of territory in a short time and reinforced the understanding that:

- Legislative changes have brought new opportunities and greater attention to the health outcomes of at-risk children.
- Success will require people working together – engaging with families and communities and using a strength's based perspective.
- State and local governments along with insurance payers and community agencies all have a role to play in working with the federal government to improve health outcomes and create coordinated service delivery.
- Research plays an important role in both understanding who is served and in testing innovations.
- Dissemination of effective innovations is critical to improving health outcomes.

This collaboration between the NASW Social Work Policy Institute, USC and PolicyLab can serve as an example of cross-system and cross-disciplinary knowledge development and can also serve as a model for others to emulate to address critical issues facing our most vulnerable children and families.

Social Work Policy Institute

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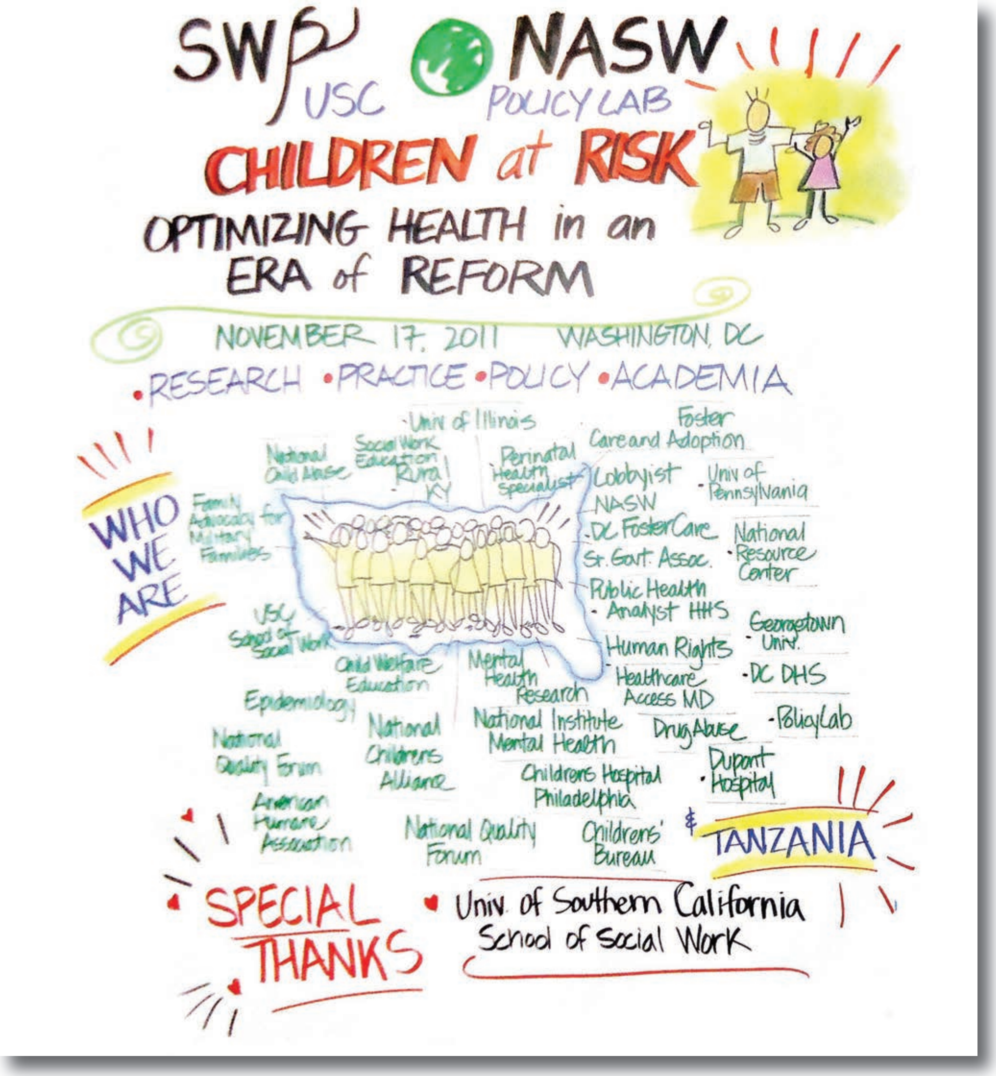
ABOUT THE SYMPOSIUM



Across the United States, increasing concerns are being raised about the health care and the health outcomes for children involved with the child welfare system. The Children's Health Insurance Program (CHIP) and the Patient Protection and Affordable Care Act (ACA) provide some benefits and safeguards for vulnerable children, but still more needs to be done. To examine the health care needs of children in the child welfare system and those who might be in jeopardy of future involvement with the system (due to abuse, neglect, immigration, and other child and family risk factors), a think tank symposium was convened by the National Association of Social Workers (NASW) Social Work Policy Institute (SWPI) in collaboration with PolicyLab of The Children's Hospital of Philadelphia and contributing partner, the University of Southern California School of Social Work (USC). *Children at Risk: Optimizing Health in an Era of Reform* took place on November 17, 2011 at NASW headquarters in Washington, DC.

> OVERVIEW OF THIS SYMPOSIUM

The symposium brought together an interdisciplinary group of key stakeholders from policy, practice, research and education, including representatives of state and federal government agencies, community-based agencies, national professional and provider organizations, universities and policy entities (see Appendix 2). Focusing on the health and health care for children in the child welfare system, the symposium agenda (see Appendix 1) included three panel presentations (see Appendix 3 for speaker biographies) that addressed research findings on health care delivery and the health characteristics of children in the child welfare system; research to policy implementation strategies to identify and improve health care outcomes, access and coverage for children served by the child welfare system; revisions of federal policies and their implementation; efforts to develop outcome measures for quality children's health care delivery, and innovative practice models that can help to guide improved outcomes for children. The third panel provided on-the-ground perspectives and helped raise issues that needed further consideration.

In addressing the health of children in child welfare, the presentations and discussions identified gaps in policies and services as well as areas that require further study. Engaging in small group deliberations, using a World Café model, participants shaped the action agenda focusing on what needs to occur to enhance policies, practices, partnerships and professional development to strengthen quality of care, access to care, and health care coverage to improve children's health and well-being. Change strategies that were identified focused on workforce development, training and technical assistance; dissemination and implementation efforts, and promotion of interprofessional and inter-organizational collaborations and cross-system innovations.

> PURPOSE OF THIS REPORT

This report is intended to serve as a resource for practitioners, administrators, educators, researchers and policy-makers who are concerned with the health and health care of children, especially of those children involved with the child welfare system. It provides an overview of the speakers' presentations along with a discussion of the key gaps and concerns that were identified. It then provides recommendations that emerged from the participants' deliberations which led to the formulation of the agenda for action. The report also includes an extensive appendix that provides resources and links to information that stakeholders might find useful in implementing the action agenda. We hope that the information provided can be a catalyst for undertaking efforts to enhance the health and well-being of children and to improve collaboration and communication among the health, behavioral health and social service systems.

> GUIDING QUESTIONS

In advance of the symposium, the participants received background materials and the following list of questions that served to guide the presentations and discussions.

> What can we learn from research about the health care needs of children in the child welfare system?
> What are the current economic and societal risk factors that result in increased health risks and injury of children?
> What strategies are states and localities currently using to improve the health outcomes for Medicaid eligible high risk children, especially those known to the child welfare system?
> What opportunities were included in recent legislation that target improving health outcomes for at-risk children?
> How can interdisciplinary, cross-system education and training be enhanced to improve health outcomes? Are there professional development and training models that integrate child welfare and maternal and child health (in social work and other disciplines) to more holistically address the practice, programs and policies that could enhance child health outcomes?
> What are the special issues related to addressing behavioral health outcomes for children in the child welfare system?
> How can we best ensure that children's health outcome measures capture the unique needs of children served by the child welfare system?
> What actions at the state and federal levels are needed to enhance policies and better disseminate information to improve practices?

SETTING THE CONTEXT

> LESSONS FROM RESEARCH ON THE HEALTH OF CHILDREN IN THE CHILD WELFARE SYSTEM

To understand the current state of health needs and health services for children in the child welfare system, Janet Schneiderman, Research Associate Professor at the School of Social Work, University of Southern California, who also served as the Academic Chair of this symposium, provided an overview of recent research. Schneiderman began by highlighting some overall statistics, noting that child neglect is more prevalent than child abuse, and that over the past several years there has been a decline in the number of children in foster care, with many children actually receiving child welfare services in their own home.

The presentation painted a picture of the health status and health care needs of children in the child welfare system. This section of the report reviews some of the key findings that were presented, covering a range of factors including:

- > Physical health status including chronic conditions and obesity
- > Risks of injury and fatalities.
- > Behavioral and developmental risks.
- > Health status differentials related to age.
- > Health care utilization, including mental health and developmental service use.
- > Caregiver issues.

Important data on the health of children in child welfare can be drawn from the National Study of Child and Adolescent Well-being (NSCAW). Schneiderman's presentation drew upon her own research, using NSCAW data and data from Los Angeles, CA, supported by the National Institute on Child Health and Human Development (NICHD), and that of many other researchers who have been carefully analyzing the NSCAW findings. The presentation brought together NSCAW findings and other data, addressing health care needs, health status, and utilization. It should be noted that some of the citations relate to national data and some are more state specific. (The PowerPoint of Schneiderman's full presentation and the references are available on the SWPI website, [www.socialworkpolicy.org]).

ABOUT THE NATIONAL STUDY OF CHILD AND ADOLESCENT WELL-BEING (NSCAW)

Created from a Congressional mandate as part of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, the Department of Health and Human Services launched NSCAW. It is the first national study that examines child and family well-being outcomes in detail and seeks to relate those outcomes to their experience with the child welfare system and to family characteristics, community environment, and other factors. The study describes the child welfare system and the experiences of children and families who come in contact with the system. It is intended to increase the knowledge needed to support service, program, and policy planning. Data presented at the symposium was based on analysis from the findings of the first longitudinal sample (NSCAW I). For more information visit www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/#overview.

According to NSCAW and other data, the developmental and physical problems of children, especially young children, who remain at home, are similar to those of children who are placed in foster care (Leslie, et al., 2005; Ringeisen, Casanueva, Urato & Cross, 2008; Schneiderman, et al., 2010). With one quarter to one third of children in foster care having a diagnosed medical problem (Sullivan & Zyl, 2008; Kortenkamp & Ehrele, 2002), it is surmised that children in child welfare may be among the most medically fragile children in the United States. Being in foster care longer, and having more visits from the agency in the past six months increases the chance that children have a diagnosed health problem (Sullivan & Zyl, 2008) and children under age six who are in foster care have more medical problems and development delays than the general population and than their older counterparts in child welfare (Berkoff, Leslie & Stahmer, 2006; Leslie, et al., 2005; Stahmer, et al., 2005; Vandivere, Chalk & Moore, 2003).

Physical Health

Chronic health conditions are common for many children in the child welfare system. National studies on physical health problems of children in the child welfare system found that 27.9% of children had a chronic medical condition, with children under age two more likely to report a chronic medical condition than older children; with rates not differing by placement, in foster care or remaining at home (Ringeisen, et al., 2008). Of children who have been in foster care for more than one year, Table 1 describes their chronic health conditions.

TABLE 1: CHRONIC HEALTH CONDITIONS OF CHILDREN IN FOSTER CARE FOR MORE THAN ONE YEAR

30% of the children have a chronic health condition

- 20% one chronic condition,
- 3.8% had two chronic conditions, and
- 3.1% had three or more conditions.

Most common chronic conditions

- 32.8 % asthma;
- 2% other respiratory problem;
- 6% allergies, repeated ear infections, and eczema or other skin disease

There is an increased risk of chronic condition for children under two years of age, if the caregiver's race/ethnicity is other than Hispanic, and if there are relatively few household members. (Jee et al, 2006)

Obesity

Evidence is starting to show that children in child welfare have higher rates of obesity than the general population. Childhood obesity is now recognized as a problem for children in child welfare (Steele & Buchi, 2008; Schneiderman, et al., 2011) and recent commentary and judicial decisions have suggested that perhaps extreme obesity, especially coupled with another chronic health condition, should be considered child neglect (Murtagh & Ludwig, 2011; Varness, et al., 2009). Furthermore, drawing on the Adverse Childhood Experiences (ACEs) study, a link has been identified between specific violence-related stressors, including child abuse and neglect, and risky behaviors and health problems in adulthood (Felitti, et al., 1998). The retrospective ACEs study found that reports of childhood maltreatment were related to obesity in adulthood. The risk of obesity increased with the severity of the maltreatment, and childhood physical and verbal abuse were most strongly related to Body Mass Index (BMI) and obesity (Williamson, Thompson, Anda, Dietz & Felitti, 2002).

Risks of Injury and Fatality

Children known to the child welfare system may be at greater risk of fatality according to recent data analyzed by Putnam-Hornstein (2011). She found that, in California, after adjusting for risk factors at birth, a prior allegation of maltreatment was a significant risk factor for later death due to injury. Furthermore, continuing to adjust for risk factors at birth, children with a prior allegation of maltreatment died from intentional injury at a rate that was 5.9 times greater than unreported children, and died from unintentional injuries at twice the rate of unreported children.

Using NSCAW data, Schneiderman and colleagues (2010) found that 10.3% of children who remain at home after a Child Protective Services (CPS) investigation had a serious injury, and this was 2.1 times more likely if the child had a chronic medical problem or if the caregiver was depressed (especially in younger caregivers).

Behavioral and Developmental Risks

When focusing on mental health and developmental problems in maltreated children, researchers found that 80% of children in child welfare are estimated to have emotional or behavioral disorders, developmental delays or other indications of needing mental health intervention, compared to 20% of the general population (Korenkamp & Ehrele, 2002; Dore, 2005).

Behavioral Problems

The rates for delinquent behavior (15%) and aggressive behavior (11%) for children in foster care are over twice as high as the rates among children in the general population (Armsden, et al., 2000). Analysis of data from NSCAW (2005) suggests that those children who are maltreated have increased likelihood of depression, subsequent substance abuse, sexual activity at an early age, and are at greater risk for teen pregnancy.

In terms of the mental health problems for children in child welfare, McCrae's (2009) analysis of NSCAW data found that 50% of child welfare-involved children score in the clinical range for disorders, with more children having externalizing rather than internalizing symptoms.

The findings indicate:

- Clinical-level thought problems (25%)
- Aggressive behavior (21%)
- Delinquent behavior (19%)
- Attention problems (18%)
- Social behavior problems (14%)
- Anxious/depressed behavior (13%)
- Withdrawn behavior (11%)
- Sexualized behavior (9%)
- Somatic complaints (7%)

Children in foster care are twice as likely as in-home children who are not receiving services to report problem behaviors; and those in group care are more likely to exhibit serious behavior problems and depression compared with children in other out-of-home settings (NSCAW, 2005). This may be due to selection bias related to which children end up in group care settings.

In regard to kinship care, placements with kin resulted in improvements in behavior problems over those children who were in other foster care settings (Barth, Green, Guo, & McCrae, 2007). Furthermore, those children who were in foster care have an increased likelihood of mental health disorders and social dysfunction in adulthood (Casey Family Programs, 2005).

Burns and colleagues (2004) found that only 7% of young people in the NSCAW sample received mental health services. For those young people who do receive mental health services, they are more likely to be male, to be in out-of-home placements, to experience multiple risk factors, to be white, and to have a caregiver with higher education (McCrae, Barth, & Guo, 2010).

It is also important to note that the mental health of caregivers is also an issue for children in child welfare, as risks for maltreatment and foster care placement can be linked to the parent's mental status, especially the mother's. Drawing from NSCAW data, Schneiderman, et al. (2010) found that injury after a CPS report is more likely if the caregiver is depressed.

Developmental Delays

Children in foster care nationally have developmental delays at five times the rate of all other children (Zimmer & Panko, 2006), with children younger than six years of age in foster care having a likelihood of developmental delays between 16 to 62% compared to 4–10% for the general population (Halfon et al., 1995; Leslie, Gordon, Ganger, & Gist, 2002; Stahmer et al., 2005; Drillien, Pickering, & Drummond, 1988; Fox & McManus, 1996). In almost half of young children in foster care in a national study, delays in cognitive, behavioral, and social skills were severe enough to indicate eligibility for early intervention services (Stahmer et al., 2005). Besides foster children having a likelihood of delays, Cooper and colleagues (2008) found that these children are not receiving the services and supports that they need to meet their developmental needs.

