

OFFICE OF THE CHILD ADVOCATE REPORT

NEEDS AND ASSETS ASSESSMENT OF THE COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN (CHEC) PROGRAM

OFFICE OF THE CHILD ADVOCATE

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I. INTRODUCTION

Coordinated health care for children in out-of-home placement has long been a priority for the Office of the Child Advocate (“OCA”), dating back to the discovery in October 2003 of four severely malnourished boys with acute and long-ignored medical needs.¹ This watershed event in the history of New Jersey’s child protection system personified the lack of a medical safety net for the State’s most vulnerable children and catalyzed reform plans.

In February 2004, the OCA released a preliminary report on this matter, “Jackson Investigation: An Examination of Failures of New Jersey’s Child Protection System and Recommendations for Reform,” concluding that the lack of coordinated medical care for children in foster care had played a role in the duration and extent of the children’s suffering.¹ Six months following the release of that report, the OCA undertook a follow-up assessment of the health status of a sampling of children in foster care in two counties. The findings of that review, released in October 2004, were disappointing: the State still did not have in place a coordinated system of medical care for the children in its care.² The Department of Human Services (“DHS”) subsequently announced that its plan to build a comprehensive health care initiative for children in out-of-home placement was, in most respects, just beginning.³ DHS pledged in late 2004 to ensure proper medical care for every child in out-of-home placement, beginning with a Comprehensive Health Evaluation for Children (“CHEC”) conducted by trained health care practitioners.

The OCA committed to monitor DHS’ implementation of CHEC to ensure quality and uniformity with regard to comprehensive screening assessments, delivery of follow-up care, and meaningful quality assurance measures. This report is the third of the OCA’s reports to date that have assessed the medical safety net in place for children in the State’s care.

A. *This Assessment*

1. Scope of Assessment

In August 2005, the OCA undertook this assessment of DHS’ coordination of health care for children in out-of-home placement in New Jersey. The OCA selected a statistically relevant sample of children statewide who received a CHEC between January 1, 2005 and April 30, 2005 to assess the overall coordination of medical care for children in out-of-home placement, including diagnostic and follow-up care within the domains of physical health, developmental health, and behavioral/mental health.

This report reflects the OCA’s findings and evaluates the progress DHS has made in establishing a continuum of coordinated medical care for children in out-of-home placement, as promised (1) in two Corrective Action Plans submitted to the OCA by DHS in response to the OCA’s February 2004 report,⁴ (2) reaffirmed in subsequent Quarterly Updates submitted by DHS to the OCA, and (3) as required by the DHS Child Welfare Reform Plan.³

2. OCA Jurisdiction

The OCA was created by statute on September 26, 2003. Pursuant to Public Law 2003, c. 187, paragraph 4(a), the Child Advocate “shall seek to ensure the provision of effective, appropriate and timely services for children at risk of abuse and neglect in the State, and that children under State supervision due to abuse or neglect are served adequately and appropriately by the State.”

3. Data Collection

To conduct this assessment, the OCA subpoenaed, reviewed, and analyzed medical information for a random sampling of children in out-of-home placement who received a CHEC between January 1, 2005 and April 30, 2005. DHS identified 217 children who met this criteria. From this, the OCA selected a statistically relevant 25 percent random sampling, which encompassed 54 children in out-of-home placement.

The OCA obtained the assistance of Anne Armstrong-Coben, M.D., a primary care pediatrician with extensive experience in New Jersey serving children in, and who recently emerged from, out-of-home placement, to conduct this audit. Dr. Armstrong-Coben directed the assessment’s overall categorization of clinical diagnoses and guided the needs and assets analysis of the current system relative to national best practice standards.

To conduct this review, the OCA obtained:

- Final CHEC reports for exams conducted between January 1, 2005 and April 30, 2005 for 54 children selected at random from a master list of 217 children;
- All medical information contained in Division of Youth and Family Services (“DYFS”) case files, as provided to the OCA by DHS, for the 54 selected children through June 30, 2005; and
- All Medicaid utilization records, including encounter data and HMO enrollment data, as provided by DHS to the OCA, for the 54 selected children, through June 30, 2005.

