



Improving Child Well-Being: Strengthening Collaboration Between the Child Welfare and Health Care Systems

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Introduction

Improving the well-being of children involved with child welfare requires close collaboration between the child welfare and health care systems. Annually in the United States, approximately 6 million children are referred to child protective services (CPS), 700,000 children are confirmed victims of child maltreatment,¹ and 250,000 children enter foster care (i.e., an out-of-home placement).^{2,3} For decades, medical providers⁴ have played an integral role working with CPS in the initial identification, evaluation, and diagnosis of child maltreatment, particularly for victims of physical abuse, sexual abuse, and medical neglect. Collaborations between the child welfare and health care systems are often more limited after the initial CPS investigation period ends, even though the complex health care needs of this population continue as they traverse the child welfare system.

This brief explores collaborations—old and new—between child welfare and medical providers. This brief aims to be a resource for states seeking to strengthen these collaborations across the continuum of child welfare services from CPS reporting and investigation to in-home protective services, foster care, and post-reunification services. Part I describes the national policy context related to the promotion of child health and well-being by the child welfare system. Part II examines promising and proven collaborative models related to the reporting and investigation of child maltreatment and the ongoing provision of child welfare services to children and families. Finally, Part III concludes with a discussion about future directions for partnerships between child welfare and health care systems.

Part I. The National Context: Expanded Health and Well-Being Requirements

The medical community's recognition of child maltreatment as a medical issue has helped to shape the development of the child welfare system. While society has long taken measures to protect children from maltreatment, historically the medical community had not regarded child maltreatment as a medical issue. This began to change by the 1950s, as the use of x-ray technology allowed medical providers to identify skeletal injury in children coming into hospitals with trauma. In the landmark 1962 medical article on *Battered Child Syndrome*, researchers showed through the systematic use of x-ray technology that child maltreatment was far more common than previously known.⁵ This new medical understanding of child maltreatment and its reach catalyzed a public outcry for action.

This outcry propelled a fundamental shift in the role of government in identifying and responding to child abuse and neglect. By 1967, all 50 states had child abuse reporting laws, most of which specified medical providers along with law enforcement, mental health providers, and educators as mandatory reporters required to report maltreatment.⁶ This new medical and legal framework for identifying and reporting child maltreatment resulted in an upsurge in the number of cases identified and a continued call for government action. In 1974, Congress passed the *Child Abuse Prevention and Treatment Act* (CAPTA), which defined a major new role for the federal government in responding to abuse and neglect. CAPTA provided federal support and direction for states' child abuse and neglect prevention, reporting, investigation, and treatment activities.⁷

Over the past fifty years, government involvement in child maltreatment has evolved from a “rescue model” that focused exclusively on safety to one that encouraged reunification when appropriate (a “family preservation model”), to the current focus on the promotion of child well-being. A number of subsequent federal laws built on CAPTA, shifting child welfare's focus towards ensuring child well-being. In 1990, the *Victims of Child Abuse Act* initiated federal funding for child advocacy centers, supporting medical providers, law enforcement, and CPS to conduct joint forensic evaluations of children who were victims of sexual abuse.⁸ Further, the 1997 *Adoption and Safe Families Act* emphasized health and safety as a priority in placement decisions, and laid out the mandate for the Child and Family Service Reviews (CFSRs).⁹ The CFSRs created a federal mechanism to monitor how well states meet national standards for child safety, permanency, and child and family well-being. Specifically, the CFSR monitors child well-being by tracking how each state ensures children in foster care “receive adequate services to meet their physical and mental health needs.”¹⁰

The *Fostering Connections to Success and Increasing Adoptions Act* (*Fostering Connections*) of 2008 elevated the importance of well-being and codified its link to child health. *Fostering Connections* encouraged greater child welfare–health care collaboration throughout all phases of a child welfare case. Specifically, state child welfare systems are required to put a plan in place for screening, assessing, and treating the health care needs of children in foster care, including their dental and mental health. Section 205 of *Fostering Connections* identifies six requirements that state plans should include:¹¹

1. A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;
2. How health needs identified through screenings will be monitored and treated;
3. How medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record;
4. Steps to ensure continuity of health care services, which may include the establishment of a medical home for every child in care;
5. The oversight of prescription medicines; and
6. How the state actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.