Young Children in Child Welfare are at the Greatest Risk

Preschoolers, in general, exposed to family violence show increased rates of disturbances in self- regulation and in emotional, social, and cognitive functioning (Cooper, Banghart & Aratani, 2010); and 32 to 42% of children in child welfare with emotional and behavioral needs are under age six (McCrae, 2009). Furthermore, the age of the first episode of maltreatment is associated with mental health problems in adulthood; noting that the younger the age of the child at the first episode, the more significant the mental health problems are in adulthood (Kaplow & Widom, 2007).

Older Youth also Experience High Health Risk Factors

According to NSCAW (2005) findings:

- Youth over age 11 are twice as likely to exhibit conduct problems as younger children receiving child welfare services.
- Youth receiving child welfare services are almost four times as likely as youth in the general population to have been pregnant or gotten someone pregnant.
- Youth living in out of home care are more likely to report problem behaviors and substance use issues than those youth receiving child welfare services in their own homes.

Health Care Utilization

A disproportionate share of Medicaid expenditures are spent on children in foster care due to the magnitude of mental health services they receive (Geen, Sommers, & Cohen, 2005) and nationally, the use of targeted case management increases Medicaid spending on foster care. Analysis by

Sullivan and Zyl (2008) of utilization data in Kentucky found that whether the child was in an urban or rural setting did not determine the adequacy of available health care resources.

According to the Department of Health and Human Services (HHS) (2005), about 30% of foster children do not get adequate health services due to providers not taking Medicaid, resulting in the absence of timely health and mental health assessments; and the lack of preventive health and dental care. Findings from NSCAW indicate that emergency room visits are higher for children who receive child welfare services than the national average, with 36% of children who remain at home using emergency departments (Schneiderman, et al., 2012) and 31% of children who are in foster care for one year (Jee, et al., 2005). The high use of emergency room care suggests that children in child welfare may not have regular primary and preventative health care services available to them.

Mental Health and Developmental Service Use

Latinos, African Americans and Asian children in foster care are less likely to receive mental health services than other children in foster care (Garland, Lau, Yeh McCabe, Hough & Landsverk, 2005). However it should be noted that not all children receiving child welfare services need mental health care and that the use of mental health care has a cultural component. On average, only 11% of children nationally who had a child protection investigation, in the NSCAW, sample received services to address all of their specific needs (Burns, et al., 2004).

Numerous studies indicate that child welfare agencies lack the necessary services, training and supports to meet the mental health and developmental needs of the children in the system (Cooper, et al., 2010: Cooper, et al., 2008; McCarthy, et al., 2004). Research indicates that there is an absence of a systemic approach to identifying children with mental health and developmental needs, a lack of collaboration across agencies and systems, and inadequate capacity among mental health providers to best serve these vulnerable children.

Caregiver Issues

Caregivers, whether birth families, kinship care providers or unrelated foster parents should have a role in health care provision. However, according to Schneiderman, et al. (2007), the voices of caregivers, such as foster parents are not part of the health delivery team. Foster parents often receive inadequate health training and may not receive the child's Medicaid card or sufficient medical information at the time of placement, nor at any time soon after placement (Schneiderman, et al., 2011). Child welfare caseworkers may help with insurance and referrals, however kinship caregivers may receive less support from caseworkers than unrelated foster caregivers. Unrelated foster caregivers, as opposed to kinship caregivers, noted that children in foster care often have poor continuity of health care and difficulties with transportation to their usual health care providers. Health care was improved if the caregiver had a pre-existing relationship with a pediatrician, which facilitated use of health care services (Pasztor, et al., 2006).

Birth parents are not necessarily included in conversations regarding their children's health care needs while the children are in foster care. They also may not access health or mental health care for themselves, perhaps due to a lack of coverage, even if their child has access to coverage through Medicaid or CHIP. The expanded access that parents will have to coverage, beginning in 2014, may well have substantial health benefits for children and parents as parents may be more likely to attend to their children's health care needs when they are also able to attend to their own. As previously noted, caregivers' mental health status is also a risk factor for children.

Thus, children in child welfare have high physical and mental health needs and developmental delays. However, they may not have regular access to the services that would best meet their needs to optimize their health and well-being.

> LEGISLATIVE PROVISIONS TO ENHANCE HEALTH CARE AND HEALTH OUTCOMES

Several recent legislative changes have especially addressed the health needs and health outcomes for children in the child welfare system. The Patient Protection and Affordable Care Act (ACA) addresses foster care in several sections, but also addresses overall issues of access, enhanced coverage and prevention. These should potentially result in improved health of children in the child welfare system. Table 2 highlights the most relevant provisions.

TABLE 2: RECENT FEDERAL LEGISLATION IMPACTING CHILDREN IN THE CHILD WELFARE SYSTEM

Fostering Connections to Success and Increasing Adoptions Act of 2009 (P.L. 110-351) (www.gpo.gov/fdsys/pkg/PLAW-110publ351/pdf/PLAW-110publ351.pdf).

> Requires states to develop a plan for the on-going oversight and coordination of health services for children in foster care, in consultation with the state Medicaid agency.
> Requires oversight of medications prescribed to children in foster care
> Provides option for youth remain in care to age 19, 20, or 21 (perhaps resulting in more consistent access to health care).
> Increases support to kinship care providers (perhaps resulting in more consistent access to health care).

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3) (http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ003.111.pdf%20).

> Provides incentives to undertake active outreach to enroll more children.

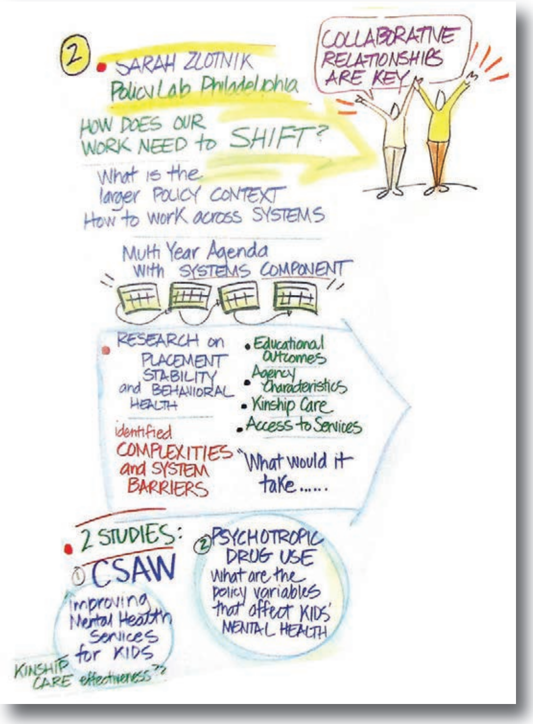
Patient Protection and Affordable Care Act of 2010 (ACA) (P.L. 111-148) (www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf).

> Promotes focus on health outcomes.
> Promotes integration of behavioral health care and primary care.
> Promotes Health Homes (section 2703), Medication Management (Section 3503), and Pediatric Accountable Care Organizations (Section 2706).
> Provides Medicaid coverage for children who were in foster care through age 26 (Section 2004) and supports transition planning (Section 2955).
> Provides $500 million for evidence-based early childhood home visiting (Section 2951).
> Provides federal subsidies for health insurance purchasing (may be through health exchanges) for families with incomes up to 400% of the federal poverty level (FPL), by 2014.

Child and Family Services Improvement and Innovation Act (P.L. 112-34) www.gpo.gov/fdsys/pkg/PLAW-112publ34/pdf/PLAW-112publ34.pdf.

> Includes provisions to track and monitor use of psychotropic medications.
> Expands demonstration programs related to drug use, beyond just Methamphetamine.

> BRIDGING RESEARCH AND POLICY TO IMPROVE THE BEHAVIORAL HEALTH OF CHILDREN IN CHILD WELFARE



Improving the health, including behavioral health, of children in child welfare requires an understanding of the individual, organizational and policy factors that impact outcomes for children. PolicyLab, an interdisciplinary research center at The Children's Hospital of Philadelphia (for information on PolicyLab see Appendix 10), uses practice-informed research to promote program and policy change for vulnerable children. In particular, PolicyLab has strong expertise in child welfare, and is currently engaged in a number of projects to more effectively and efficiently bridge research, practice and policy in the child welfare system. Because of this work, PolicyLab was an important collaborator, along with USC, in planning this symposium (and was a catalyst in engaging pediatricians and health care professionals in the event). Sarah Zlotnik, PolicyLab's Senior Strategist, provided an overview of several PolicyLab projects that demonstrate the center's systems-level approach and attention to strategic impact in its work.

Children's Stability and Well-being Study

The Children's Stability and Well-being (CSAW) study investigates the impact of child welfare system characteristics on placement stability and child well-being. Previous work with NSCAW data by Dr. David Rubin, PolicyLab director, informed the design and execution of this study with its finding that placement instability was associated with poor behavioral health outcomes (Rubin, O'Reilly, Luan, Localio, 2007). To better understand the mechanisms through which the system influences a child's placement and behavioral health trajectories, Rubin launched the CSAW study (supported by the NICHD, the William Penn Foundation, and the Stoneleigh Foundation). Developed in close collaboration with child welfare, school district, and foundation partners, CSAW followed a cohort of 403 children ages three to eight for 24 months.

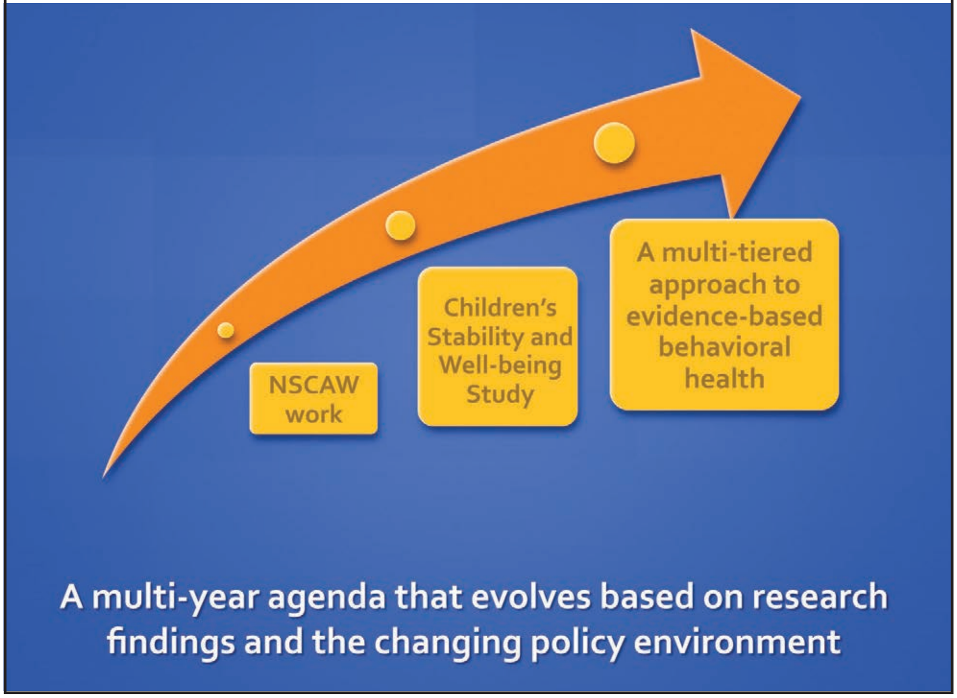
Specifically, the study sought to better understand the structural opportunities to promote placement stability and child well-being by examining the following:

1. The impact of placement stability on educational outcomes;
2. Agency characteristics (including workforce) affecting placement stability; and
3. The relationship between kinship care, placement with siblings, placement stability and behavioral health.

Early CSAW findings indicated that children in foster care have significant behavioral health needs. Over a third of children entering their first placement had behavioral problems, as measured by the Child Behavior Checklist (CBCL). Further, children's behavior was a leading reason cited for children's placement moves (Noonan, et al., 2009; Rubin, et al., 2007). Evidence also demonstrates that children in foster care often have limited access to quality behavioral health services and that these services and child welfare services are poorly integrated (Burns, et al., 2004). To understand what it requires to build a system of care that improves behavioral health outcomes of children in child welfare, PolicyLab investigated evidence-based behavioral health services for children, both pharmacological and non-pharmacological, and how these services could be best funded, operationalized, and monitored.

PolicyLab is piloting the implementation of evidence-based behavioral health interventions in the City of Philadelphia in an effort to strengthen the behavioral health system's capacity to support quality interventions that work. Specifically, PolicyLab is evaluating the delivery of a two-tiered intervention: Parent- Child Interaction Therapy and Child Adult Relationship Enhancement, a behavioral management training for caregivers. Efforts were made to prioritize capacity building and sustainability by co-locating behavioral health services in two foster care agencies, training local mental health providers to deliver the services, and identifying public funding (blending of Medicaid and child welfare funding) to support the services beyond the conclusion of the research study.

FIGURE 1: THE STEPS IN BUILDING POLICYLAB'S POLICY-RELEVANT RESEARCH PORTFOLIO



A multi-year agenda that evolves based on research findings and the changing policy environment

Use of Psychotropic Medications in Foster Care

As PolicyLab is on-the-ground learning about the operational challenges families face in the receipt of evidenced–based behavioral services, the center is concurrently engaged in a national project to examine trends in psychotropic medication usage for children in foster care. With funding from the Agency for Healthcare Research and Quality (AHRQ), PolicyLab is using 50-state Medicaid data from 2002-2007 to examine rates of psychotropic medication and antipsychotic medication prescription for a) children in foster care, and b) all children enrolled in Medicaid. In addition, the study incorporates an analysis of states' child welfare and mental health policies examining their rules for oversight (red flags), consent, and mental health screening and assessment, as well as the states' overall Medicaid structure. This analysis enables PolicyLab to examine the Medicaid data in the context of policy changes in order to identify how patterns in systems' approaches potentially shape patterns of usage. Moving forward, a central goal of the analysis is to inform best practices in prescription and oversight.

PolicyLab's Lessons Learned

PolicyLab serves as a catalyst and convener in the field of health policy for children. The center works with stakeholders to address implementation and sustainability concerns and it uses policy-informed research to understand barriers to meeting the health and behavioral health needs of children in child welfare.

From PolicyLab's efforts to bridge research and policy, there are a number of lessons to be learned:

- Attention to timeliness and a solution-oriented approach are essential;
- Development and maintenance of truly collaborative relationships is necessary.
- A focus on both *process* and *content* is needed when trying to shift approaches to both research and policy.
- Researchers can play a critical role in strengthening a public system's capacity to better meet the needs of children.

LEGISLATION AND GAO REPORT RAISES PROFILE OF PSYCHOTROPIC MEDICATION USE

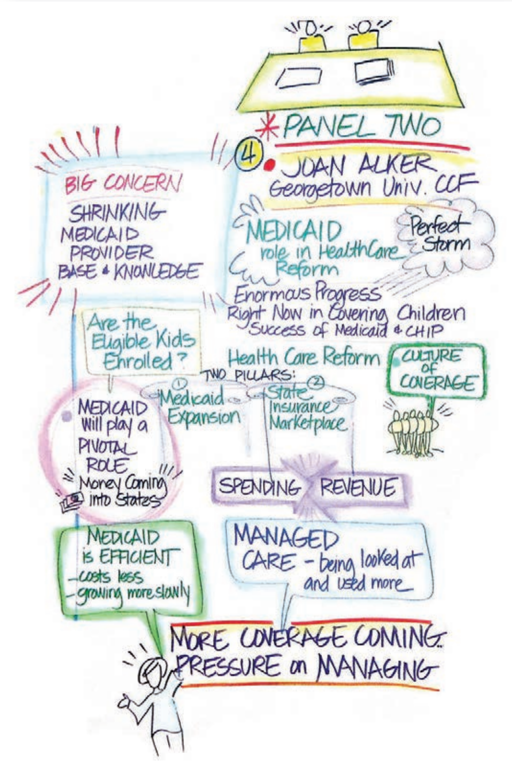
It should be noted that there is growing concern about high rates of psychotropic medication use in children in foster care, resulting in the provisions related to oversight and monitoring of usage that were included in the 2011 Child and Family Services Improvement and Innovations Act. In addition, a high rate of media attention was garnered when the Government Accountability Office (GAO) released a December 2011 report HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions (www.gao.gov/assets/590/586570.pdf), spurring action by HHS (Samuels, 2012).

> PUBLIC HEALTH CARE COVERAGE FOR CHILDREN

To understand how we can better meet children's health care needs it is important to understand the current national landscape related to public programs that cover children as this has implications for children served in child welfare as well as those who are at risk of entering care. Joan Alker, co-executive director of the Georgetown University Health Policy Institute's Center for Children and Families (ccf.georgetown.edu), provided a detailed review of Medicaid and Children's Health Insurance Program (CHIP) coverage, including the implications for coverage in the ACA.