The OCA developed a uniform assessment instrument in consultation with health care providers from the State’s Regional Diagnostic and Treatment Centers (“RDTCs”) and DYFS-contracted nurses. The instrument collected information in three major categories:

- (I) Demographic Information: gender, ethnicity, date of birth, date and reason child entered out-of-home placement, date of CHEC, prior DYFS history, exam site;

- (II) History: person accompanying child to CHEC and length of relationship with child, known medical provider, known previous illnesses & surgeries, known family history, immunization status, mental health history, educational profile; and
- (II) CHEC and Plan of Care: identification of physical, developmental, and behavioral/mental health concerns, recommendations, and follow-up as indicated by review of the DYFS case file and/or Medicaid encounter data.

B. Major Findings

The current CHEC system falls significantly short in providing comprehensive, coordinated medical care for children in out-of-home placement:

- Of approximately 5,000 unduplicated children who have entered out-of-home placement in 2005, only 994 (20 percent) children received a CHEC through November 30, 2005. Therefore, approximately 80 percent of children entering out-of-home placement have not received a CHEC.
- CHECs are not occurring in a timely manner. Children within this sample waited an average of 48 days from the time of placement to the time of the CHEC. Furthermore, and despite the CHEC program requirement that the time between referral and the CHEC be “within 10 working days of appointment request,” this audit revealed that children waited an average of 24.6 days from the first request for an appointment. (Appendix, Table 3)
- Children in out-of-home placement are frequently accompanied to the CHEC site by individuals with little knowledge of their health care history or needs. (Report, Table 1)
- The children within this sample had multiple and complex health care needs in the areas of physical, developmental, and mental health. Ninety-six percent of children were diagnosed with medical conditions, the most prevalent medical diagnoses being: dental/oral health concerns (54.7%), delayed screens (50%), immunizations – delayed or unknown (40.7%), skin/dermatologic concerns (38.9 %) and vision/hearing concerns (29.6%). Sixty-eight percent of children were diagnosed with developmental/academic issues and 61.1 percent were diagnosed with mental health/behavioral issues. (Appendix, Tables 8 & 9)
- There was inadequate follow-up for children’s identified medical, developmental, and mental health problems in the current system. This audit revealed that 2.2 percent of children received follow-up care for all CHEC diagnoses, 75.6 percent of children received follow-up care for some CHEC diagnoses, and 22.2 percent of children received no follow-up care for their CHEC diagnoses within the review period. (Appendix, Table 11)

- DHS's current Medicaid HMO enrollment system for children entering out-of-home placement contributes to the delay in the establishment of the child's medical home and contributes to poor follow-up and poor coordination of health care for children. (Appendix, Table 7)
- DHS's current management of health care records and information for children in out-of-home placement is inadequate. There is no centralized health record or system for collecting health data.
- Although it is outlined in DHS' CHEC Request For Qualifications ("RFQ") and its Office of Children's Services' ("OCS") Medical Plan, there is no system in place to monitor and evaluate the current CHEC process and health outcomes for children in the State's care.

C. The Children

Children in out-of-home placement throughout the United States are an especially vulnerable population with varied and complex needs. As a group, these children are sicker than homeless children or children living in the poorest sections of inner cities.⁵ Alumni of foster care have been shown to have post-traumatic stress syndrome at two times the rate of U.S. War Veterans.⁶ Medical conditions are estimated to affect between 30-80 percent of children in foster care, emotional and behavioral health problems affect 35-80 percent of this population, and developmental disabilities affect approximately 20-60 percent of these children.⁷⁻¹²