These requirements represent the first time that federal law explicitly articulated that child welfare agencies are responsible for child health outcomes. The legislation guides states to develop their plan “in consultation with pediatricians and other experts in health care,” signaling that collaboration is necessary for states to fulfill these mandates.¹²

Subsequent federal legislation and policy guidance continue to expand child welfare’s focus on well-being with a growing emphasis on trauma and mental health. The 2011 *Child and Family Services Improvement and Innovation Act* required state child welfare agencies to ensure the monitoring and treatment of emotional trauma related to child maltreatment and the oversight of psychotropic medications (i.e., medications to treat a mental health condition) by children in foster care.¹⁰ Further, the act reauthorized the U.S. Department of Health and Human Services (HHS) to approve Title IV-E Waiver Demonstration Projects allowing states to test new financing and service delivery models to improve outcomes for children and families involved with child welfare, especially their well-being.¹³ Subsequent HHS information memorandums encouraged states to coordinate across child welfare and health care systems to meet these requirements through joint planning, funding, and staffing.^{14,15} HHS reinforced this collaboration through a jointly released 2012 letter from the Administration for Children and Families, the Centers for Medicaid and Medicare Services, and the Substance Abuse and Mental Health Services Administration to all state child welfare, Medicaid, and behavioral health directors.¹⁶ These expanded health and well-being requirements are prompting both state child welfare and health care systems to revisit how they collaborate, especially beyond the investigative stage of a case.

Simultaneously, health care systems are facing increasing pressure to assume responsibility for the health outcomes of their patients and to develop a more patient-centered care delivery system. The 2009 *Children’s Health Insurance Program Reauthorization Act* established a federally funded program to develop and track new measures in health care delivery, including targeted measures for children in foster care.¹⁷ In 2010, the *Patient Protection and Affordable Care Act* created incentives and rules for health care systems to view themselves as responsible for overall patient health rather than individual episodes of health care.¹⁸ Driven by shifts in both accountability and financing structures, medical providers are developing a more comprehensive approach to patient health, which includes the expansion of partnerships outside medicine such as medical providers working with child welfare staff.

Collectively, these new standards point towards child welfare systems that are better prepared to respond to the unique health needs of children who are abused and neglected. Up to 80 percent of children in child welfare are estimated to have significant mental health needs.^{19,20,21} Children who are maltreated have higher

rates of physical health problems,^{22,23,24} and often these problems are undiagnosed or untreated prior to entering care.²⁵ One-third of children in child welfare are estimated to have a chronic health condition.²⁶ Further, almost all children in child welfare have significant trauma histories.²⁷ Trauma exposure (i.e., adverse childhood experiences) can compound physical and mental health challenges long-term, and may inalterably change a child’s brain structure.²⁸ The mounting research about the effect of maltreatment on well-being has contributed to an increasing recognition that children’s social, emotional, and health needs should be addressed in all stages of their involvement with the child welfare system.

Part II. Opportunities for Collaboration

Improving the well-being of children in child welfare requires an interdisciplinary approach. In this section, we describe examples of collaborative models across the child welfare and health care systems, and explore specific strategies that are being employed by states and local jurisdictions in this regard. Multiple strategies are identified, as what may be effective in one jurisdiction may not be the right model for another. Our discussion begins with a description of collaborative models that occur in the CPS investigative stage, and follows with a review of collaborative models to support children after abuse or neglect is substantiated, in the “ongoing child welfare services stage.” For each model, we identify information on the related policy and funding structures for use by interested jurisdictions.