Acknowledging that there has been remarkable progress to lower the rate of uninsured children, 2008 had the lowest rate since data began to be collected in 1987. This is due to both the availability of Medicaid and CHIP; and despite budget challenges, almost all states are holding Medicaid and CHIP coverage steady. This is also due to the "maintenance of effort" provisions of the ACA. A number of states are also continuing to move forward with initiatives that are aimed at increasing coverage (13 states) and achieving administrative efficiencies to enrollment and renewal procedures (14 states). However, as more children access coverage, the disparity of coverage between children and adults is growing since the rate of uninsurance is lower for children than adults. Moreover, children's rates of uninsurance are decreasing while adults' rates are increasing.

To increase children's coverage rates, one important area of focus has been enrolling children who are eligible for coverage but are uninsured. It is believed that 65% of children who are currently uninsured would be eligible for Medicaid and CHIP (Kenney, 2011). Many of these children are in mixed immigration households. There are a number of initiatives focused on addressing the barriers at the state level and to enhance communications among different service sectors to increase coverage for eligible children. The Centers for Medicaid and Medicare Services (CMS) has issued grants to stimulate



enrollment (www.medicaid.gov/State-Resource-Center/Medicaid- and-CHIP-Program-Portal/Medicaid- and-CHIP-Program-Portal.html).

Opportunities in the Affordable Care Act

Once the full provisions of the ACA kick-in in 2014, it is expected that 32 million people will access health care coverage and that 94% of the population will be covered. The goal for 2014 is that a culture of coverage will develop. For children in the child welfare system, there will be a requirement that states maintain Medicaid coverage when children leave foster care, up to age 26, although the federal guidance is not yet issued. The ACA also included $1.5 billion over 5 years for the establishment of evidence- based home visiting programs for young children and their parents, providing an expanded focus on prevention. In addition, the development of medical homes, it is believed, will lead to more stable care and greater coordination of comprehensive care, benefitting children in the child welfare system.

This culture of coverage shift can be viewed as a pillar for serving kids. The expansion of Medicaid to cover people with incomes up to 133% of the federal poverty line (FPL) will include many parents/adults of these high risk children, and may help stimulate more regular access to care. With parents able to access coverage for themselves, they also may make sure that their children receive the needed care.

Families with incomes up to 400% of the FPL will be eligible to receive federal subsidies to purchase health care through the new state exchanges that will be operational in 2014. Federal law requires states to develop "no wrong door" enrollment processes, allowing families to enroll in the program (exchange, Medicaid, CHIP) that best fits their circumstances. States are also required to offer web-based enrollment, and much needs to be done to create easily accessible health information technology systems for this to move forward effectively. For many in the managed care industry, 2014 is viewed as a business opportunity with the high level of new funds that will be available through Medicaid.

Medicaid Use by Foster Children

Specific to children in the foster care system, it is important to understand their relationship to Medicaid. All children in foster care are categorically eligible for Medicaid. Although foster children represent only 3.7% of non-disabled children enrolled in Medicaid, they account for 12.3% of this group's expenditures according to a study by the Urban Institute (Geen, Sommers & Cohen, 2005). Restating the high incidence of mental health needs of foster children that has been previously noted, mental health service use is 8 to 15 times higher for children in foster care than other high risk, low income children enrolled in Medicaid (Harman, et al., 2000) and these children are prescribed psychotropic drugs at a higher rate than other children. Some are concerned that as states look to cut costs in tight budget times, these users of a disproportionate amount of services might be at risk.

Medicaid and State Revenue

In thinking about the funding of health care services through Medicaid it is important to consider that there are two sides to the state budget equation: expenditures and revenue. Medicaid enrollment has gone up, while revenues go down, and the enhanced Federal Medical Assistance Percentages (FMAP) are vital to states addressing budget shortfalls. Per capita Medicaid is growing more slowly than private sector health care and it costs less, partially due to the low reimbursement rates for providers.

Managed Care

Many states are continuing to look to managed care to solve their problems related to both budgets and coverage. As of 2010 all states and DC (except for Alaska, New Hampshire and Wyoming) were using comprehensive Medicaid Managed Care. Nearly 66% of all Medicaid beneficiaries are enrolled in managed care and about 17 states have statewide capitated managed care for foster children. Children in care cannot be placed into managed care without a waiver, but states are mandating more populations into managed care that were previously excluded. Mental health, once carved out of managed care, is now being carved back in. Under health reform Medicaid will expand, especially with the many more adults receiving coverage. Concern continues, however, that budget pressures to manage care may pose a threat to health care access for high-using children, as accessing quality care might become even more compromised. This also occurs when there are restrictions on the number of types of therapies or the number of doctor visits that might be covered in one day. Issues related to essential benefits under the ACA may also affect what benefits are available as we move forward to 2014.

> INNOVATIONS FOR CARE OF CHILDREN IN CHILD WELFARE

Recognizing that children in child welfare have high mental health needs that need to be better addressed, Kamala Allen, Vice President for Program Operations of the nationally-focused Center for Health Care Strategies (CHCS) (www.chcs.org) provided information on models that are being developed to achieve better outcomes for these children who are high service users. Allen noted that this is a watershed moment as several forces have come together to leverage improvements to behavioral health care for children in foster care, and these levers are helping to shape several CHCS initiatives. Levers include three key pieces of previously highlighted recent legislation:

- *Patient Protection and Affordable Care Act:* Health Homes and Medication Management Provisions.
- *Fostering Connections to Success and Increasing Adoptions Act:* Coordinated Health Plans, Medication Oversight programs.
- *Child and Family Services Improvement & Innovations Act:* Psychotropic medication, Demonstration Grants.

These legislative imperatives, together with the Center for Medicaid and Medicare Services (CMS) federal grant program, the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant Program (www.cms.gov/CHIPRA/Downloads/CHIPRA_Quality_Demo.pdf) and support from several foundations have provided CHCS with the resources to undertake independent quality improvement projects, data mining and policy analysis. The key projects focused on children in foster care are:

- *Faces of Medicaid: Children's Behavioral Health Service Utilization and Expenditure Study.*
- *CHIPRA Care Management Entities Collaborative.*
- *Child Welfare Quality Improvement Collaborative.*

In addition, CHCS has launched a national initiative, *Improving the Use and Monitoring of Psychotropic Medication among Children in Child Welfare: A Multi-State Collaborative* in which up to five states will participate in a learning network to reduce inappropriate prescribing of these medication. Further, they will launch a *Child Welfare Model of Care Project* next year. These CHCS efforts are all based on the following premises:

- Children in child welfare and particularly those in foster care are a special needs population.

- In spite of the relatively small numbers, efforts at federal, state, and local levels focusing on access, quality and outcomes of health-related care for the child welfare population are emerging, warranted and gaining traction.
- Psychotropic medication use is a central issue to improving the quality of care and outcomes for children in child welfare.
- Continued attention to developing effective systems to monitor and improve care – and the policies to support them – is needed.

Faces of Medicaid

The *Faces of Medicaid* project examined Medicaid claims data for 2005 and specifically looked at children in foster care. Findings indicate that foster children are 3% of the Medicaid population and 15% of the Medicaid users of behavioral health services; and 32% of foster children used Medicaid behavioral health services compared to 5% of TANF recipients. A significant number of foster children in the sample received the following mental health services:

- 60% used therapeutic outpatient counseling.
- 44% used psychotropic medications.
- 20% used family therapy/ education/training.
- 17% used substance abuse treatment.

Further, the use of other high-cost restrictive services among children in foster included:

- 6% used Medicaid residential treatment.
- 5% used Medicaid inpatient psychiatric treatment.

The rate of use of behavioral health care by children in foster care exceeds even that of children who qualify for Medicaid due to their SSI/disabled status, with 26.4% of those children using such services. Consequently, it might be useful to look at care and payment strategies related to both groups. The Medicaid Managed Care Enrollment report from CMS indicates that, based on 2008 data, 35 states now enroll foster children into some form of managed care and 73% of Medicaid children overall are enrolled in managed care (CMS, 2010). These figures indicate, as has previously been discussed, the use of managed care is on the uptick.

Quality Improvement Initiatives

To ensure that the health and behavioral health needs of children in foster care are being met through these managed care efforts, CHCS launched a three year initiative, the *Child Welfare Quality Improvement Collaborative*, in 2008. Working in nine states with their Medicaid managed care organization (MCO), the goal of the collaborative was to improve access, coordination and appropriateness of care. The outcomes of the project found that overall aims were achieved and it also established partnerships between the MCO and the child welfare agencies. See Appendix 4 for an overview of the MCO child welfare initiatives. A toolkit highlighting these efforts will be available (in March 2012) on the CHCS website (www.chcs.org/info-url_nocat 5108/info-url_nocat_list.htm?attrib_id=14260).

Children's Health Insurance Program Reauthorization Act (CHIPRA) Initiative

A third CHCS initiative is a five year CHIPRA quality demonstration grant from CMS to test provider- based models that look across all of the systems with which the children in foster care are involved. The project – being undertaken by a three-state collaborative, including Maryland, Georgia, and Wyoming – focuses on the implementation and expansion of *Care Management Entities* (CME). CME are an organizational entity that provides a youth-guided, family-driven, and strengths-based approach to care, offering intensive care coordination across public agencies and providers and access to home- and community-based services and peer supports as alternatives to costly residential and hospital stays. The state-specific CMEs are to achieve four goals:

- Improving access to home and community-based care.
- Improving clinical and functional outcomes.
- Improving youth and family resiliency.
- Improving costs of care.

The initiative includes both national and collaborative- sponsored evaluations.

> BEHAVIORAL HEALTH NEEDS OF CHILDREN IN CHILD WELFARE: A VIEW FROM BEHAVIORAL HEALTH

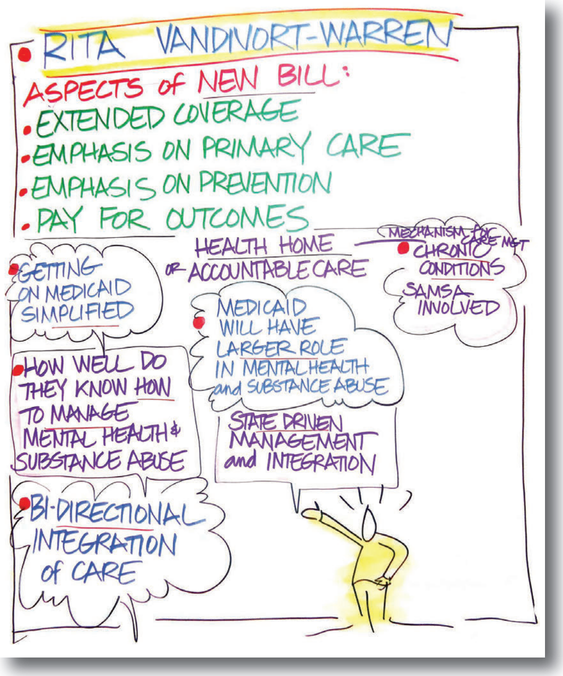
Focusing more specifically on overall behavioral health, Rita Vandivort-Warren, Senior Public Health Analyst at the Substance Abuse and Mental Health Services Administration (SAMHSA) (www.SAMHSA.gov) provided an overview related to how provisions of the ACA can expand behavioral health care coverage, improve care and promote healthy communities. The goals of the ACA are to:

- Expand coverage
- Better integrate primary care
- Emphasize prevention and wellness for those who may have chronic conditions
- Pay for outcomes, not visits or units of service.

It is critical that the efforts on reducing costs and lowering health care growth also include attention to behavioral health as these conditions drive up health care costs. In regard to the expanded coverage in 2014, the plans must include essential mental health and substance abuse benefits at parity with other health needs, and there will also be a focus on prevention. Access to either Medicaid or state exchange plans will be through a single portal and there will be simplified documentation. As previously noted, those who are up to the 400% of the federal poverty level (FPL) will be eligible for participating in a state health exchanges.

As a result of the implementation of the ACA many with substance abuse needs will become covered by health insurance for the first time. However there are concerns about how adequately Medicaid currently covers treatment for those with substance abuse diagnosis. Also, since Medicaid is mostly implemented through managed care, there is a lack of clarity about how exactly the benefits and services will be provided.

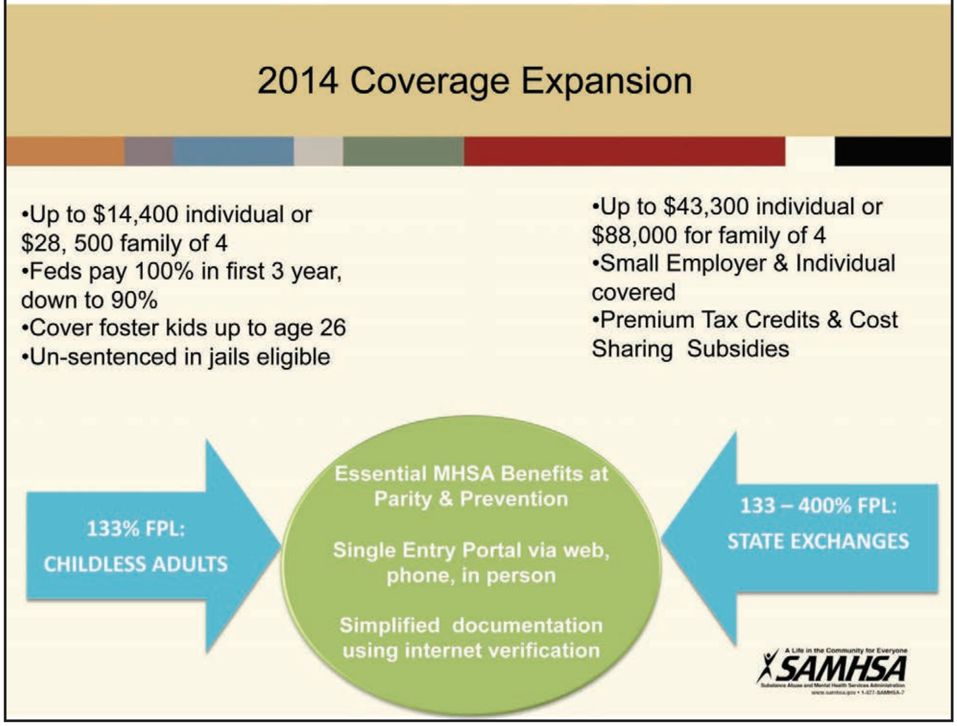
For behavioral health care there is intent for bi-directional integration, with behavioral health care provided in the primary care setting and with primary care accessible through the mental health and substance abuse treatment providers. It is not currently clear how to best serve persons with high rates of co-occurrence with multi-disciplinary team treatment, and if technology can facilitate virtual integration, when care is received at different sites. In addition, there are concerns about confidentiality for those persons receiving substance abuse treatment, with the more restrictive confidentiality requirements of 42CFR Part II.



In these integrated care models, both the advent of Medicaid Health Homes and accountable care organizations (ACO) will have the potential of bringing new care models that are better coordinated, higher quality and more cost-effective. Both Health Homes and ACOs emphasize team planning and care coordination, patient-centered treatment, support for transitions from hospitals and patient and caregiver support.

According to Section 2703 of the ACA related to Medicaid Health Homes, optional coverage can include those with chronic conditions (or at risk) including mental health and substance use disorders. For the initial two years, CMS will provide a 90% match, providing a big incentive to states. Section 2703 also requires states to consult with SAMHSA on prevention and treatment of mental health and substance abuse conditions. New Health Home services include:

FIGURE 1: 2014 COVERAGE EXPANSION



2014 Coverage Expansion

•Up to $14,400 individual or $28, 500 family of 4
•Feds pay 100% in first 3 year, down to 90%
•Cover foster kids up to age 26
•Un-sentenced in jails eligible

•Up to $43,300 individual or $88,000 for family of 4
•Small Employer & Individual covered
•Premium Tax Credits & Cost Sharing Subsidies

133% FPL:
CHILDLESS ADULTS

Essential MHSA Benefits at Parity & Prevention

Single Entry Portal via web, phone, in person

Simplified documentation using internet verification

133 – 400% FPL:
STATE EXCHANGES

- Comprehensive care management.
- Care coordination and health promotion.
- Family and patient support.
- Comprehensive transitional care.
- Referral to community and social support services.