The OCA's findings indicate that children in out-of-home placement in New Jersey largely resemble their peers nationwide in their need for a strong support network and their disproportionately high rates of physical, developmental, and mental health problems.¹³ The children within this sample were removed from their homes for a variety of reasons, including physical and sexual abuse, neglect, parental substance abuse, poverty, parental mental illness, homelessness, and domestic violence. (Appendix, Table 2) Based on CHEC findings for this sample population, 96.3 percent of children had diagnosed medical conditions, 61.1 percent had diagnosed mental health/behavioral conditions, and 68.5 percent had diagnosed developmental/academic issues. (Appendix, Table 9)

D. New Jersey's Plan of Action

In September 2004, as part of the Child Welfare Reform Plan, DHS released its RFQ to provide CHEC services within 13 counties in the State. The focus of CHEC is to provide comprehensive, coordinated health services in a timely, flexible, and culturally sensitive manner to meet the unique needs of children entering out-of-home placement. According to DHS' plan, these comprehensive services "must be delivered in an integrated fashion and be provided within 30 days of a foster care placement."¹⁴ The notion of performing an extensive evaluation of children within a specified period of time of placement stemmed from DHS' "goal in keeping with the well being of the child and Child Welfare League of America Best Practice Guidelines."¹⁵ The scope of services covered at the CHEC is extensive and includes providing Early and Periodic Screening,

Diagnosis and Treatment Services (“EPSDT”), screening for pregnancy and sexually transmitted diseases, screening for substance abuse, as well as comprehensive mental health and neuro-developmental assessments (see RFQ for full details).¹⁴ DHS decided this comprehensive evaluation should be provided at one facility in a seamless manner. According to a June 7, 2005 OCS “Medical Issues in the Child Welfare System” update, “CHEC exams began in November 2004.”¹⁶

The CHEC is intended to be one component of a continuum of services addressing the health care needs of children in out-of-home placement. When a child comes into the care of DHS through DYFS, he/she is to have a pre-placement exam within 24 hours. A CHEC is then supposed to be scheduled by the child’s DYFS caseworker and is to take place within 30 days of the child’s removal. This exam is supposed to be scheduled within 10 days of referral from DYFS to the CHEC provider. After the CHEC, a post-assessment case conference is supposed to occur with “the foster parent and DYFS caseworker encompassing developmental, physical and mental health findings, need for referral or follow-up, and education regarding the significance of these findings.”¹⁴ A Plan of Care with summation and priorities for follow-up care is to be completed and “provided to the foster parent, the DYFS caseworker, the [CHEC] site care coordinator, the HMO care manager, the primary care provider, the mental health provider and any other specialists involved in the child’s care within 14 calendar days of evaluation.”¹⁴

The OCS’ Medical Plan states, “The CHEC and its resulting treatment recommendation provide a vital framework for the further delivery of health services to children in out-of-home placement. These recommendations are being implemented and monitored by DYFS staff, resource parents and DYFS nurse consultants to ensure that a child’s emerging physical and mental health needs are evaluated and met.”¹⁵ The child is then to receive ongoing health care with a primary care provider.

The RFQ describes a system for the monitoring and evaluation of CHEC. This includes establishment of a Quality Improvement Committee for evaluating and measuring clinical outcomes, including quality improvement plans. This is supposed to occur at each CHEC site on a quarterly basis and documentation of committee activities, agendas, attendance sheets and supporting documents are to be reported to DHS’ Division of Medical Assistance and Health Services (“DMAHS”) quarterly to ensure continued monitoring and program evaluation.¹⁴