CPS Investigative Stage

As highlighted previously, medical providers have long played a critical role in the reporting and investigation of child abuse and neglect. Every state is required to enact laws outlining requirements for the mandatory reporting of suspected child abuse. According to the 2010 *CAPTA Reauthorization Act*, each state’s laws must include “provisions and procedures for an individual to report known and suspected instances of child abuse and neglect.”²⁹ Under these laws, medical providers are mandatory reporters in every state, U.S. territory, and the District of Columbia.^{30,31} Medical providers, however, can fail to diagnose and report cases of abuse among children presenting for care of abusive injuries, which can lead to children suffering complications from additional undiagnosed injuries as well as ongoing abuse.^{32,33,34} Recognizing the challenges in diagnosing child maltreatment in the medical setting and the need to improve medical providers’ knowledge about child maltreatment, states have increasingly begun mandating that medical providers complete child maltreatment focused education. New York state law, for example, has required that certain medical providers complete two hours of training on the identification of child maltreatment prior to initial licensure, but does not require any ongoing education.³⁵ More recently, the Commonwealth of Pennsylvania passed legislation requiring physicians to complete training on child maltreatment recognition and reporting as part of their required biennial license renewal.³⁶ Professional organizations including the American Academy of Pediatrics, the largest professional membership organization for pediatricians, also has standards to guide medical providers in screening and medical examination when abuse or neglect is suspected, as well as tools for determining when to make a CPS report.^{37,38}

Nationally, medical providers are responsible for over 200,000 calls annually to state child abuse hotlines, making up about 8 percent of all yearly hotline calls.³⁹ While general medical providers are important mandated reporters, these complex cases may require more time and expertise than general medical providers can devote.⁴⁰ To support general medical providers, board certified child abuse pediatricians are a critical resource to help evaluate and diagnose suspicious injuries. Since 2009, the American Board of Pediatrics

includes this field as a board-certified pediatrics subspecialty; and since 2010, the Accreditation Council of Graduate Medical Education provides accreditation oversight of the 24 child abuse pediatrics training programs in the United States.⁴¹ Over the past two decades, pediatric hospitals have increasingly developed specialized multidisciplinary teams dedicated to the complex evaluation and care of victims of child maltreatment.⁴² These medical programs provide a necessary infrastructure to train medical providers how to accurately determine the likelihood that injuries are due to abuse and neglect using specific scientific criteria. When medical providers are specially trained in child abuse, the rate of substantiated cases increases and number of unfounded cases reported to CPS goes down.⁴³ Medical providers might also be involved in completing a medical evaluation after a report has been made to CPS. The purposes of the medical evaluation may include identifying the child's health needs and/or helping to establish a diagnosis of abuse or neglect. States vary in their protocols of which children receive a medical evaluation, and the minimum level of specialized training a provider must complete.

There are many long-standing models related to interdisciplinary CPS reporting and investigation. At the core of the strategies are access to medical providers trained in child abuse pediatrics and models that foster multidisciplinary partnership between child welfare agencies and medical providers. Specific strategies are identified below.

Strategy 1: Creating Hospital-based Child Protection Teams in Collaboration with CPS.

A hospital-based child protection team is a multidisciplinary group of professionals including medical providers with specialized expertise in evaluating, reviewing, and diagnosing children suspected of abuse and/or neglect. These teams offer expert diagnostic opinion and help with forensic medical evidence collection, work with the child's primary treatment team, and serve as the hospital's liaison to CPS and law enforcement. Over 70 percent of children's hospitals have child protection teams of some scope.⁴⁴ They are most common in academic medical centers,⁴⁵ and less likely in smaller hospitals and rural settings.⁴⁶ Hospitals with child protection teams had more thorough documentation, evaluations, referrals for follow up, and greater partnership with law enforcement and CPS. These partnerships often continue well after the initial medical encounter to optimize investigators' knowledge of the medical findings as they make their decisions.^{47,48} Despite the benefits of child protection teams, most programs lack a sustainable funding mechanism. In a survey by the National Association of Children's Hospitals and Related Institutions, approximately three-quarters of children's hospitals that responded reported that hospitals subsidize their child abuse programs. The hospitals reported contributing between \$10,000 to \$1,239,000 annually to sustain the programs, depending on the program's size.⁴⁹ The majority of injured children, however, receive care at non-pediatric hospitals without specialized child protection teams where an evaluation and diagnosis of maltreatment is less likely to be made.⁵⁰

A model that has been used to strengthen access to child protection teams is a state funded hospital affiliated team. In 1998, New Jersey established this model through legislative action with the creation of four regional diagnostic testing centers that are affiliated with major teaching hospitals to evaluate and treat abused and neglected children. Building on this model, the state of Illinois initiated in 2001 a program in Chicago, IL, ensuring young children with serious injuries alleged to be the result of abuse had access to a child protection team.