Although not specific to children with substance abuse and mental health disorders, some of the critical issues from the perspective of SAMHSA regarding integrated care and the Medicaid Health Home option for states include:

- **Screening:** Even if person only suffering from chronic physical illnesses, still need to screen for substance abuse, tobacco and depression, since those with chronic health needs are also at risk for behavioral disorders. [SAMHSA Model: Screening, Brief Intervention Referral and Treatment (SBIRT) - www.samhsa.gov/prevention/SBIRT/index.aspx].
- **Services:** If Health Home includes those with behavioral health disorders, the array of community- and evidenced-based services, such as medication assisted treatments for addictions; assertive community treatment including crisis teams; supported employment;, peer and recovery support services, multi-systemic therapy, etc. should be considered.
- **Linkage:** Assess how primary care and behavioral health care integrate for joint planning and treatment in practical terms.
- **Behavioral Health Providers as Health Homes:** When program includes persons with mental health and/or substance abuse needs, can behavioral health providers be Health Homes if they meet all of the physical health requirements?

The move to greater use of electronic health records and health information technology are also bringing new issues to health care delivery in regard to privacy and confidentiality as well as related to coordination of care.

Overall, the major drivers of the ACA are that more people will have insurance coverage; Medicaid will have a bigger role in mental health and substance abuse disorders than before; there will be an increased emphasis on primary care and coordination with specialty care; and home and community-based services are encouraged with less reliance on institutional care. Preventing diseases and promoting wellness will become a higher priority and there will be a move toward paying for episodes and outcomes of care, and not for visits or high use of advanced technology.

Balancing these drivers of the ACA, are concerns about the flexibility that states will have as the major implementers. Yet the ACA says 3157 times that "the Secretary shall…", so clearly there are federal tasks on which the HHS Secretary must either provide guidance or regulations. In addition, two key actions yet to take place are how HHS defines the essential benefits and what the outcome will be when the Supreme Court takes action related to the ACA case now before it.

> MEASURING CHILD HEALTH OUTCOMES

With the emphasis in the ACA on outcomes, it is important to better understand the development and use of standardized measures to assess health outcomes. The symposium included information on the work of the National Quality Forum (NQF) which reviews, endorses and disseminates measures regarding health care delivery. (See Appendix 11 for more detailed information about NQF's work).

Suzanne Theberge, Project Manager at the NQF, provided an overview of NQF's work related to endorsing voluntary national consensus standards for measuring and publicly reporting on health care performance. As a standard setting organization, NQF's roles are to develop voluntary consensus standards related to performance measures, serious reportable events, preferred practices and frameworks. They accomplish this by bringing together government representatives, payers, clinicians, researchers and other health care industry stakeholders, together with consumers. NQF serves as a neutral convener, hosting both the Measurement Application Partnership (www.qualityforum.org/ map/) and the National Priorities Partnership (www.qualityforum.org/Setting_Priorities/NPP/National_Priorities_Partnership.aspx) created as part of the ACA.

Standardized performance measures are tools to assess quality that can be used to compare the performance of providers, facilities, and states. Measurement is important because it can drive improvement, inform consumers and other stakeholders, and can influence payment.

Measures endorsed by NQF consider importance (impact on patient outcomes) and meeting scientific reliability criteria. In addition, the following issues are all considered when identifying and endorsing measures.

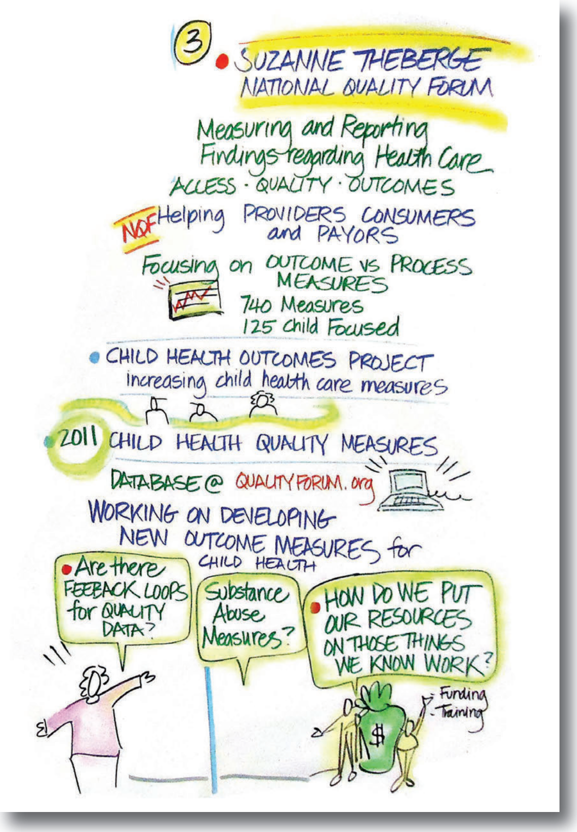
- > Feasibility of data collection.
- > How the measure is being used.
- > How understandable it is to multiple audiences.

The health care delivery stakeholders, including consumers, are invited to comment on NQF proposed measures and to use performance measures in their work. A database of measures is available at www.qualityforum.org/qps.

In regard to outcome measures in child health, the NQF, in February 2011, completed a child health outcomes project which endorsed 15 outcome measures that cover overall health and care for children. They cover both the results of care such as admission rates and mortality rates for various conditions and also assess mortality or adverse event rates related to procedures, like certain surgeries. At the population level, they assess issues of access to care as well as insurance. Examples include:

- > Healthy term newborn.
- > Standardized mortality ratio for neonates undergoing non-cardiac surgery.
- > Number of school days children miss due to illness.
- > Children who have inadequate insurance coverage for optimal health.

The NQF, as of November 2011, has endorsed over 140 measures related to child health, most recently in the Child Health Quality Measures project that was completed at that time. Endorsed child health measures include:



- Hearing screening prior to hospital discharge.
- Annual dentist visit.
- Asthma emergency department visit.
- Developmental screening by two years of age.

For more information visit www.qualityforum.org/Projects/c-d/Child_Health_Quality_Measures_2010/Child_Health_Quality_Measures_2010.aspx.

As the work of NQF moves forward in regard to outcomes measures, there will be expanded focus on disparities and population health; an increasing number of patient-reported outcomes, a move toward electronic measures and additional outcome measures that will respond to stakeholder needs. For more information visit, www.qualityforum.org.

OPTIMIZING CHILDREN'S HEALTH OUTCOMES: PERSPECTIVES FROM THE COMMUNITY

To provide a more local perspective on optimizing the health of children at risk, a panel of people who represent prevention and health promotion and coordinated health and human service delivery offered their input at the symposium.

> OPTIMIZING HEALTH IN RURAL COMMUNITIES

Deirdra Robinson, a health care researcher and faculty member at Morehead State University in Kentucky and the incoming president of the NASW Kentucky Chapter provided a perspective from rural communities. Quoting NASW 2010 Sarnat Award recipient, Dr. Gilbert Friedell, she cited "if the problem is in the community, the solution is in the community."

This should be an important mantra when addressing issues of health outcomes and health care access. Using a strengths perspective she noted that Appalachia is not necessarily deprived of resources. Rather, there are resources that can be more fully accessed to promote health and well-being. She also noted there are often trans-generational outcomes related to both child welfare and health, with new generations having similar needs as those who have come before them. This can be because in rural areas there traditionally has not been a focus on preventative care. Additionally, there are not always timely referrals to services, such as meeting the behavioral needs of children in schools.

In rural areas, the use of non-traditional providers is important and should be recognized. This might include organizations like the county Extension Offices which host various groups such as homemakers. As the ACA is implemented, health departments in communities need to be engaged as the cornerstones of community-based public health care. In addition, to improve health outcomes and to highlight health risks, it is important to have data and use it clearly and make it meaningful to the people that it impacts.

As one example of an effective community-based health intervention, Robinson highlighted a recent community-based event held in her area to promote awareness of diabetes. To increase the focus on prevention and to begin to stem the high rates of diabetes in rural communities, fun community events related to diabetes management were staged at Wal-Mart. Rather than expecting people to come to the service providers – the community events get the health providers to go to the community. Having events and community-based programs where people naturally go in the community (e.g., Wal-Mart) decreases anxiety and allows for more positive interactions. This recent community event on a Saturday at Wal-Mart included representatives from Medicaid (who want to ensure that eligible children are enrolled in CHIP), and others who were engaged in health education and awareness.

> PROMOTING FAMILY-CENTERED, CROSS-SYSTEM COLLABORATION TO IMPROVE HEALTH AND WELL-BEING

Drawing from his extensive experience in directing public agencies in several states and localities, David Berns, the current director of the Department of

Human Services in the District of Columbia (DC) provided his perspective on the importance of family-centered, strengths-based service delivery, with a focus on prevention and economic security. The details about Berns' perspective can be found in a recent article, "Is our business family-centered" that was published in the *Journal of Family Strengths* and can be accessed at http://digitalcommons.library.tmc.edu/jfs/vol11/iss1/3/.

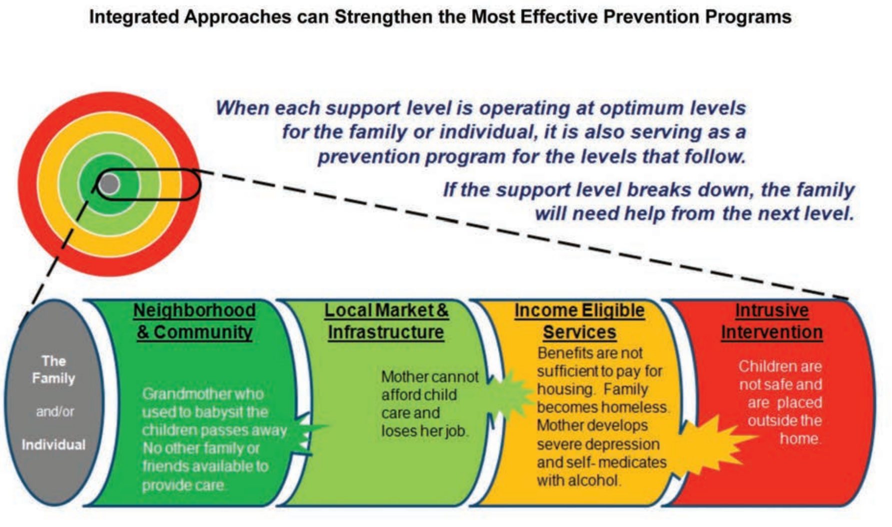
Berns, who recently came to DC to modernize the District's Temporary Assistance to Needy Families (TANF) program, noted that if we can provide for the economic security of families, we have a better chance of preventing them from coming into contact with the child welfare or juvenile justice communities. Furthermore, if we can strengthen health departments and health care delivery, then as they engage with families there can be prevention of more serious health problems and a greater focus on well-being.

From Berns' experience, rather than families having multiple case managers for each of their presenting problems, a truly family-centered approach would have one case manager with the big picture. For families involved with the child welfare system, for example, it is important to gather clear information about what brought the family to the attention of child welfare in first place – was it homelessness; being left alone because the parents had to take on multiple jobs; was it due to immigration issues. It is important to look at solutions across systems rather than to think that families' lives can be improved with a focus from just within one system. This often just makes things harder for them. Berns suggested that designing a system that works for people needs to be done at a community level rather than trying to change just one agency. He also reinforced the need to invest more in up-front services.

When Berns was director of Human Services in El Paso County, CO – a very conservative community – he was able to make changes to develop one of the most successful and humane welfare programs in the country (Hutson, 2003). Now in DC, he is working to reform the system so that families can progress out of the welfare system. With a goal of eliminating poverty, there needs to be a different approach to welfare. For example, rather than adding one more case manager to a family, Berns suggests that efforts should be made to maximize current funding and resources by using an existing case management provider and to only have one service plan so that needs can be addressed more holistically. Berns also suggests maximizing use of community service providers and supplementing them with state resources rather than supplanting them or creating duplicative services. Another key principle relates to client choice. Thus, if a client feels more comfortable working with someone from the domestic violence agency rather than the child welfare agency or the school – let them, and then train the workers to maximize communication and to report back. Figure 4 is illustrative of Berns' vision.

Berns also noted that within public agencies we often hear that the staff can be victims, too, considering themselves to be overworked, underpaid, and underappreciated. No matter where you are in an organization, he posited that 85 percent of what we do is controlled by someone else, and thus we need to fully take control over the 15 percent of what we do that we control ourselves. He suggested that a healthier workforce requires that we work on what we have control over and let go of what we do not have control over and that those within health and human services need to build hope and promote strengths in order to have better outcomes for themselves and for their clients.

FIGURE 4: INTEGRATED APPROACHES CAN STRENGTHEN THE MOST EFFECTIVE PREVENTION PROGRAMS



> A PROGRAM TO MEET HEALTH CARE NEEDS IN CHILD WELFARE

The consent decree from a class action lawsuit in Baltimore City required that action be taken to meet the health needs of the children in foster care. Thus a medical managed care unit, MATCH (Making All of the Children Healthy), was created in 2009 as a project of Baltimore HealthCare Access, Inc. (just renamed HealthCare Access Maryland), the Baltimore City Department of Social Services (DSS) and the Baltimore Mental Health Systems. The MATCH program (see overview in Appendix 8) is a project that combines the medical case management expertise of HealthCare Access with partners who are staff of the Baltimore city child welfare and mental health agencies.

Rachel Dodge, a pediatrician who is director of MATCH, described the services that their interdisciplinary team provides which include: health care system navigation; care coordination for children in foster care; medical assistance enrollment; education; and advocacy. MATCH teams are matched with permanency units at Baltimore City DSS to improve communication between the two agencies.

To be able to resolve challenges around medical assistance and enrollment in managed care, MATCH is listed as the address for all Medical Assistance correspondence. All children newly entering foster care are required to have an initial health screen within five days; a comprehensive medical exam; a dental exam (if three years or older); a mental health assessment, and a developmental assessment (if less than three years old). Medical case management is provided by nurses for children with complex medical needs and by licensed social workers for children with complex mental health needs. In Baltimore there are a high number of older children in the system because of historical challenges that the system has faced, and children have sat in the system for a long time. This creates a need to support health care transition as they age out of the system.

Some of the barriers to meeting the health care needs of children in foster care, mirroring the research described earlier, include discontinuity of care; incomplete health histories; difficulty in monitoring access to and provision of health care; multiple placements; and gaps in health coverage, sometimes delayed by moving on and off Medical Assistance (MA) and between MA and the managed care organization (MCO) (where getting back into the MCO can take an additional 10 days). Other challenges include difficulty accessing medical providers to see children within five days of entry; foster parents who want to take children to their own providers, suggesting there needs to be a cultural shift to maintain continuity of care for the children with their usual primary care providers; and challenges in infant and toddler assessment completion because of issues regarding foster/kinship parents agreeing to participate in the assessment, confidentiality issues, and issues working with and within early childhood systems. In addition, Medicaid enrollment codes do not easily identify the children who are in foster care, and there is confusion around sharing of health information due to the child's legal status and concerns regarding HIPAA.

It is hoped that the development and implementation of Medical Homes and Medicaid Health Homes will further reinforce the maintenance of children with their primary health care providers (especially when the goal is reunification) and will help to optimize their health outcomes. For foster parents, this is a transition as they have been used to taking foster children in their care to the health care providers chosen by the foster parents, rather than maintaining their connections to their family of origin providers.

CHALLENGES AND OPPORTUNITIES TO OPTIMIZING HEALTH AND HEALTH CARE FOR AT RISK CHILDREN: KEY ISSUES IDENTIFIED

Drawing from the presentations and discussions by the participants the following key issues were discussed.

It is critical to continue to grow the research base, both in terms of analysis of available NSCAW, administrative and other data, across systems, and also to support and encourage testing of interventions. These will further our understanding of the clinical, organizational and policy issues that can support or impede enhanced outcomes for children at risk and their families. In regard to NSCAW:

- NSCAW data have provided an important window to more fully understand the characteristics/ profiles and needs of children in the child welfare system.
    - Advocacy for continuing funding for NSCAW, and support for analysis of NSCAW data are important, as there was some lack of clarity about the current status of NSCAW's funding.
    - It is useful that NSCAW II includes more focus on linkages to the juvenile justice system than did NSCAW I.
- Investments in intervention research as well as in more comprehensive data collection continue to be needed.
- The comparative analysis of national, state and intra-state data is valuable and leads to better understanding of who is in the child welfare system. This should then lead to provision of more targeted, developmentally appropriate and evidence-based services.
- There is a need for more information about children in kinship care and what the impact of provisions of recent legislation will be on their health outcomes.

The health profiles of children who are in foster care are similar to children who are receiving child welfare services in their homes.

- There is a need to attend to the health and mental health needs of all children who receive child welfare services, and at all ages.
- Preventive services for those children and families who are risk of entering the child welfare system due to their health, behavioral health or developmental needs should be available.
- More supportive services to address the health and behavioral health needs of high risk parents can prevent children from needing child welfare services and also enhance the children's health outcomes.