II. THE OCA AUDIT

A. *National Practice Parameters*

Child welfare agencies and health care providers are fortunate to be able to draw direction from published guidelines which address the delivery of health care services for children and adolescents in foster care. These include defined standards of health care delivery and management that promote quality health care and wellness for the complex and medically needy population of children and adolescents in foster care.¹⁷⁻¹⁹ The American Academy of Pediatrics (“AAP”) provides detailed standards (practice

parameters) that can and should be used by states to plan and evaluate the delivery of health services for children in foster care.¹⁷ In 2002, Georgetown University Child Development Center (“Georgetown University”) completed a three-year project to identify and describe promising approaches for meeting the health care needs of children in foster care.¹⁸ This study identified eleven critical components required to meet the health care needs of children in foster care. The Child Welfare League of America’s (“CWLA”) Standards for Health Care Services for Children in Out-of-Home Care is another effective tool addressing these issues.¹⁹ In fact, New Jersey’s OCS does refer to these standards within its medical plan as resources for “best practice concepts for assuring excellence in health care delivery and the development of a medical home for each child in care.”¹⁵ The OCA has relied on the relevant standards from these resources to review the CHEC program.

B. Needs and Assets of CHEC Measured Against National Practice Parameters

1. Time Frame

Practice Parameter

National Recommended Practice Parameter

The AAP and the CWLA recommend a comprehensive health assessment to occur within 30 days of a child’s out-of-home placement.^{17, 19} Other guidelines call for the evaluation to occur “shortly after placement.”¹⁸

CHEC Practice Parameter

As defined by DHS, CHEC is to occur within 30 days of out-of-home placement.¹⁴

Findings

The audit found that CHEC practice diverged significantly from best practices, national standards, and the program’s published guidelines. Children within this sample waited an average of 48 days from the time of placement to the time of the CHEC. Furthermore, and despite the CHEC RFQ requirement that the time between referral and CHEC exam be “within 10 working days of appointment request,” this audit revealed that children waited an average of 24.6 days.

- ❖ *A 6-month-old child’s CHEC exam occurred on April 14, 2005, 10 weeks after he entered out-of-home placement on February 3, 2005 and one month after his caseworker made a CHEC referral on March 1, 2005. (OCA File 2/3)*
- ❖ *An eight year old boy was removed from his home on December 10, 2004. He was initially referred for a CHEC on February 1, 2005 and ultimately received a CHEC on February 10, 2005 - two months after removal. Up until the time of the CHEC this child’s last documented medical check-up was on August 2, 2002. (OCA File 67/22)*

Conclusion/Recommendations

DHS has not implemented the CHEC as defined. Despite the expectation that the CHEC is to occur within 30 days of out-of-home placement, a majority of the time it does not. Explanations for non-compliance with CHEC timelines vary. One CHEC site indicated evaluations are slowed because DYFS has not standardized the referral and appointment process, leaving it to individual caseworkers or resource families. Another CHEC site reports it is experiencing an overwhelming volume of referrals, such that the number of children being referred to the CHEC program is far beyond the center's capacity. Despite a maximum evaluative capacity of 10 children per week and an average completion rate of eight evaluations per week, this center receives approximately 25 referrals per week for new cases. As a result, the center averages a two-month waiting period. This CHEC site pointed to staffing as one issue, since limited staffing hinders the center's capacity to increase treatment volume. The site indicated that DYFS routinely makes referrals to CHEC months after a child's initial entry into out-of-home placement.

Addressing the referral issue, the OCA recommends that DYFS update its Form: 11-2, The Child's Medical Examination Form, completed at the pre-placement exam, with a prompt to require the caseworker to schedule a CHEC. As of October 2005, DHS reports that 99.3 percent of children for whom a pre-placement exam was required received one. In light of this statistic, creating linkages between the pre-placement exam and the CHEC could lead to a more timely CHEC, ultimately benefiting children in out-of-home placement.

2. Provider

Practice Parameter

National Recommended Practice Parameter

The medical provider should be a board-certified pediatrician or family physician or a pediatric or family nurse practitioner. They should have experience in providing comprehensive primary care as well as have experience in the areas of child abuse, neglect, sexual abuse, developmental and behavioral issues in infants, children, and adolescents.¹⁷ The AAP states: "The health care professional who performs the comprehensive health assessment ideally should continue to follow the child or adolescent throughout his or her stay in foster care, and possibly beyond."¹⁷ CWLA Standards state: "Whenever possible the Comprehensive Health Assessment should be completed by the same health provider who will be managing the continuing health needs of the child."¹⁹

CHEC Practice Parameter

The CHEC RFQ extensively details the qualifications required of health care practitioners doing CHECs.¹⁴ These fall within recommended guidelines. However, the current CHEC system does not support the CHEC provider becoming the child's primary care provider throughout his or her stay in out-of-home placement.