Local Example: Multidisciplinary Pediatric Education and Evaluation Consortium (Chicago, IL)

Model: The [Multidisciplinary Pediatric Education and Evaluation Consortium \(MPEEC\)](#) operates child protection teams in three Chicago children's hospitals. The teams include board-certified child abuse pediatricians, and operate in partnership with the Illinois Department of Children and Family Services, the Chicago Police Department, and the Chicago Children's Advocacy Network.

Services: MPEEC provides expert medical diagnoses for child abuse; timely second opinions; and comprehensive investigation, diagnosis, and treatment for abuse allegations of serious injuries (bone fractures, internal injuries, head trauma, bruises and burns) in children under age three. Additional MPEEC programs conduct training and education for medical providers, child welfare staff, and community partners. MPEEC provides services to 200 to 300 children annually.

Funding: The program was initially established in 2001 as a pilot with \$1 million state dollars annually for a three-year period. The program is sustained through continued general state funds, CAPTA dollars, and foundation grants.^{51,52}

Strategy 2: Establishing Child Advocacy Centers.

Child advocacy centers (CACs) have been established widely nationwide to provide effective, efficient, multidisciplinary, child-centered forensic evaluations for sexual abuse. CAC teams include CPS investigators, law enforcement officials, victim advocates, medical providers, and mental health providers to investigate instances of child sexual abuse and, in rarer instances, for physical abuse or severe neglect evaluations. This approach minimizes the number of times a child needs to be interviewed by combining interviews from multiple providers. The CAC's forensic evaluation helps CPS make a determination of maltreatment and aids law enforcement in whether there should be criminal prosecution against the alleged perpetrator of the maltreatment. The information is gathered in the forensic interview and medical evaluation to a standard that can be used if criminal prosecution proceeds.

The first CAC was founded in 1985, and now there are nearly 800 CACs across the United States.⁵³ The CAC model expanded as a result of the 1990 *Victims of Child Abuse Act* and its subsequent reauthorization,⁵⁴ as well as by state-specific legislation. The benefits of collaborative models, like CACs, include greater access to forensic medical evaluations, greater satisfaction with child and family support, and increased rates of case substantiation of prosecution of child maltreatment crimes where warranted.^{55,56,57}

Local Example: Western Kansas Child Advocacy Center

Model: [The Western Kansas Child Advocacy Center \(WKCAC\)](#)⁵⁸ was established in 2004, the same year that the Kansas legislature created statewide standards and funding for the growth of CACs.⁵⁹ WKCAC serves 29 counties in western Kansas, providing child-focused facilities where forensic interviews occur in cases of alleged physical, emotional, or sexual abuse. Due to the rural nature of the region, services are provided in three stand-alone facilities as well as by a traveling mobile unit specially equipped for forensic interviews.

Services: WKCAC provides services to children up to 18-years-old. In addition to forensic interviews and medical evaluations, the WKCAC provides mental health care. The program is staffed by a multidisciplinary team that includes law enforcement officials, CPS investigators, mental health providers, a victim's advocate, medical providers, and child advocacy center staff. WKCAC serves 150-200 children annually.

Funding: The WKCAC budget is under \$500,000. Operational funding is in part from a state legislature created fund overseen by the state attorney general, and made up of fees (\$100) assessed to perpetrators of crimes against minors.⁶⁰ WKCAC funding is also from federal and state grants, county funds, and private donations.

Strategy 3: Identifying Mentor Hospitals.

The mentor hospital model expands the availability of child abuse pediatrics expertise to local community hospitals. Children's hospitals with child abuse expertise serve as regional centers of excellence, supporting local hospitals in the screening assessment, diagnosis, and treatment of child maltreatment. Medical providers from the mentor hospital provide training and in-person and telemedicine consultation on complex child maltreatment cases. The mentor hospital structure greatly expands access to board-certified child abuse pediatricians, particularly in rural areas. Legislative action established the mentor hospital model statewide in Texas and other models are underway regionally elsewhere in the country.