Innovations are underway to better meet the health needs of children in foster care, at both individual and systems levels.

- Developing strategies that maintain continuity of care and coverage is essential, especially since children go in and out of foster care.
- Assuring communication among health care providers should be a priority; and transfer of information among different health care providers and between the health and social service systems needs to be enhanced.
- Implementation of some health programs in child welfare are creating changes in foster families' roles. It has been an accepted practice in many locales for foster families to choose foster children's health providers based on the foster families' preference and location. Program models like MATCH work to keep children's health care with their primary care provider to promote greater continuity of care. This may be viewed as less convenient by the foster family. Thus, optimizing children's health care may require adjustments and changes in expectations, as efforts to provide higher quality and more consistent health care services are implemented.

There are variations among how MCOs operate. This may be due to variations in states' policies in terms of structure of MCO programs, including differences in how they work with and communicate with other agencies and service providers.

- It would be helpful to have effective early adaptors serve as guides and mentors to those who are developing new health care program models for children served by the child welfare system.

- Enhancing health care services for children receiving child welfare services will require addressing child, family and system issues; and also require grappling with concerns related to confidentiality, cross-system data access and shared outcomes.
- The physical and behavioral health needs of both children at risk and their parents need to be more fully and consistently addressed, including enhancement of preventative services.

High risk populations are now better identified, suggesting that new, more targeted and evidence-based services could be provided.

- There are a number of innovations underway to better meet the mental health needs of children in care. However, more attention is also needed to physical health concerns – e.g., control of diabetes and asthma in children.
- Examination of obesity finds that when obese children enter foster care, they continue to be obese while in care, suggesting the need for targeted interventions for the child and the caregivers.
- For children in immigrant families, especially if families are undocumented, they may not regularly access health care for themselves or their children.
- Children in the system have high rates of developmental delays suggesting that screening and early intervention are important.
- The evidence-based early childhood home visiting program included in the ACA is one vehicle to meet the developmental needs of high risk children and to support and train parents.

MATERNAL, INFANT AND EARLY CHILDHOOD HOME VISITING PROGRAM

The Patient Protection and Affordable Care Act (P.L. 111-148) established a $1.5 billion federal grant program, the Maternal, Infant and Early Childhood Home Visiting Program, to support state-based home visiting programs serving families with young children and families expecting children. This program is being implemented through collaboration between the Maternal and Child Health Bureau at HRSA and the Children's Bureau in coordination with several other federal agencies. In September 2011 the Secretary of HHS announced that $224 million dollars had been awarded to 49 states in both formula and discretionary grants. Resources on evidence-based home visiting programs can be found at www.pewcenteronthestates.org/initiatives_detail.aspx?initiativeID=52756; http://supportingebhv.org/; & http://mchlibrary.info/guides/homevisiting.html.

Children receiving foster care services are high users of psychotropic medications.

- There is insufficient availability of high quality behavioral health services for children in the foster care system.
- Despite the focus on using psychotropic medications, effective psychotherapeutic evidence-based interventions have been identified, but are not widely implemented.
- Greater emphasis should be placed on what services and interventions would work best, and not based on cost or which interventions are easiest to administer.

There is a need for better communication and collaboration across systems.

- Several of the efforts to provide health care within the child welfare system can serve as models to other states and localities (e.g., MATCH Baltimore, MD and Starlight Pediatrics, Rochester, NY).
- HHS is making efforts to enhance communication and collaboration among state child welfare directors, Medicaid directors and behavioral health directors to decrease the rate of usage of psychotropic medications and to improve mental health outcomes.
  - A recent letter from ACF, CMS and SAMHSA's a good federal start (www.childwelfare.gov/systemwide/mentalhealth/effectiveness/jointlettermeds.pdf).
  - The three agencies will convene webinars and meetings with state Medicaid and child welfare directors in 2012 (www.childwelfare.gov/systemwide/mentalhealth/effectiveness/psychotropic.cfm).

PARTNERING TO IMPROVE HEALTH CARE FOR CHILDREN IN FOSTER CARE

In November 2010, growing out of PolicyLab's research on system factors influencing the health of children in foster care, PolicyLab together with the National Association of Public Child Welfare Administrators (NAPCWA) and the Fostering Connections Resource Center at Child Trends sponsored a cross-system meeting for states to share strategies how to best coordinate health care for children in child welfare. At the meeting, over 100 people came together including child welfare directors, health experts, Medicaid leadership, and key health partners and included ten state cross-system teams with representatives from both health and child welfare. The sessions highlighted leading efforts from around the country to better coordinate and deliver care in the era of Fostering Connections with a particular focus on data sharing and the oversight of psychotropic medications. For more see: www.fosteringconnections.org/healthconvening.

Expansion of access to health coverage for parents beginning in 2014 may also improve access to care for at risk children and a decrease in health and mental health problems (including depression) for mothers.

- Outreach is essential to encourage coverage and use of the health care system for those who need it.

There are a growing number of available evidence-based practices (EBP) that can be used to enhance outcomes for at risk children.

- Different evidence-based practices target different populations and problems.
- Information on a wide array of evidence-based practices needs to be available.

RESOURCES ON EVIDENCE-BASED CHILD WELFARE INTERVENTIONS

- California Evidence-Based Child Welfare Clearinghouse – www.cebc4cw.org
- CDC Community Guides – www.thecommunityguide.org
- Child Welfare Information Gateway – www.childwelfare.gov/management/practice_improvement/evidence/ebp.cfm
- National Child Traumatic Stress Network www.nctsn.org
- National Registry of Effective Programs and Practices – www.nrepp.samhsa.gov.

- Agencies need assistance in the process of effectively adapting and adopting evidence-practices, which requires an understanding of organizational climate and culture, readiness to adapt and staff capacity and competency.
- Issues of staff turnover can impact how programs are implemented and also affect client outcomes.
- Implementation of EBPs needs to fit with the community's culture and needs.

Training and availability of competent and qualified health and human services professionals to bridge the health and child welfare systems are essential.

- Low reimbursement rates for specialty care often discourage physicians from participating in Medicaid. This which may be reversed by provisions in the ACA that require that rates be raised to Medicare levels.
- Caregivers may have difficulty in locating specialty care providers.
- Health care providers and child welfare staff need to be trained to work together and to collaborate to enhance outcomes.
- Providers need to work together and partner with families and with children in care.
- Training and support on evidence-based interventions and how they can be implemented are needed.
- Health and child welfare service providers need to recognize and support family strengths and encourage family members' voices in health decisions.
- Universities can facilitate interdisciplinary training and educational opportunities among physicians, nurses, social workers, psychologists and educators to better support foster children and other children and families at risk.

The politicization surrounding the ACA should be viewed as a very high stakes concern.

- Many see it as a proxy debate around the role of government in intervening in social problems.
- Controversy focuses on issues of enhanced access and the breadth of Medicaid coupled with the tight budgets in states and at the federal level.
- The ACA provides opportunities for expanded and higher quality health care for at risk children and their families.

DEVELOPING AN AGENDA FOR ACTION

The goal of the six working groups was to identify action steps that should be taken to improve health outcomes, enhance communication and collaboration, promote the use of evidence-based practices, and to better serve children and families. The following six questions were addressed with each participant having an opportunity to provide input into three, using the World Café process.

Questions for Working Groups

1) What communication strategies can be improved to acquaint service providers and agency administrators with effective models, resource information, and policy opportunities to better meet the health needs of children in the child welfare system?
2) What further research, measures and data are needed to better understand the health needs, health outcomes, and health care access issues for children in the child welfare system or at risk of being in the child welfare system?
3) What roles can national organizations take, working together with federal agencies to more fully enhance access and quality health care for children at risk? Who needs to work together? To what ends?
4) What can universities, including schools of social work, medicine, law, public health and nursing, do to improve health outcomes for children at risk? What is needed in the curriculum? What kinds of partnerships are needed among disciplines and with community service providers?
5) What policy changes (enhancements) at the state and federal levels are necessary to improve outcomes for children in the child welfare system and those at risk of the child welfare system? What are specific (and potentially winnable) opportunities on the horizon?
6) What stakeholders need to work together at the federal and state levels? - What leadership is needed? What tools are needed?

After the working groups output was posted so that each participant could vote for their three priority actions. Of the more than 60 recommendations suggested by the working groups, the following list identifies the recommendations that were prioritized by the participants. Based on the voting the following recommendations were prioritized:

- > **Improve communications between agencies, providers and managed care organizations.**
- > **Create a more focused and coordinated effort to address health care needs of children served in the child welfare system at the highest levels with state and federal governments.**
- > **Ask children and families what outcomes are important to them.**
- > **Promote access and continuity of care for children who have contact with the child welfare system.**
- > **Ensure that the voices of families, communities and foster care alumni are included in the development of models to address health care needs in the child welfare system.**
- > **Clarify the authority to consent for health care, early intervention and other services for those who are in the foster care system and those who are served in their own home.**
- > **Create systems of communication to achieve better understanding and accountability.**
- > **Promote the establishing of cross-disciplinary committees, working groups and projects within universities to examine how to improve health outcomes.**

> SUMMARY RECOMMENDATIONS

In order to accomplish these efforts it will be required that:

- > National organizations continue to work together.
- > Research to policy efforts like those undertaken by PolicyLab be emulated in other jurisdictions and supported through government, foundation and insurer funding.
- > Model program efforts be systematically and competently evaluated and that findings be broadly disseminated.
- > Interdisciplinary education, training, planning and service delivery be supported and encouraged.
- > Families and communities be engaged in planning and implementing

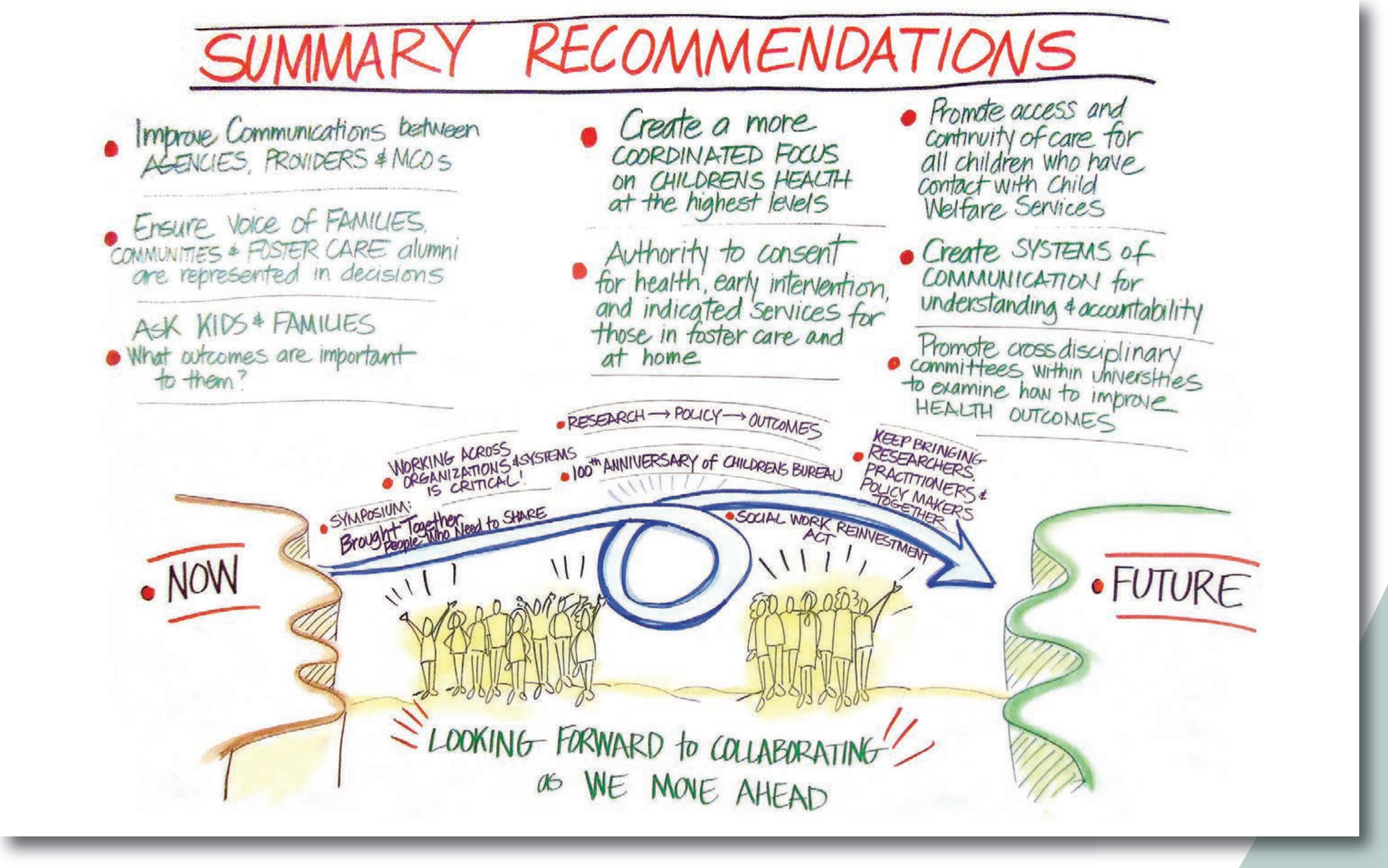
services and research studies.

- Greater attention be paid to developing, testing and endorsing health outcomes that address psychosocial needs and well-being.
- Recent legislative enhancements related to the health and well-being of at-risk children and families be well communicated to stakeholders and effectively implemented.
- Policy-makers seek input and guidance from family members, foster care alumni and service providers in order to implement the most effective and evidence-based services.
- Federal research agencies, i.e., the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ) work in consort with entities that fund programs and innovations so that research can inform policy and practice and so that practice issues can inform future research endeavors.

Children at Risk: Optimizing Health in An Era of Reform brought together key stakeholders with experiences at the federal, state and local levels, drawing from research, practice, and policy expertise. This convening covered a great deal of territory in a short time and reinforced the understanding that:

- Legislative changes have brought new opportunities and greater attention to the health outcomes of at-risk children.
- Success will require people working together – engaging with families and communities and using a strengths-based perspective.
- State and local governments along with insurance payers and community agencies all have a role to play in working with the federal government to improve health outcomes and create coordinated service delivery.
- Research plays an important role in both understanding who is served and in testing innovations.
- Dissemination of effective innovations is critical to improving health outcomes.

This collaboration between the Social Work Policy Institute, USC and PolicyLab can serve as an example of cross-system and cross-disciplinary knowledge development and can also serve as a model for others to emulate to address critical issues facing our most vulnerable children and families.



SUMMARY RECOMMENDATIONS

- Improve Communications between AGENCIES, PROVIDERS & MCOs
- Ensure Voice of FAMILIES, COMMUNITIES & FOSTER CARE alumni are represented in decisions
- ASK KIDS & FAMILIES What outcomes are important to them?
- Create a more COORDINATED FOCUS on CHILDRENS HEALTH at the highest levels
- Authority to consent for health, early intervention, and indicated services for those in foster care and at home
- Promote access and continuity of care for all children who have contact with Child Welfare Services
- Create SYSTEMS of COMMUNICATION for understanding & accountability
- Promote cross disciplinary committees within universities to examine how to improve HEALTH OUTCOMES

- RESEARCH → POLICY → OUTCOMES
- WORKING ACROSS ORGANIZATIONS & SYSTEMS IS CRITICAL!
- 100th ANNIVERSARY of CHILDRENS BUREAU
- KEEP BRINGING RESEARCHERS, PRACTITIONERS & POLICY MAKERS TOGETHER
- SYMPOSIUM: Brought Together People Who Need to SHARE
- SOCIAL WORK REINVESTMENT ACT

LOOKING FORWARD to COLLABORATING as WE MOVE AHEAD

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APPENDIXES

APPENDIX

1 > CHILDREN AT RISK: OPTIMIZING HEALTH IN AN ERA OF REFORM

AGENDA

Thursday, November 17, 2011

Hosted by the NASW Foundation Social Work Policy Institute
In collaboration with contributing partners, The School of Social Work, University of Southern California, and PolicyLab of The Children's Hospital of Philadelphia.