Findings

The current medical care model for children in out-of-home placement, of which CHEC is an important component, diverges in some respects from AAP and CWLA guidelines. The current structure of the CHEC is not a primary care model and does not anticipate that the CHEC doctor will treat children post-evaluation. Furthermore, the manner in which New Jersey administers Medicaid to children in out-of-home placement hinders their receipt of seamless medical care. Upon entering out-of-home care, children who are already enrolled in Medicaid prior to their entry into out-of-home placement, are disenrolled from their existing Medicaid HMOs in anticipation of their enrollment in a fee-for-service Medicaid program under a new DYFS Medicaid number. Current practice allows the child's resource family 60 days to either select an HMO for the child or request an exemption from HMO enrollment. As a result, a child may be enrolled in one HMO prior to entering out-of-home care, disenrolled upon out-of-home placement, and 60 days later re-enrolled in that same, or a different, HMO. This administrative structure negatively impacts children in out-of-home placement by disrupting care. Although a resource family has 60 days to select an HMO and identify a primary care physician for the child in care, the CHEC is to be performed within 30 days of the child's entry into out-of-home placement. Ensuring follow-up care is very difficult when a child does not have an identified primary care physician at the time of the CHEC with whom evaluation results can be shared and linkages made. Nearly two-thirds of the children (35) children in this sample had an identified primary care provider at the time of the CHEC (70%, n = 50), but just over one-third of the children did not. (Appendix, Table 4)

Once enrolled in the HMO system, many children still do not experience seamless coverage. Only 48.1 percent of children within this audit remained in the same HMO without interruption. Eleven percent of children changed HMO plans. Another 9.3 percent of children remained in the same HMO but experienced gaps in coverage. (Appendix, Table 7)

Conclusion/Recommendations

The OCA is impressed with the competency and commitment of the medical practitioners who perform CHEC services. The review of the final CHEC reports revealed thorough physical and mental health exams and well-thought out Plans of Care. Many of the CHEC providers offered advice in the planning for this audit and answered OCA's questions throughout the process. The commitment of these centers, their concentration of skill and compassion, and the talent and dedication of their professional staff are assets for children in out-of-home care.

Linkages between the CHEC provider and the primary care doctor who is responsible for follow-up care need to be strengthened. In the best practice models described previously, the CHEC provider could also serve as the pediatrician who would follow the child throughout his/her stay in foster care. The initial medical assessment is an opportunity to establish a medical home.²⁰ Indeed, a stable, ongoing relationship with

health care providers, both medical and mental health, is crucial to improve health outcomes for children in out-of-home placement.⁷ An ongoing relationship with the child and family can provide valuable insights about the child's needs and the ability of a family to meet them.¹³ Where that is not possible, the linkage between the CHEC site and the primary care pediatrician must be strong enough to ensure effective communication and care.

DHS' present HMO enrollment structure needs to be revised to allow children to receive seamless medical care, uninterrupted by changes in placement status. A child's enrollment in an HMO should not be disrupted by nature of his/her out-of-home placement. Better alternatives include allowing a child to remain in his/her existing HMO and/or working with resource families to expedite the establishment of a medical home equipped with specialized resources for these children and families.