State Example: Medical Child Abuse Resource and Education System Grant Program (Texas)

Model: The [Medical Child Abuse Resource and Education System \(MEDCARES\)](#) program is designed to support regional initiatives in the evaluation and treatment of victims of child abuse and neglect through partnerships between mentor hospital centers of excellence (hospitals, academic health centers, and health care facilities with expertise in pediatric health care) and smaller regional hospital child abuse programs (mentee hospitals).⁶¹ The Texas Department of State Health Services runs the program.

Services: The MEDCARES services include on-site trainings, case review, consultations, education, and telemedicine support by the centers of excellence to their mentee hospitals.

Funding: The program is funded through the 2009 Texas bill, S.B. 2080.⁶² The legislature provided \$2.5 million for the program, which was awarded to eight centers of excellence throughout the state.

Ongoing Child Welfare Services Stage

As noted previously, child welfare agencies and medical providers have more experience in collaborating at the front-end of the child welfare system; there has been more limited collaboration between child welfare agencies and medical providers in most jurisdictions when a child enters out of home placement, or receives in-home services after an abuse or neglect report has been substantiated. Recently, there has been an increased focus on improving the health care for children in foster care who have guaranteed access through Medicaid health insurance coverage. The American Academy of Pediatrics' *Fostering Health* recommends an enhanced health care visit schedule and receipt of care through a medical home^{63,64} for all children in foster care.⁶⁵ The enhanced visit schedule specifies children should have an initial health screening within 24 hours of entry into care, a comprehensive health evaluation within the first month, and annual well-child visits (or consider at least two health care supervision visits per year for children under 6 years).⁶⁶ Despite the guaranteed Medicaid coverage and these recommendations, ensuring children in foster care's access to high quality health care is often challenging due to the low margin available to most pediatric practices to provide their services, and the limits many practices have on accepting new Medicaid patients.

Even more difficult is ensuring high-quality health care services for children who remain in-home, who are the vast majority of children receiving ongoing child welfare services. These children have similarly high rates of health and mental health problems as children in foster care,^{67,68,69} yet they do not have the same guaranteed access to Medicaid, nor do most medical programs target these children. Both groups of children may lack a consistent medical provider or their medical provider may have limited knowledge about child welfare, hindering care continuity and effective information sharing as children traverse through the child welfare system.

A growing number of jurisdictions have developed collaborative models to meet the unique health needs of children involved in the child welfare system. However, unless state resources are provided or external funds are identified, there are significant barriers to implementing these models. This is largely because the models exceed what is traditionally reimbursed by Medicaid through more frequent visit schedules and comprehensive services. In particular, medical reimbursement is often provided only for assessment and treatment associated with a medical condition and not for tracking a child's status or participating in interdisciplinary meetings. However, states are expanding how they use Medicaid to fund these services,^{70,71} and the federal IV-E child welfare waiver has given states increased flexibility to ensure child well-being.⁷²

Later we describe a number of strategies jurisdictions have developed to strengthen access to quality health care services, information sharing, and coordinated case planning for a child receiving ongoing child welfare services. It must be noted that while the section focuses primarily on physical health care services, ensuring access to high quality mental health care including access to evidence-based mental health services is also incumbent on the health care and child welfare systems.

Strategy 1: Hiring Child Welfare Medical Directors.

An increasing number of states and cities have hired child welfare medical directors to provide strategic leadership and in-house medical expertise related to meeting the health needs of children involved in child welfare. Child welfare medical directors serve a number of functions that typically include expert consultation on medically complex child welfare cases, consultation on clinical reviews of the children's physical health, oversight of the child welfare agency's health services, and acting as a liaison to the health community. In

2010, 16 states were reported having a child welfare medical director,⁷³ along with numerous large metropolitan areas including Baltimore, MD; Philadelphia, PA; and Chicago, IL. Several positions were established by legislation, others were created as a result of a lawsuit that involved children's health needs, and others were created by administrative directive.