NASW National Office: 750 First Street, NE, Suite 700, Washington, DC

REGISTRATION AND CONTINENTAL BREAKFAST

WELCOME, INTRODUCTIONS AND GOALS

PANEL 1 – SETTING THE CONTEXT

- **Lessons from Recent Research on Children in Child Welfare and Health Care**
  Janet Schneiderman, USC, Symposium Academic Chair
- **Bridging Research and Policy to Improve the Behavioral Health of Children in Child Welfare**
  Sarah Zlotnik, PolicyLab
- **Measuring Children's Health Outcomes – Current Status and Future Efforts**
  Suzanne Theberge, National Quality Forum

PANEL 2 – LEGISLATION AND IMPLEMENTING POLICIES TO IMPROVE HEALTH OUTCOMES

- **Public Coverage for Children in an Era of Reform**
  Joan Alker, Georgetown University Center for Children and Families
- **Innovations in Health-Related Care for Children in Child Welfare**
  Kamala Allen, Center for Health Care Strategies

PANEL 3 – IMPROVING SYSTEMS, DEVELOPING LINKAGES, PROVIDING CARE ON THE GROUND

- **A View from Appalachia**
  Deirdra Robinson, Morehead State University
- **A State and Local Perspective – Agencies Working Together for Families**
  David Berns, Department of Human Services, Washington, DC
- **Integrating Behavioral Health Care into Health Care**
  Rita Vandivort-Warren, Substance Abuse and Mental Health Services Administration
- **Health Care in Child Welfare**
  Rachel Dodge, MATCH Program, Baltimore, MD

LUNCH

ACTION GROUPS

REPORT BACK & SUMMARY AND CONCLUSIONS

ADJOURN

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Former Director in the Ministry of
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Anna Swai
Development Director

3 > SPEAKER BIOGRAPHIES

Kamala Allen, MHS
Vice President, Program Operations Director, Child Health Quality Center for Health Care Strategies (CHCS)
Kamala Allen, MHS is the vice president for program operations and director of child health quality at the Center for Health Care Strategies (CHCS). In these roles, Ms. Allen is responsible for ensuring the quality and efficiency of overall organizational programming, and providing direct oversight of all CHCS' child-focused initiatives. She has extensive experience in the application of quality improvement methodologies and the use of managed care in public child-serving systems, and is also responsible for the direction and financial management of the Children in Managed Care initiative, which has been funded since 1995 by the Annie E. Casey Foundation. Ms. Allen holds a master of health science in maternal and child health from the Johns Hopkins University's Bloomberg School of Hygiene and Public Health. She earned a bachelor's degree in psychology with a concentration in developmental disabilities from the University of California at Los Angeles.

Prior to assuming her current responsibilities, Ms. Allen was associate director for special projects for the Robert Wood Johnson Foundation's Medicaid Managed Care Program, where she oversaw the development and execution of state agency training programs in health care quality, and served as associate director for program analysis and communications. She also worked as a program analyst in the U.S. Department of Health and Human Services' Maternal and Child Health Bureau's Office of Program Development, where she was a contributing author to the 1994 Bureau White Paper; and as project coordinator for the states' responses to the Title V Block Grant Guidance. Ms. Allen was the project coordinator at the Centers for Disease Control's Maryland Center for Adolescent Health Promotion and Disease Prevention, where she co-developed and oversaw the implementation of a school-based health promotion curriculum in two Baltimore middle schools.

Joan Alker, MPP
Co-Executive Director, Georgetown Center for Children and Families
Research Associate Professor, Georgetown University Health Policy Institute
Joan Alker, MPP is co-executive director at the Georgetown Center for Children and Families and a Research Associate Professor at the Georgetown University Health Policy Institute. Her work focuses on health coverage for low-income children and families, with an emphasis on state Medicaid initiatives including waivers, premium assistance policies, immigrant issues, and cost-sharing.

A frequent speaker and commentator, Alker has over twenty years of experience working on issues affecting low-income families. She holds a Master of Philosophy in politics from St. Antony's College, Oxford University and a Bachelor of Arts with honors in political science from Bryn Mawr College.

David A. Berns, MSW
Director, Department of Human Services
Government of the District of Columbia
David A. Berns, MSW appointed by District of Columbia, Mayor Vincent C. Gray, serves as the Director of the Department of Human Services (DHS). Mr. Berns comes to DHS from the Casey Family Programs where he served as the Executive Vice President for Child and Family Services since 2006. He provided strategic direction to the foundation's nine field offices in Arizona, California, Idaho, Texas and Washington, and its Indian Child Welfare office in Colorado. Prior to joining the Casey Family Programs, Mr. Berns served as director of the Arizona Department of Economic Security. In Arizona, he managed a staff of 10,000 employees and a budget of $2.7 billion, leading Arizona's welfare programs, development disabilities services, employment services, child welfare, child support, aging and community services.

Mr. Berns received his Master of Arts in Public Administration from Northern Michigan University and his Master in Social Work and bachelor's degree from Michigan State University. Mr. Berns was named Social Worker of the Year in 1999 by the Colorado chapter of the National Association of Social Workers. He also received the Award for Excellence in Public Child Welfare Administration from the National Association of Public Child Welfare Administrators.

Rachel Dodge, MD, MPH, FAAP Medical Director for Foster Care, Baltimore HealthCare Access, Inc.
The MATCH Program at BCDSS
Rachel Dodge, MD is a general pediatrician with training in public health, research methods, leadership, and advocacy. She received her medical degree from the University of Maryland, School of Medicine in 2002 and completed the pediatric residency program at Rainbow Babies and Children's Hospital/University Hospitals of Cleveland in 2005. Dr. Dodge completed the General Pediatric Academic Development Fellowship at the Johns Hopkins School of Medicine and earned a Master's of Public Health degree from the Johns Hopkins Bloomberg School of Public Health. Currently, Dr. Dodge is the medical director of the MATCH (Making All The Children Healthy) Program, a project of Baltimore HealthCare Access and Baltimore City Department of Social Services. In this role, she oversees the coordination of health care for Baltimore City children in foster care and works closely with the pediatric primary care, dental and mental health communities. In addition, Dr. Dodge is an Assistant Professor of Pediatrics at Johns Hopkins University School of Medicine and is an Attending Physician in the Johns Hopkins Harriet Lane Pediatrics Clinic.

Deirdra Robinson, ABD, MSW
Instructor, Morehead State University
Deirdra Robinson received her BSW and MSW from the University of Kentucky. Having grown up in a rural town in Eastern Kentucky, her passion for social justice led her to work in community development. Ms. Robinson is an instructor at Morehead State University in the Department of Sociology, Social Work and Criminology. Her research and community development work focuses on health disparities and rural health issues. She is currently the President-elect for the National Association of Social Workers-Kentucky Chapter. Deirdra is also working on her dissertation, with an anticipated completion of her Doctorate of Philosophy in Social Work in 2011.

Janet U. Schneiderman, PhD, RN
Associate Professor, University of Southern California, School of Social Work
Symposium Academic Chair
Janet U. Schneiderman, PhD, RN, is an associate professor at the University of Southern California, School of Social Work. She has been researching the health and health care of children in child welfare for the last 10 years. Dr. Schneiderman has a KO1 from the Eunice Kennedy Shiver National Institute of Child Health and Human Development to study the prevention of medical neglect in the child welfare system. The emphasis of this mentored research award is to study health problems of maltreated children and how caregivers (birth parents and foster caregivers) access and use pediatric health services to prevent and treat their child's health problems. Recently, she has begun looking at obesity in maltreated children, the relationship of psychological problems and developmental changes with obesity, as well as how foster care affects obesity rates.

Suzanne Theberge, MPH
Project Manager, National Quality Forum
Suzanne Theberge is a project manager at the National Quality Forum, where she works on NQF's child and maternal health projects. She has worked at a range of reproductive health and child health-focused organizations in Boston, New York City, and Washington, DC. She holds an MPH in Population and Family Health from the Mailman School of Public Health at Columbia University.

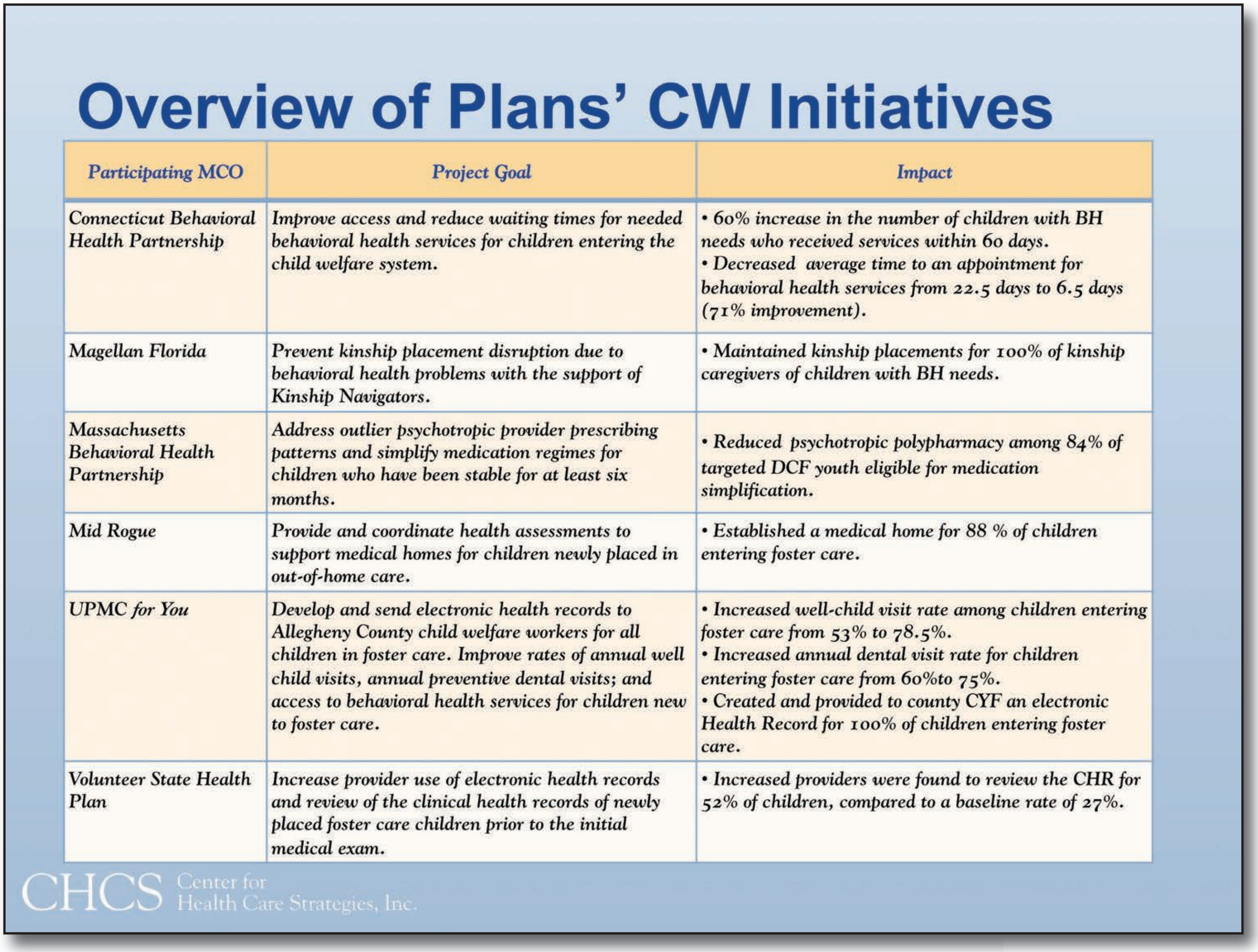
Rita Vandivort-Warren, MSW
Senior Public Health Analyst, Division of Services Improvement, CSAT, SAMHSA
Rita Vandivort-Warren, MSW is a Senior Public Health Analyst in the Division of Services Improvement, CSAT, SAMHSA. She serves as the expert on financing and cost of treatment, center lead on Medicaid and health reform issues, directs cost studies, and provides technical assistance on financing to states, grantees and providers. Previously, she worked at the National Association of Social Workers on managed care, mental health and substance abuse, and Medicaid. In Hawaii, Rita worked at the Queen's Medical Center in Honolulu as Ambulatory Psychiatric Manager and created a foster family for elderly program funded under a Home and Community Based Waiver.

Joan Levy Zlotnik, PhD, ACSW
Director, Social Work Policy Institute
Joan Levy Zlotnik, PhD, ACSW is director of the Social Work Policy Institute in the NASW Foundation. She previously served as executive director of the Institute for the Advancement of Social Work Research and as staff director of NASW's Family Commission and as a Government Relations Associate at the NASW. She was also Director of Special Projects and Special Assistant to the Executive Director at the Council on Social Work Education.

She holds a PhD in Social Work from the University of Maryland, an MSSW from the University of Wisconsin-Madison, and a BA from the University of Rochester. Dr. Zlotnik is a fellow of the Gerontological Society of America and an NASW Social Work Pioneer® and was recognized by the National Institute of Health's (NIH) Social Work Research Working Group for her efforts on behalf of social work research at NIH.

Sarah Zlotnik, MSW, MSPH
Senior Strategist, PolicyLab: Center to Bridge Research, Practice, and Policy at The Children's Hospital of Philadelphia Research Institute
Sarah Zlotnik, MSW, MSPH, is a senior strategist at PolicyLab: Center to Bridge Research, Practice, and Policy at The Children's Hospital of Philadelphia Research Institute. Ms. Zlotnik provides organizational support across the Center and leads the Center's strategy for research impact. She works with project teams to incorporate the policy and practice context in research design and coordinates the Center's communications strategy and engagement with stakeholder partners. Ms. Zlotnik's most recent projects focus on cross-system efforts to improve physical and mental health care for children in the child welfare system. Additionally, Ms. Zlotnik is a course instructor with the University of Pennsylvania School of Medicine's Masters of Science of Health Policy program. Prior to joining PolicyLab, Ms. Zlotnik provided technical support to HIV/AIDS organizations in the United States, Cambodia, and South Africa. Ms. Zlotnik's direct-service experience includes running programs for families in public housing and working in therapeutic foster care. Ms. Zlotnik holds a master of social work and masters of science of public health with a specialization in maternal and child health from the University of North Carolina - Chapel Hill.

4 > CENTER FOR HEALTH CARE STRATEGIES' OVERVIEW OF THE CHILD WELFARE INITIATIVES MANAGED CARE ORGANIZATIONS'



Overview of Plans' CW Initiatives

Participating MCO	*Project Goal*	*Impact*
Connecticut Behavioral Health Partnership	*Improve access and reduce waiting times for needed behavioral health services for children entering the child welfare system.*	*• 60% increase in the number of children with BH needs who received services within 60 days.* *• Decreased average time to an appointment for behavioral health services from 22.5 days to 6.5 days (71% improvement).*
Magellan Florida	*Prevent kinship placement disruption due to behavioral health problems with the support of Kinship Navigators.*	*• Maintained kinship placements for 100% of kinship caregivers of children with BH needs.*
Massachusetts Behavioral Health Partnership	*Address outlier psychotropic provider prescribing patterns and simplify medication regimes for children who have been stable for at least six months.*	*• Reduced psychotropic polypharmacy among 84% of targeted DCF youth eligible for medication simplification.*
Mid Rogue	*Provide and coordinate health assessments to support medical homes for children newly placed in out-of-home care.*	*• Established a medical home for 88 % of children entering foster care.*
UPMC for You	*Develop and send electronic health records to Allegheny County child welfare workers for all children in foster care. Improve rates of annual well child visits, annual preventive dental visits; and access to behavioral health services for children new to foster care.*	*• Increased well-child visit rate among children entering foster care from 53% to 78.5%.* *• Increased annual dental visit rate for children entering foster care from 60%to 75%.* *• Created and provided to county CYF an electronic Health Record for 100% of children entering foster care.*
Volunteer State Health Plan	*Increase provider use of electronic health records and review of the clinical health records of newly placed foster care children prior to the initial medical exam.*	*• Increased providers were found to review the CHR for 52% of children, compared to a baseline rate of 27%.*

CHCS Center for Health Care Strategies, Inc.