3. Attendance, Family, and Cultural Competence

Practice Parameter

National Recommended Practice Parameters

The AAP recommends that the child or adolescent, foster parents, health care manager, caseworkers, and, when possible, birth parents attend this exam.¹⁷ Other guidelines include family participation, especially when reunification is a goal, as a critical component. Families – birth, foster, and adoptive families – are viewed as partners in providing health care. They are involved as a vital source of information about the child's health history and needs, the child's ongoing health care, and are critical to the transition from out-of-home placement to permanency.¹⁸ For true comprehensive care, the families' strengths and needs should be incorporated into the child's plan of care. CWLA Standards state, "To obtain the most complete information and to facilitate the reuniting of children, parents or relevant members of the extended family should be encouraged, where appropriate, to participate in the Comprehensive Health Assessment."¹⁹

In addition, if this exam is to be culturally competent, the child should be assessed within the context of the family/caregivers culture, beliefs, and environment. People's cultures and beliefs shape their view of health, illness, and healing. In addition, foster care has a culture of its own.

CHEC Practice Parameter

The CHEC RFQ states "children presenting for these services **may be** accompanied by a foster parent, DYFS case worker or case aide."¹⁴ (emphasis added)

Findings

This audit revealed that of the 54 children presenting for CHEC exams, the resource parent was present for 20 of them (37%) and the birth parent was present for one

(1.9%). There were four instances where the child, the youngest being just shy of four months old, was accompanied to the examination only by a DYFS transportation aide.

The OCA's findings are summarized below in Table 1, with "f" denoting "frequency," "M" denoting "mean," and "Mdn" denoting "Median."

Table 1.

Person Accompanying Child to CHEC(n = 54)

Single Accompanying	f	%	Age of Child (in years; .08 = 1 mo.)		
			M	Mdn	Age Range
Caseworker (CW)	19	35.2	8.7	9.6	[.16 – 16.5]
Foster Parent – resource (FP-res)	11	20.4	3.2	0.3	[.06 – 16.5]
Foster Parent – relative (FP-rel)	9	16.7	6.8	5.5	[.08 – 16.7]
Transportation Aide (TA)	4	7.4	5.4	2.3	[0.3 – 16.6]
Birth Parent (BP)	1	1.9	.16	.16	n/a
Other (total)	2	3.7	2.3	2.3	[2.0 – 2.6]
Multiple Accompanying	8	14.8	2.9	1.5	[.08 – 9.0]

Health care providers noted in multiple instances that the individual with the child could provide no useful information about the child's health history. There was evidence of CHEC providers making efforts to call resource parents to get further history or clarification. In nine (16.7%) instances, the resource parent accompanying the child was the primary historian while in seven (13%) instances it was the caseworker who provided the doctors with the child's background. In only one case was the birth parent the historian, and in four instances the child, between the ages of 13 and 16, was the historian. There were some instances where doctors taking historical information received said information from multiple sources. In six (11.1 %) reports, the caseworker and the child were the historians. There were four reports that indicated that the caseworker and resource parent provided historical data for the child. (Appendix, Table 5)

- ❖ *A four-year-old girl received a CHEC on January 31, 2005. The CHEC doctor noted that his only record review was of a pre-placement exam. DYFS provided no other documents, and the transportation aide who accompanied the child had almost no knowledge of the child and was unable to provide any information necessary for the CHEC evaluation, which negatively impacted the scope of the evaluation. (OCA File 36/118)*
- ❖ *Female siblings, five and one half years old and two years and eight months old, received CHECs on February 7, 2005 and February 8, 2005 respectively. The older child was accompanied by a grandmother who relayed family medical history simply as "mom and grandmom are very tall." The younger child was accompanied by a family friend/godmother who indicated that the family has a "history of heart disease and hypertension." (OCA Files 65/186 and 66/212)*

Conclusion/Recommendation

The current system falls short in providing a comprehensive medical evaluation because of the inadequacy of resource parent participation and historian familiarity with the child's health. A good portion of what a health care practitioner does for a child or adolescent is based upon the history, not just history attained from medical records but

information from an oral history, such as responses to specific questions. Not having this information can lead to missed or incorrect diagnoses. The health care provider also gives anticipatory guidance which helps provide the patient or caregiver with essential tools and information to lead a healthier life and improve safety.