Local Example: Making All of the Children Healthy program's Medical Director (Baltimore, MD)

Model: The Baltimore City Department of Social Services has a full-time medical director who is responsible for ensuring that children in foster care receive coordinated health care services through the [Making All of the Children Healthy \(MATCH\)](#) program.⁷⁴ MATCH was created in 2009 as the result of class action lawsuit that required the city to address the health needs of children in foster care. The Medical Director is overseen by HealthCare Access Maryland's Executive Team, and works in collaboration with the Baltimore City Department of Social Services and the Baltimore Mental Health systems.

Services: MATCH's medical director oversees interdisciplinary teams of nurse case managers, medical professionals, and mental health specialists who provide coordinated services to children in foster care. These services include a comprehensive health assessment within five days of entering the system, medical case management for children with complex medical and behavioral needs, and coordinated routine exams.

Funding: MATCH is funded by the Maryland State Department of Human Resources and the Baltimore City Department of Social Services.

Strategy 2: Creating Foster Care Health Clinics.

Health care provision through a specialized clinic is a growing strategy being employed to meet the health needs of children in child welfare. These specialized clinics provide children an evaluation, initial health screen, and a comprehensive health assessment upon entry into foster care. In Worcester, MA, the Foster Children Evaluation Services program within the University of Massachusetts Department of Pediatrics conducts health care evaluations upon entry into the foster care system, in collaboration with the Worcester Department of Children and Families. Other clinics serve as the initial entry point for the health evaluation and as the child's medical home, seeing all children in foster care for routine care (e.g., Starlight Pediatrics in Rochester, NY) or only children who lack a regular medical provider upon entry into care (e.g. Fostering Connections Program, Nationwide Children's Hospital, Columbus, OH). Programs are hospital-based or community-based. Medicaid-eligible services are covered. However, services that exceed the current Medicaid schedule of services (e.g., a health examination when a child enters foster care, if the child had one in the last calendar year) may not be supported, and need to be supplemented through state, county, or private dollars. Currently, all the clinics in this model are locally run, and have not yet been brought to scale state-wide, or even within their local jurisdictions. Research findings show that that medical care provided through a foster care clinic enhances communication between caseworkers, foster parents, and medical providers.⁷⁵ Through its active attention to screening and assessment, this model has also been shown to increase prompt identification and treatment of children with mental health needs and developmental disorders.^{76,77}

Local Example: Starlight Pediatrics (Rochester, NY)

Model: Founded in 1989, Starlight Pediatrics is the oldest centralized medical home for children in care in the nation. Starlight serves all children in family-based foster care throughout Monroe County, NY, caring for approximately 700 children and providing 3,400 visits annually.⁷⁸

Services: Starlight's services include universal health, mental, and developmental screening; comprehensive health assessments; primary care; coordination of specialty referrals with child welfare (including health, early intervention, and behavioral health); onsite mental health evaluations; health care management; and education to caregivers. A health summary is provided to child welfare after each child's health visit.

Funding: Starlight's clinical services are covered by Medicaid and managed care, however these funds do not cover care management, which is paid for with county dollars. The center also receives significant grant funding for special projects.

Strategy 3: Establishing and/or Designating Special Child Welfare Managed Care Organizations.

Recognizing that children in foster care have an elevated health risk profile, a number of states have worked with managed care organizations (MCOs) to expand health care access and quality. MCOs pay a capitated rate per client assuming the risk for the members enrolled in its plan. This contrasts with the traditional fee for service model that pays for each episode of care. One payment strategy is moving all children in foster care to a standalone, specialized MCO. This model differs from the more common approach where children in foster care are dispersed between the state's broader Medicaid MCO plans, and are only a small subset of the plan's overall membership. Texas was the first state to adopt a standalone MCO. Texas' STAR Health program, managed by Superior Health Plan Network, provides health, behavioral health, and dental care; an electronic health passport; 24-hour nursing phone consultation; and care management. Another approach is the creation of a preferred provider organization (PPO) with enhanced reimbursement for medical providers accepting children in foster care, as was established in Illinois. Since the PPO's initiation in Illinois, there has been a significant increase in the number of children receiving immunizations, attending well-child visits, and having an identified primary care physician.⁷⁹

State Example: HealthWorks (Illinois)