5 > SELECTED RESOURCES — HEALTH CARE & CHILDREN AT RISK

GOVERNMENT REPORTS

Organization/TITLE	URL	Description
HHS – CMS Low Cost Health Insurance for Children and Families **OVERVIEW CHILDREN'S HEALTH INSURANCE PROGRAM**	www.cms.gov/LowCostHealthInsFamChild/ www.cms.gov/CHIPRA	The Low Cost Health Insurance for Children and Families on the CMS website provides an array of information including an overview of the reauthorization, information for state Medicaid Directors and information on outreach grants and information on the Healthy Start, Grow Smart" health education series
HHS the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF) **AFFORDABLE CARE ACT (ACA) MATERNAL INFANT AND EARLY CHILDHOOD HOME VISITING PROGRAM**	www.acf.hhs.gov/earlychildhood/docs/ACA_home_visiting_overview.pdf	Describes home visiting program established under the ACA
US Preventive Services Task Force **FIRST ANNUAL REPORT TO CONGRESS ON HIGH-PRIORITY EVIDENCE GAPS FOR CLINICAL PREVENTIVE SERVICES**	www.uspreventiveservicestaskforce.org/annlrpt/tfannrpt2011.pdf	Oct. 2011 USPTF report to Congress, required by the ACA, notes that further research is needed regarding interventions in primary care to prevent child abuse and neglect ; and that evidence gaps relating to specific populations and age groups that deserve further research include screening and treatment for depression in children
HHS – National Institute of Mental Health – **CHILD AND ADOLESCENT MENTAL HEALTH**	nimh.nih.gov/health/topics/child-and-adolescent-mental-health/index.shtml	Contains featured publications and current research topics on child and adolescent mental health.
HHS Administration for Children and Families – Office of Refugee Resettlement: **HEALTH BENEFITS**	www.acf.hhs.gov/programs/orr/benefits/health.htm	Provides information on health challenges to refugees, the medical screening process, health promotion and prevention.
HHS – Agency for Healthcare Research and Quality: **CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)**	www.ahrq.gov/chipra/	Describes efforts of the AHRQ, Centers for Medicare & Medicaid Services (CMS), and CHIPRA Federal Quality Workgroup to implement selected provisions of the legislation related to children's health care quality.

Organization/TITLE	URL	Description
HHS – ACF **INTEROPERABILITY TOOLKIT ENHANCES SERVICE INTEGRATION**	www.acf.hhs.gov/interop/toolkit.pdf	As States prepare for various technological changes and upgrades associated with the implementation of the Affordable Care Act (ACA), the Department of Health and Human Services (HHS) and the Administration for Children and Families (ACF) have released a toolkit, which aims to facilitate greater communication and service integration between State agencies and their health partners. The toolkit provides up-to-date information and resources to support the efforts of workers and agencies in order to better serve clients and achieve better outcomes.
National Institutes of Health Surgeon General's **WORKSHOP ON MAKING PREVENTION OF CHILD MALTREATMENT A NATIONAL PRIORITY: IMPLEMENTING INNOVATIONS OF A PUBLIC HEALTH APPROACH**	www.surgeongeneral.gov/topics/childmaltreatment/	Summarizes exchange of perspectives from leaders of diverse disciplines during a workshop aimed at elucidating ways to implement effective strategies for preventing child maltreatment using a public health approach.
HHS – CDC **THE EFFECTS OF CHILDHOOD STRESS ON HEALTH ACROSS THE LIFESPAN**	www.cdc.gov/ncipc/pub-res/pdf/Childhood_Stress.pdf	This 2008 report from the CDC by Middlebrook and Audage provides an overview of the Adverse Childhood Experiences study and its implications.
HHS – Administration for Children and Families, Office of Child Support Enforcement **PROMOTING CHILD WELL-BEING AND FAMILY SELF-SUFFICIENCY**	www.acf.hhs.gov/programs/cse/pubs/factsheets/child_support/health_care_coverage.pdf	Describes how the Child Support Enforcement Program assists in increasing health coverage for children and their parents.

ORGANIZATION REPORTS AND POLICY BRIEFS

Organization/TITLE	URL	Description
PolicyLab: Center to Bridge Research, Practice, and Policy **MEETING THE MENTAL HEALTH NEEDS OF CHILDREN**	http://policylab.us/images/pdf/e2a2-mental%20health.pdf	This 2010 Examines the evidence surrounding key issues in children's mental health and proposes policy actions to improve outcomes for children and their families
Center for Health Care Strategies **MEDICAID MANAGED CARE FOR CHILDREN IN CHILD WELFARE**	www.chcs.org/publications3960/publications_show.htm?doc_id=683204	This 2008 issue brief examines the complex physical and behavioral health care needs and associated costs for children in child welfare and outlines critical opportunities and challenges within Medicaid to better manage care for this high-risk, high-cost population.
American Public Human Services Association Health Services Division **MEDICAID AND CHIP IN 2014: A SIMPLE SEAMLESS PATH TO AFFORDABLE COVERAGE**	http://hsd.aphsa.org/Home/doc/CMCS_MAGI_Slides.pdf	The Health Services Division of APHSA provides an overview of expanded coverage that kicks-in in 2014.
Alliance for Health Reform **THE FUTURE OF CHILDREN'S HEALTH COVERAGE**	www.allhealth.org/publications/Child_health_insurance/The_Future_of_Childrens_Health_Coverage_98.pdf	Reviews changes in children's health coverage based on provisions of the ACA

Organization/TITLE	URL	Description
American Humane Assn, Children's Defense Fund, Center for the Study of Social Policy, Child Welfare League of America and ZERO to THREE – **A CALL TO ACTION ON BEHALF OF MALTREATED INFANTS AND TODDLERS**	www.americanhumane.org/assets/pdfs/children/zero_to_three.pdf	This document represents the collective vision of important steps that can and should be taken in policies, programs, and practices to better address the developmental needs of infants and toddlers who come to the attention of the child welfare system.
Kaiser Family Foundation – Kaiser Commission on Medicaid and the Uninsured – **KEY FACTS: CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA). KEY FACTS: STATE ADOPTION OF COVERAGE AND ENROLLMENT OPTIONS IN THE CHILDREN'S HEALTH INSURANCE REAUTHORIZATION ACT OF 2009**	www.kff.org/medicaid/ www.kff.org/medicaid/upload/7863.pdf www.kff.org/medicaid/8146.cfm	Kaiser Commission provides Links and a range of Resources and information Fact Sheets on Medicaid and children's health insurance coverage.
Child Welfare Information Gateway **USE OF PSYCHOTROPIC MEDICATIONS: STATE AND LOCAL EXAMPLES**	www.childwelfare.gov/systemwide/mentalhealth/effectiveness/pmslexamples.cfm	This resource provides examples of State policies, guidelines, and information regarding the use of psychotropic medications for children and youth, with a focus on foster care.
National Resource Center for Permanency and Family Connections **FOSTERING CONNECTIONS: HEALTH CARE PROVISIONS OVERVIEW**	www.nrcpfc.org/fostering_connections/PL110-351.html#205	Provides overview of the health care provisions of Sections 202 and 205 of the Fostering Connections Act, and amendments to Fostering Connections based on the ACA.
National Resource Center for Permanency and Family Connections: **FOSTERING CONNECTIONS IN HEALTH CARE**	www.nrcpfc.org/fostering_connections/health_care_services.html#overview	Links to reports on promising practices and policies regarding health for children in foster care and those aging out of care. Includes resources on transition age youth and exemplar comprehensive health care oversight and coordination plans addressing continuity of care, medical homes, and unique needs of special populations. Includes links to wealth of evidence based practices and research reports on these topics.
National Federation of Families for Children's Mental Health – **PUBLIC POLICY: HEALTH CARE REFORM IMPLEMENTATION**	http://ffcmh.org/what-we-do/policy	Includes FAQs about health care reform implementation and mental health parity, child enrollment information, the Patient's Bill of Rights, and eliminating health care disparities.
Technical Assistance Partnership for Child and Family Mental Health (TA Partnership): **SUPPORTING PARENTS WITH MENTAL HEALTH NEEDS IN SYSTEMS OF CARE**	www.tapartnership.org/docs/Supporting%20Parents%20With%20Mental%20Health%20Needs%20Issue%20Brief.pdf	Drawing on the responses of 15 communities implementing systems of care (SOC) grants through the U.S. Department of Health and Human Services' Comprehensive Community Mental Health Services for Children and Their Families Program, this issue brief explores how SOC principles and practices can be used to assess parental mental health needs, engage and support caregivers, and increase access to services. Several successful approaches to assessing potential mental health needs were highlighted.
Georgetown University Health Policy Institute Center for Children and Families **FULFILLING THE PROMISE OF HEALTH CARE REFORM – IMPLEMENTATION RESOURCES FOR STATES**	http://ccf.georgetown.edu/index/hcr	Provides a broad array of resource information including Guides and regulations for implementing Medicaid and CHIP changes, exchange coverage and tax credits, and insurance market reforms,

Organization/TITLE	URL	Description
Mathematica Policy Research, Inc. **CHILDREN IN FOSTER CARE: CHALLENGES IN MEETING THEIR HEALTH CARE NEEDS THROUGH MEDICAID**	www.mathematica-mpr.com/publications/PDFs/fostercarebrief.pdf	2001 Policy Brief – To address problems related to the health care of children in foster care, policymakers must have detailed information about health status, health care utilization, and Medicaid expenditures.
ALL CHILDREN MATTER: HOW LEGAL AND SOCIAL INEQUALITIES HURT LGBT CHILDREN	www.children-matter.org/	A compendium of resources related to outcomes for LGBTQ youth, put together by the Movement Advancement Project, including NASW, Evan Donaldson Adoption Institute & CWLA as partners.
Annie E. Casey Foundation – **KIDS COUNT: STATE FACT SHEETS ON HEALTH AND WELL-BEING OF AMERICA'S CHILDREN**	www.aecf.org/MajorInitiatives/KIDSCOUNT/StateFactSheets.aspx	Fact sheets comparing indicators of health and well-being for children in low-income and higher-income families, based on data from the American Community Survey and the National Survey of Children's Health.
Annie E. Casey Foundation – **ADDRESSING THE MENTAL HEALTH NEEDS OF YOUNG CHILDREN IN THE CHILD WELFARE SYSTEM: WHAT EVERY POLICYMAKER SHOULD KNOW**	www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={1FA2AA3F-9C9A-4DAA-A36D-5FC99CA8B99E}	An issue brief exploring what is known about young children in the child welfare system, how maltreatment impacts their development, and services currently offered to help them.
National Immigration Law Center – **HEALTH CARE FOR IMMIGRANTS AND REFUGEES**	www.nilc.org/immspbs/health/index.htm	Links to policy summaries on the implementation of the Immigrant Children's Health Improvement Act (ICHIA), the expanded state option coverage for immigrants after the passage of CHIPRA in 2009, and how the ACA affects immigrants.
Tufts University Clinical and Translational Science Institute **MULTI-STATE STUDY ON PSYCHOTROPIC MEDICATION OVERSIGHT IN FOSTER CARE**	http://160.109.101.132/icrhps/prodserv/docs/Executive_Report_09-07-10_348.pdf http://160.109.101.132/icrhps/prodserv/docs/Study%20Appendix_FINAL.pdf	This study identifies the states that have policies or written guidelines regarding psychotropic medication oversight for youth in foster care and describes challenges and innovative solutions implemented by States. The accompanying Appendix includes State tools and resources.
Council on Social Work Education – **CSWE GUIDE TO PATIENT PROTECTION AND AFFORDABLE CARE ACT**	www.cswe.org/File.aspx?id=48334	Provisions relating to social work that were included in the Patient Protection and Affordable Care Act of 2010
NASW Legal Defense Fund **SOCIAL WORKERS AND HEALTH CARE REFORM**	www.socialworkers.org/ldf/legal_issue/2011/042011.asp	Legal Defense Fund Legal Issue of the Month, April 2011

6 > EXAMPLES OF ORGANIZATION POLICY POSITIONS

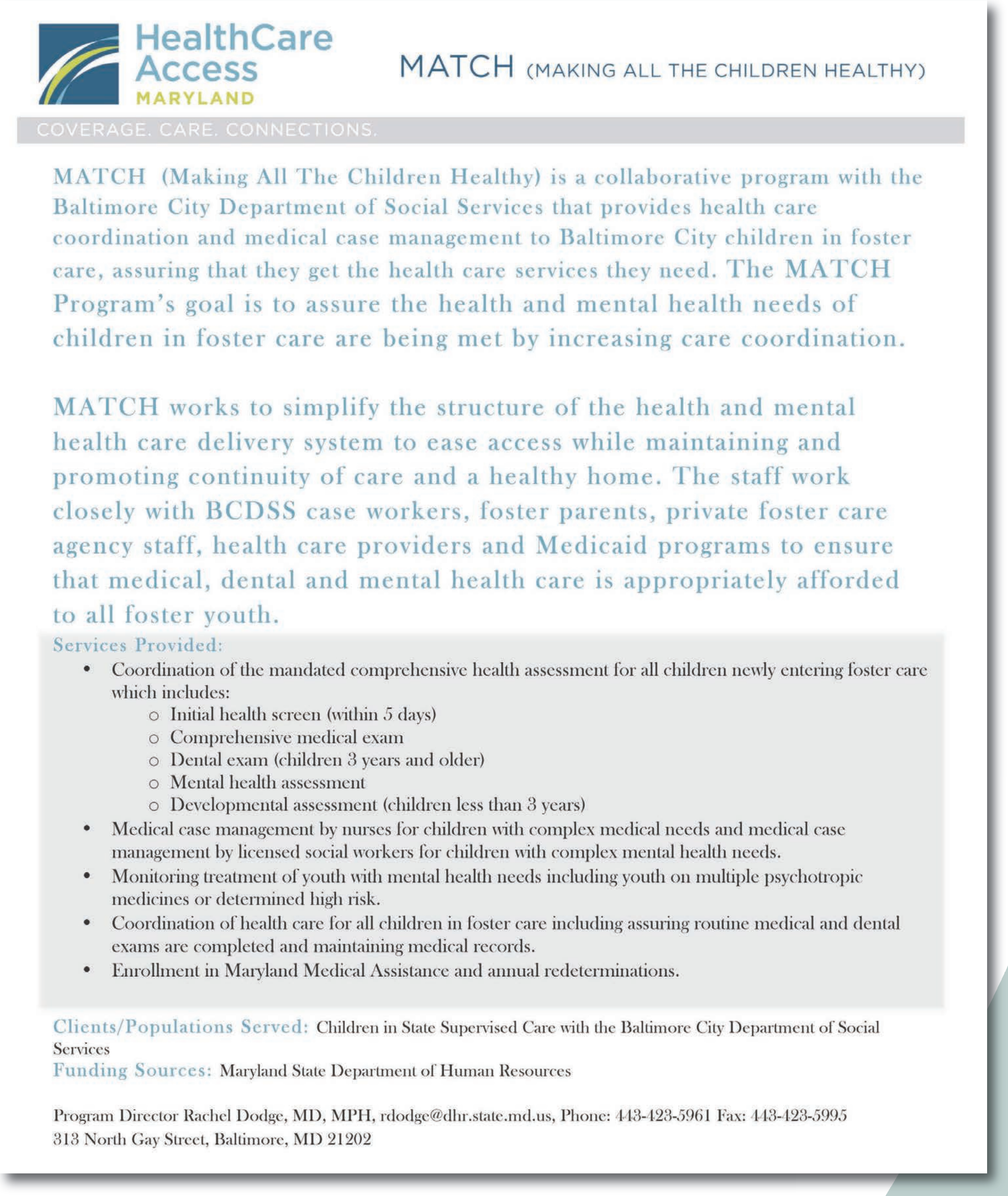
Organization	Title	URL	Date	Description
American Academy of Pediatrics-Committee on Early Childhood, Adoption, and Dependent Care	Health Care of Young Children in Foster Care	http://aappolicy.aappublications.org/cgi/content/full/pediatrics;109/3/536	March 3, 2002	All children in foster care need to receive initial health screenings and comprehensive assessments of their medical, mental, dental health, and developmental status, with results of these assessments included in court-approved social services plan and linked to the provision of individualized comprehensive care that is continuous and part of a medical home.
American Academy of Pediatrics-Committee on Pediatric AIDS	Identification and Care of HIV-Exposed and HIV-Infected Infants, Children, and Adolescents in Foster Care	http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/1/149	2000; Reaffirmed Sept 3, 2011	As a consequence of the expanding human immunodeficiency virus (HIV) epidemic and major advances in medical management of HIV-exposed and HIV-infected persons, revised recommendations are provided for HIV testing of infants, children, and adolescents in foster care.
American Academy of Pediatrics-Committee on Early Childhood, Adoption, and Dependent Care	Developmental Issues for Young Children in Foster Care	http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/5/1145	Nov. 2000	The following issues should be considered when social agencies intervene and when physicians participate in caring for children in protective services: early brain and child development, attachment, children's sense of time, response to psychological stress, effects of neglect, comprehensive assessments of children before and after placement in foster care, treatment, placement issues, parental roles and kinship, parent-child visitation, stables placement versus legal custody versus permanence.
American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics	Translating Developmental Science Into Lifelong Health Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician:	http://aappolicy.aappublications.org/cgi/reprint/pediatrics;129/1/e224.pdf	2011	AAP endorses a developing leadership role for the entire pediatric community–one that mobilizes the scientific expertise of both basic and clinical researchers, the family-centered care of the pediatric medical home, and the public influence of AAP and its state chapters–to catalyze fundamental change in early childhood policy and services.