The OCA believes it is essential for the child's primary caregiver (resource parent, relative caregiver, etc.) to attend the CHEC appointment where the caregiver is familiar with the child's history. Where that is not the case, the DYFS caseworker should attend too, and bring as much of the child's historical health information as is available. Where appropriate, this evaluation presents an opportunity to engage the birth family as well. The CHEC affords an opportunity to address the health care needs of a medically challenged population, but to do so requires the event be prioritized in the work of resource families, DYFS caseworkers and, where possible, birth families. In the world outside of foster care, most parents and health care providers would not tolerate a child attending an appointment alone, or being escorted solely by persons with little knowledge of the child's history, needs, and daily experiences. Indeed, DHS might label these practices, to which children in its stead are being subjected, "neglect" in some instances. Such practices should not be acceptable for children in the State's care, especially when a significant number of these children may have experienced recent maltreatment, warranting heightened scrutiny.

4. Management of Health Care Data and Information

Practice Parameter

National Recommended Practice Parameter

The management of health care data and information is integral to positive health outcomes, well-being, and permanency for this vulnerable population.¹⁷ Although information management is the responsibility of the child welfare agency, it is a function that requires medical expertise. The AAP outlines this function to include:

(1) "Information gathering, which encompasses the procurement of historical information through familial interviews and other routes, maintenance of a medical file, and the development of data information systems capable of retrieving data about an individual child and aggregating data to promote responsible systems oversight; and

(2) Obtaining medical consents."¹⁷

CHEC Practice Parameter

Currently, DHS uses its Child's Medical Examination Form (DYFS Form: 11-2), the DYFS file, and Medicaid claims to document and gather medical information for children in out-of-home care. The OCS Medical Plan expresses hope that Medicaid claims data can be utilized to populate relevant fields in the New Jersey Statewide Protective Investigation, Reporting and Information Tool ("NJ SPIRIT"). According to

DHS, this electronic system is being designed to automate case management functions and “will also support integration of health care needs into case practice by defining and tracking a unique set of clinical events related to medical/mental health interventions that need to be monitored by the office nurse.”¹⁵

Findings

The audit revealed that many children arrived at their CHEC exam without any medical records, despite evidence of available records within their DYFS chart. Review of the DYFS files revealed no systemized process of recording medical data. As a result, auditors read through pages and pages of information to extract medical information. In addition, DYFS Form: 11-2, The Child’s Medical Examination Form, used to record medical information and mentioned in the CHEC RFQ, is outdated, having been last revised in February 1984. A comparison of Medicaid claims data and the DYFS files revealed discrepancies in the documenting of children’s medical care in some instances.

Although they provide a similar scope of services, the various CHEC sites use different formats for recording information and for their final CHEC report. This lack of uniformity makes review and quality assurance more difficult.

- ❖ *A thirteen-year-old boy had a CHEC on April 15, 2005 and received a Td booster at that time. He received an unnecessary Td booster on June 18, 2005. (OCA File 40/128)*
- ❖ *A four-month-old girl with prenatal drug exposure received a CHEC on April 28, 2005. The CHEC doctor noted extreme frustration that DYFS did not forward more than the hospital discharge summary for her review despite the child having had routine well care pre-CHEC. DYFS did not forward results of the infant’s HIV tests, which forced the CHEC staff to subject the infant to an uncomfortable and unnecessary test. (OCA File 46/166)*
- ❖ *An eight-year-old boy received a CHEC on February 10, 2005. The CHEC doctor noted “no records (medical, educational, psychological, or otherwise) were provided by the Division making a thorough evaluation difficult for the CHEC doctor to complete.” (OCA File 67/22)*
- ❖ *A thirteen-year-old boy received a CHEC on April 15, 2005. The DYFS file contains a Health Care Provider Collateral dated November 2004 wherein the doctor who had been treating the child since 1993 noted that he has asthma. At the time of CHEC, neither a review of the file nor the caseworker’s history identified asthma as one of the child’s medical conditions. (OCA File 40/128)*
- ❖ *A ten-week-old boy in out-of-home placement due to parental substance abuse, homelessness, and neglect received a CHEC on April 14, 2005. The CHEC doctor noted he did not have medical birth records to review. (OCA File 22/69)*