Model: All children in out of home care receive health insurance through [HealthWorks of Illinois](#), a state-sponsored PPO Medicaid health plan.⁶¹ The plan was established 1993 in Cook County (Chicago), IL, and rolled out to all counties by 1995. Children are immediately eligible for insurance upon enrollment into foster care. In addition, child welfare nurse specialists, who are registered nurses, are assigned to each Department of Children and Family Services (DCFS) region to provide health care consultation. DCFS and the Department of Human Services run HealthWorks collaboratively.⁸⁰

Services: HealthWorks provides a designated medical home and specialized case management. The foster parent can choose any credentialed HealthWorks provider. Credentialed providers complete specialized training and receive an enhanced reimbursement rate, including a monthly management fee, for each child they treat in foster care. In accordance with the American Association of Pediatrics' *Fostering Health* recommendations, all children enrolled receive

an initial health screening within 24 hours and a comprehensive evaluation within one month of entry into care. HealthWorks assists families in accessing primary and specialty care services. HealthWorks also actively monitors health outcomes including asthma and behavioral health disease management indicators.⁸¹

Funding: The annual budget for the administration of the health plan is approximately \$3.5 million. Medicaid covers the costs for health care services.⁸²

Strategy 4: Embedding Nurses in Child Welfare Agencies.

Embedding nurses into child welfare systems is used by states to provide health care management and care coordination. The model is premised on the fact that child welfare staff do not have the time, or clinical expertise, to closely monitor and ensure the health needs of children in foster care. The nurse case manager typically monitors the child's health needs and coordinates appointments and referrals to specialists. Some programs provide a nurse case manager to oversee all children in care, like Utah's Department of Health's Fostering Healthy Children Program.⁸³ This program is funded using Medicaid case management dollars, and embeds a nurse manager in the child welfare agency at a rate of 1 nurse per 100 children. Other models, like Baltimore's MATCH program, assigns a nurse case manager only to children in foster care with complex health conditions. MATCH is funded jointly by the city and the state child welfare agency.⁸⁴ It is important to note, that if funding is provided through Medicaid's administrative case management billing codes, then none of the services can be for direct health care provision.

State Example: Child Health Unit (New Jersey)

Model: In May 2007, the [New Jersey Department of Children and Families](#) launched a program that embeds a nurse-led Child Health Unit in each of NJ's 47 local child welfare offices.^{85,86} Each Child Health Unit is staffed with a clinical nurse coordinator, health care case managers (nurses), and administrative support staff. Every child in foster care is assigned a health care case manager, with a ratio of 1 nurse to 50 children. The model was established in New Jersey pursuant to a consent decree that resulted from litigation against the state.

Services: The Child Health Unit is responsible for ensuring that appropriate physical and mental health services are provided for each child in foster care in its jurisdiction, and for coordinating the collection and dissemination of relevant health records. Nurses participate in family team meetings and home visits in collaboration with child welfare caseworkers.

Funding: The Child Health Unit is funded through a state federal Medicaid administrative match.

Part III. Next Steps and Conclusion

This brief makes the case for greater collaboration between the child welfare and health care systems throughout a child's involvement with child welfare. Over the last ten years, with the ever increasing fiscal pressures to do more with less, there has been growing recognition by federal and state policymakers and practitioners about the need for improved collaboration between child welfare and health care systems to

achieve shared outcomes. In the past, collaborative models primarily focused on reporting and screening during the CPS investigative stage of a child welfare case. More recently, models are emerging that continue collaboration throughout all phases of a child's involvement with the child welfare system. States are also experimenting with new Medicaid payment models, MCOs and PPOs, that specialize in the unique needs of this population of children.

As jurisdictions consider partnerships between child welfare and health care systems, there are a number of lessons learned from the models already in place. These lessons provide a set of core elements for consideration with any child welfare–health care system collaboration.

Use multidisciplinary teams.