Organization	Title	URL	Date	Description
American Academy of Child and Adolescent Psychiatry and the Child Welfare League of America	AACAP/CWLA Policy Statement on Mental Health and Use of Alcohol and Other Drugs, Screening and Assessment of Children in Foster Care	www.aacap.org/cs/root/policy_statements/aacap/cwla_policy_statement_on_mental_health_and_use_of_alcohol_and_other_drugs_screening_and_assessment_of_children_in_foster_care	2003	Children removed from their caregivers by child welfare agencies should receive immediate mental health and use of alcohol and other drugs screening followed by a comprehensive mental health and use of alcohol and other drugs assessment and periodic reassessments.
National Association of Social Workers	Relevant Public and Professional Policy Positions	www.naswpress.org/publications/practice/inside/speaks-toc.html	2009-2012	Published in Social Work Speaks – new edition to be published in January 2012. Adolescent Health; Adolescent Pregnancy and Parenting; Child Abuse and Neglect; Early Childhood Care and Services, Family Policy; Family Violence, Foster Care and Adoption; Health Care Policy; HIV and AIDS; Homelessness; Immigrants and Refugees; Lesbian, Gay, and Bisexual; Mental Health; Physical Punishment of Children; Poverty and Economic Justice Public Child Welfare; Racism; Rural Social Work; Youth Suicide.

7 > USEFUL WEBSITES

Organization	URL
Alliance for Health Reform	www.allhealth.org
American Academy of Pediatrics	www.aap.org
Center for Health Care Strategies – Children's Health	www.chcs.org
Child Health Insurance Research Initiative	www.ahrq.gov/chiri
Child Welfare Information Gateway (includes access to the T/TA NETWORK)	www.childwelfare.gov
Child Welfare League of America	www.cwla.org
Children's Defense Fund	www.childrensdefense.org
Children's Health Matters	www.childrenshealthmatters.org
Children's Partnership	www.childrenspartnership.org
The Commonwealth Fund	www.commonwealthfund.org
Covering Kids and Families	www.coveringkidsandfamilies.org
First Focus	www.chcs.org http://firstfocus.net/
Georgetown University	
Center for Child and Human Development	gucchd.georgetown.edu
Center for Children and Families	ccf.georgetown.edu/
National Technical Assistance and Training Center for Children's Mental Health	gucchdtacenter.georgetown.edu/
Fostering Connections Resource Center	www.fosteringconnections.org
Kaiser Family Foundation	www.kff.org
KidsHealth	www.kidshealth.org
Medicaid Medical Directors Learning Network	www.ahrq.gov/news/kt/mmdln.htm
National Traumatic Stress Network	www.nctsn.org
National Academy for State Health Policy	www.nashp.org
National Federation of Families for Children's Mental Health	www.ffcmh.org/
PolicyLab, The Children's Hospital of Philadelphia	www.research.chop.edu/policylab
Social Work Policy Institute, NASW	www.socialworkpolicy.org
NASW Center for Workforce Studies & Social Work Practice	http://workforce.socialworkers.org/ www.socialworkers.org/practice/
The Reach Institute	www.thereachinstitute.org
The Robert Wood Johnson Foundation	www.rwjf.org
Urban Institute	www.urban.org

8 > MATCH



HealthCare Access
MARYLAND
COVERAGE. CARE. CONNECTIONS.

MATCH (MAKING ALL THE CHILDREN HEALTHY)

MATCH (Making All The Children Healthy) is a collaborative program with the Baltimore City Department of Social Services that provides health care coordination and medical case management to Baltimore City children in foster care, assuring that they get the health care services they need. The MATCH Program's goal is to assure the health and mental health needs of children in foster care are being met by increasing care coordination.

MATCH works to simplify the structure of the health and mental health care delivery system to ease access while maintaining and promoting continuity of care and a healthy home. The staff work closely with BCDSS case workers, foster parents, private foster care agency staff, health care providers and Medicaid programs to ensure that medical, dental and mental health care is appropriately afforded to all foster youth.

Services Provided:

- Coordination of the mandated comprehensive health assessment for all children newly entering foster care which includes:
    - Initial health screen (within 5 days)
    - Comprehensive medical exam
    - Dental exam (children 3 years and older)
    - Mental health assessment
    - Developmental assessment (children less than 3 years)
- Medical case management by nurses for children with complex medical needs and medical case management by licensed social workers for children with complex mental health needs.
- Monitoring treatment of youth with mental health needs including youth on multiple psychotropic medicines or determined high risk.
- Coordination of health care for all children in foster care including assuring routine medical and dental exams are completed and maintaining medical records.
- Enrollment in Maryland Medical Assistance and annual redeterminations.

Clients/Populations Served: Children in State Supervised Care with the Baltimore City Department of Social Services

Funding Sources: Maryland State Department of Human Resources

Program Director Rachel Dodge, MD, MPH, rdodge@dhr.state.md.us, Phone: 443-423-5961 Fax: 443-423-5995
313 North Gay Street, Baltimore, MD 21202

9 > NASW RESOURCES

Social Work Practice Perspectives and Practice Updates

- ***Supporting the Child Welfare Workforce to Reduce Child Maltreatment***
  www.socialworkers.org/assets/secured/documents/practice/children/child_maltreatment.pdf
- ***The Medical Home Model: What Is It and How Do Social Workers Fit In?***
  www.socialworkers.org/assets/secured/documents/practice/health/medical%20home%20practice%20update_April_2011.pdf
- ***Accountable Care Organizations (ACOs): Opportunities for the Social Work Profession***
  www.socialworkers.org/assets/secured/documents/practice/health/ACOs%20Opportunities%20for%20SWers.pdf
- ***2011 Medicare Changes for Clinical Social Workers***
  www.socialworkers.org/assets/secured/documents/practice/clinical/PP%202011%20Medicare%20Changes.pdf
- ***Adolescent Depression and Suicide Risk: How Social Workers Can Make a Difference***
  www.socialworkers.org/assets/secured/documents/practice/adolescentDepression0211.pdf
- ***Domestic Violence and Human Trafficking: Double Jeopardy for Immigrant Women in the United States***
  www.socialworkers.org/login.asp?ms=restr&ref=/assets/secured/documents/practice/diversity/WKF-NL-67710.DomesticViolence.pdf
- ***Domestic Violence and Women of Color: Complex Dynamics***
  www.socialworkers.org/assets/secured/documents/practice/diversity/Domestic%20violence%20and%20women%20of%20color2011.pdf
- ***Engaging Young People in Their Transition Planning***
  www.socialworkers.org/assets/secured/documents/practice/engaging%20young%20people%20in%20transition.pdf
- ***Healthy People 2020: Social Work Values in a Public Health Roadmap***
  www.socialworkers.org/assets/secured/documents/practice/healthyPeople2020.pdf
- ***The Impact of Immigration Detention on Children and Families***
  www.socialworkers.org/practice/intl/2011/HRIA-FS-84811.Immigration.pdf
- ***The Childhood Obesity Epidemic: The Social Work Response***
  www.socialworkers.org/assets/secured/documents/practice/health/childhood%20obesity%20practice%20update.pdf

NASW Center for Workforce Studies (workforce.socialworkers.org)

- ***Assuring the Sufficiency of the Front-Line Workforce: National Study of Licensed Social Workers***
  workforce.socialworkers.org/studies/natstudy.asp#spe

  To better predict the adequacy and sufficiency of the social work labor force, in 2004, the Center carried out a landmark study and also did special sector reports for Children and Families, Aging, Behavioral Health and Health Care.

NASW Occupational Profiles
http://workforce.socialworkers.org/whatsnew.asp#profiles

NASW Standards

- ***NASW Standards for Social Work Practice with Clients with Substance Use Disorders***
  www.socialworkers.org/practice/standards/NASWATODStatndards.pdf
- ***NASW and ASWB Standards for Technology and Social Work Practice***
  www.socialworkers.org/practice/standards/NASWTechnologyStandards.pdf
- ***NASW Standards for Social Work Practice in Health Care Settings***
  www.socialworkers.org/practice/standards/NASWHealth careStandards.pdf
- ***NASW Standards for Clinical Social Work in Social Work Practice***
  www.socialworkers.org/practice/standards/NASWClinicalSWStandards.pdf
- ***NASW Standards for Social Work Practice in Child Welfare***
  www.socialworkers.org/practice/standards/NASWChildWelfareStandards0905.pdf
- ***Continuing Education and the Social Work Profession***
  www.socialworkers.org/practice/standards/NASWContinuingEdStandards.pdf
- ***NASW Standards for the Practice of Social Work with Adolescents***
  www.socialworkers.org/practice/standards/NASWAdolescentsStandards.pdf
- ***NASW Standards for Integrating Genetics into Social Work Practice***
  www.socialworkers.org/practice/standards/GeneticsStdFinal4112003.pdf
- ***NASW Standards For Cultural Competence in Social Work Practice***
  www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf
- ***NASW Standards For School Social Work Services***
  www.socialworkers.org/practice/standards/NASW_SSWS.pdf
- ***Indicators For Cultural Competence in Social Work Practice***
  www.socialworkers.org/practice/standards/NASWCulturalStandardsIndicators2006.pdf

NASW Public and Professional Policy Statements

Social Work Speaks, Eighth Edition presents, in one comprehensive and unabridged collection, the policy statements adopted by the NASW Delegate Assembly in 2008. (Updated policies from the 2011 Delegate Assembly will be available in January 2012). A list of policies can be found in Table 2 above.

Relevant NASW Credentials for Child Welfare and Health Care Social Workers

The following NASW certifications are relevant to child welfare and/or health care social workers:

- **Certified Advanced Children, Youth and Family Social Worker (C-ACYFSW) –** The C-ACYFSW is designed for social workers who promote the well-being of children and families.
- **Certified Advanced Social Work Case Manager (C-ASWCM) –** The C-ASWCM establishes social workers as professionals in a range of settings.
- **Certified Social Work Case Manager (C-SWCM) –** The C-SWCM is established for case managers in a range of settings with a BSW degree.
- **Certified Children, Youth and Family Social Worker (C-CYFSW) –** The C-CCYFSW is a specialty credential for the BSW, gives credibility to professionally trained children, youth and family social workers.
- **Certified Social Worker in Health Care (C-SWHC) –** The C-SWHC is a specialty credential designed for social workers who address the biopsychosocial components of health and/or mental health from a strengths perspective and use their knowledge to develop standards of practice, recommend health policy, improve health programs and ensure patients, families and organizations receive high quality and state of the art social work services.
- **Diplomate in Clinical Social Work (DCSW) –** The DCSW represents the highest level of expertise and excellence in clinical social work.
- **Academy of Certified Social Workers (ACSW) –** The ACSW represents leadership of the profession from direct service to research and systems analysis for individuals, families, groups, and communities.

10 > POLICYLAB RESOURCES

POLICYLAB RESOURCES (www.policylab.us)
The mission of PolicyLab at The Children's Hospital of Philadelphia is to achieve optimal child health and well-being by informing program and policy changes through interdisciplinary research.

PolicyLab develops evidence-based solutions for the most challenging health-related issues affecting children. As part of our commitment to transform "evidence to action," we bridge the gap between academic communities and the real world by engaging in research that is both responsive to community needs and relevant to policy priorities. This approach requires that PolicyLab projects involve investigators, practitioners, policymakers, and families throughout the research process, from design to dissemination. By partnering with stakeholders in traditional health care and across the community, PolicyLab identifies the programs, practices, and policies that support the best outcomes for children and their families.

Evidence to Action Briefs

- **Securing Child Safety, Well-being, and Permanency Through Placement Stability in Foster Care**
  http://policylab.us/index.php/publications/evidence-to-action/45-policylab-position-paper.html
- **Meeting the Mental Health Needs of Children**
  http://policylab.us/index.php/publications/evidence-to-action/150-meeting-the-mental-health-needs-of-children-.html
- **Preventing Adolescent Pregnancy**
  http://policylab.us/index.php/publications/evidence-to-action/211-preventing-adolescent-pregnancy.html

Research at a Glance Brief

- **Psychotropic Medication Use among Children in Foster Care: A National and State-Level Perspective**
  http://policylab.us/images/pdf/policylab2012_psychotropic_medication_in_foster_care_study.pdf

11 > THE NATIONAL QUALITY FORUM & CHILD HEALTH MEASUREMENT: OVERVIEW *(prepared by the NQF)*

The **National Quality Forum** (NQF) is a nonprofit organization that operates under a three-part mission to improve the quality of American health care by: Building consensus on national priorities and goals for performance improvement and working in partnership to achieve them;

- Endorsing national consensus standards for measuring and publicly reporting on performance; and
- Promoting the attainment of national goals through education and outreach programs.
- NQF's membership includes a wide variety of health care stakeholders, including consumer organizations, public and private purchasers, physicians, nurses, hospitals, accrediting and certifying bodies, supporting industries, and health care research and quality improvement organizations.

Over the past two years, NQF has endorsed almost 60 measures of child health, in two recent projects, ***Child Health Outcomes*** and ***Child Health Quality Measures***, adding to a measure portfolio that already included many child health measures addressing children of all ages from neonates to adolescents, and including topics from general health and care to condition-specific measures.

In early 2010, we completed the endorsement process for 15 child health outcome measures, addressing general health assessments as well as specific procedures and conditions such as neonatal surgery and asthma. The measures endorsed in the 2009 **Child Health Outcomes** project provide important data on the outcomes, or results of care provided to children, such as admission rates and mortality rates for conditions like asthma and gastroenteritis. Measures also assess mortality rates and adverse events for procedures like non-cardiac surgery and cardiac catheterization. Additional measures address population health outcomes, including the number of school days missed due to illness and the number of children who have inadequate insurance to achieve optimal health.

Just this fall, NQF endorsed an additional 44 measures of general child health. The 2010 **Child Health Quality Measures** project was designed to enrich NQF's portfolio of child health standards, at the request of the Centers for Medicare and Medicaid Services. The new measure set is the result of an increased need for population-health based measures addressing the unique needs of children, from prenatal screenings to adolescent-specific check-ups, and they cover a range of issues important to the healthy development of children, including well-child care, obesity screening, oral health, and mental health.

In addition, NQF has recently launched a new project on **Perinatal and Reproductive Health**. This project will endorse measures on reproductive health care, pregnancy, childbirth, and neonatal care. The project is currently reviewing the submitted measures and expects endorsement of the set in May, 2012.

12 > ABOUT THE COLLABORATORS

NASW SOCIAL WORK POLICY INSTITUTE (www.socialworkpolicy.org)

The Social Work Policy Institute, founded in 2009, is a division of the NASW Foundation. Its mission is:

- To strengthen social work's voice in public policy deliberations.
- To inform policy-makers through the collection and dissemination of information on social work effectiveness.
- To create a forum to examine current and future issues in health care and social service delivery.

Through convenings, briefings, development of action reports, and collaborations and partnerships, the Social Work Policy Institute strengthens the connections between research, practice, policy and education. Reports from previous symposium, information on evidence-based practice and an array of resources and tool-kits are available on its website.

POLICY LAB, Children's Hospital of Philadelphia (www.policylab.us/)

The mission of PolicyLab at The Children's Hospital of Philadelphia is to achieve optimal child health and well-being by informing program and policy changes through interdisciplinary research.

PolicyLab develops evidence-based solutions for the most challenging health-related issues affecting children. As part of their commitment to transform "evidence to action," they bridge the gap between academic communities and the real world by engaging in research that is both responsive to community needs and relevant to policy priorities. This approach requires that PolicyLab projects involve investigators, practitioners, policymakers, and families throughout the research process, from design to dissemination. By partnering with stakeholders in traditional health care and across the community, PolicyLab identifies the programs, practices, and policies that support the best outcomes for children and their families.

UNIVERISTY OF SOUTHERN CALIFORNIA SCHOOL OF SOCIAL WORK (www.usc.edu/socialwork)

The University of Southern California's School of Social Work (www.usc.edu/socialwork) ranks among the nation's top 10 social work graduate programs (U.S. News & World Report), with the oldest social work master's and PhD programs in the West. A recognized leader in academic innovation, experiential learning, online education and translational research, the school prepares students for leadership roles in public and private organizations that serve individuals, families and communities in need. This is the only program in the nation offering a military social work curriculum track to prepare social workers to meet the needs of veterans and their families. The school is also a campus exemplar for its research efforts, with funding exceeding $30 million. Their research institute, the Hamovitch Center for Science in the Human Services, was the first endowed center for interdisciplinary social work research and remains a pioneer in translational science.

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NASW foundation

NASW
National Association of Social Workers

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