Across the models, formats that allow for closer partnerships between law enforcement, child welfare, mental health, and medical providers improve outcomes. During the CPS investigative stage, teaming through CACs and child protection teams increases the accuracy and efficiency of case processing and reduces the duplication of potentially retraumatizing interviews children and families must complete. In the ongoing services stage for children involved with child welfare, foster care clinics that include multidisciplinary teams improve communication with child welfare and strengthen linkages to services. Currently, there is limited funding for multidisciplinary teams due to the siloed nature of funding, and because teaming activities (e.g., collaborative case conferencing) are often not Medicaid reimbursable. Blended funding, enabled by federal Title IV-E waivers and hopefully soon through child welfare finance reform, creates an opportunity to more comprehensively provide high quality health care including evidence-based mental health and dental care for children across the continuum of child welfare services.

Support specialization, and make sure specialists are available to generalists.

Across the models, children are served better when specialized health care expertise is embedded within child welfare (e.g., nurse case managers) and when specialized child maltreatment expertise is embedded in health care (e.g., child protection teams in hospitals). While these models recognize that most services can be, and are best provided by frontline caseworkers and general medical providers, complex cases require specialized expertise. How and when to bring in the expert consultation requires the development of protocols and training to most efficiently and effectively deliver services and design the workforce.

During the investigative CPS stage, telemedicine is emerging as an innovative tool in health care and should be evaluated as one of the solutions to address the disparity, particularly in remote settings, between the numbers of people trained in child abuse pediatrics and the clinical need. The use of new technologies, especially telemedicine, can enable expansion of training and the provision of second opinions and consultations for accurate maltreatment diagnoses. More systems that incentivize this collaboration and creatively expand access to specialized services, like the MEDICARES mentor hospital model in Texas, are needed.

Enable effective information sharing.

Increasingly, models that are most impactful have developed streamlined mechanisms to share information between agencies and across the child's team. The adoption of electronic health passports for children in foster care enables their medical providers increased access to health information. Through MOUs, consents on entry into foster care, and a greater understanding of where HIPAA does and does not provide a barrier to information sharing, the effective use of data can support improved case planning and collaboration across

the child's child welfare team. Furthermore, if these data sharing agreements are mutually agreed upon and established, the information systems of agencies need to enable the fluidity of this data sharing across interdisciplinary systems.

Identify long-term sustainable funding mechanisms.

The challenge is to design models that can be sustained long-term, and developed with existing state and federal funding streams. One of the key strategies must be to utilize Medicaid funding where possible. For example, models that blend child welfare and Medicaid funding provide a model to support program sustainability, for example Utah's use of Medicaid administrative case management funds to provide embedded nurses in child welfare offices. Unfortunately, many of the programs discussed above were developed as a result of a lawsuit or health tragedy, which amplified the need for action. In particular, funding streams must emphasize the provision of services for children receiving in-home services, as well as in foster care.

With the current transformations underway in the payment and delivery of both health care and child welfare services, now is an opportune time for action by states and local jurisdictions to strengthen the health care provision for children involved with child welfare. We believe the next ten years portends great advances in collaborative models across the continuum of child welfare services. And with this greater partnership, we can advance child well-being.

Resources

Resource Pages:

- American Academy of Pediatrics' [Healthy Foster Care America](#)
- Child Welfare Information Gateway's [Child and Youth Well-Being](#)
- National Resource Center for Permanency and Family Connections' [Health and Child Welfare Page](#)

Summary Papers:

- American Academy of Pediatrics' [Fostering Health: Health Care for Children and Adolescents in Foster Care](#)
- Center for Health Care Strategies' [Making Medicaid Work for Children in Child Welfare](#)
- National Children's Hospitals and Related Institutions' [Defining the Children's Hospital Role in Child Maltreatment](#)
- SPARC's [Medicaid and Children in Foster Care](#)
- SPARC's [Medicaid to 26 for Youth in Foster Care: Key Steps for Advocates](#)
- Urban Institute's [How Health Care Reform Can Help Children and Families in the Child Welfare System](#)



The First Focus State Policy Advocacy and Reform Center (SPARC), an initiative funded by the Annie E. Casey Foundation, Jim Casey Youth Opportunities Initiative, and Walter S. Johnson Foundations, aims to improve outcomes for children and families involved with the child welfare system by building the capacity of and connections between state child welfare advocates. You can visit us online at www.childwelfaresparc.org or on Twitter at [@ChildWelfareHub](https://twitter.com/ChildWelfareHub).

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Notes

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