Conclusion/Recommendation

Lack of medical information is a universal, documented barrier to the provision of health care to children in foster care.^{7, 11} However, this audit reveals some obvious opportunities for improvement. From the moment of removal, DYFS case practice should include efforts to obtain essential medical and family history. Other states have developed trainings and checklists for child welfare workers (caseworkers and nurses) to

help in this process.²⁰ Implementing the mandatory use of a medical passport or lifetime child health record would lead to improved care and decreased instances of duplication of services. Each child should have a separate medical record within his/her DYFS chart that is easily accessible, updated regularly, and can be copied and given to any provider of health care services. Were this to be in existence, the children within this sample would have received better care. The CHEC providers have vocalized and documented in CHEC reports frustration with the lack of information they receive and critical time wasted which would be better spent providing services. As mentioned previously, DYFS Form: 11-2, The Child's Medical Examination Form, was last revised in 1984. The OCA recommends creating a revised form which reflects current pediatric practice and standards of care. A quality form is the first step toward documenting health care and could be used as a reliable source for health information.

OCS' Medical Plan places confidence in the use of a Medicaid claims file stating "this file can become the basis of a 'medical passport' which can help provide assurance of continuity of care."¹⁵ However, the OCS Medical Plan later states that Medicaid claims are not always submitted in a timely fashion. Under current Medicaid law in New Jersey, it is permissible for up to a year to pass from the time of provision of a Medicaid service to the submission of a Medicaid claim. Therefore, Medicaid data cannot serve as a real-time indicator of children's care. Providers are left to rely on caseworkers' notes, which may or may not be timely, thorough, or in the file at all. The OCA encourages DHS to assess its claims system for opportunities to improve timeliness and, in turn, the health care of children.

The OCA recommends the use of standardized CHEC forms/reports. Although each site produces a thorough final report, the lack of standardization can make it more difficult for the reader (especially the lay reader, such as DYFS caseworkers and resource parents) to interpret. This is important as the system is dependent upon many stakeholders, with and without medical backgrounds, to follow plans of care and get these children the follow-up and quality health care they require. Resource parents and DYFS caseworkers should be consulted about CHEC report formatting and readability. If readers have difficulty interpreting the reports' conclusions and need for follow-up, this needs to be addressed. Some states have created abbreviated reports for caseworkers and foster parents.¹⁸

5. Components of Assessment

Practice Parameter

National Recommended Practice Parameter

A full review of the recommended components of a comprehensive health assessment is beyond the scope of this report. However, several core components are crucial, including a physical examination, immunization update, health education, and appropriate screening exams (PPD, anemia screen).^{17, 19} The assessment should include medical, mental health, and neuro-developmental components. In addition, observation of the parent-child interaction is "an important part of this encounter,"¹⁷ as is discussion

with the foster parent about numerous pertinent issues. The assessment should conclude with review of the treatment plan, review of specialty referrals, and a next appointment should be given.

CHEC Practice Parameter

The CHEC RFQ describes the expected extensive medical, mental health, and neuro-developmental assessments that are to all take place. These fall within recommended guidelines.

Findings

This audit revealed thorough and complete evaluations by the CHEC sites. Children received extensive evaluations in all the recommended core component areas. The lack of health information/medical records did appear to be a barrier to providing fully comprehensive care. Many of the CHEC reports did not include information on the parent-child interaction but this would be expected based on the data previously presented on who attends these exams.

There were numerous instances where the CHEC provider noted a need for immunizations or lab screenings, which were not completed during the CHEC. The OCA observed numerous cases where children left their CHEC still with delayed immunizations or necessary screenings.

- ❖ *For one 17-month-old child, it was noted to be an “Urgent” need that the child receive multiple immunizations. However, they were not given at the CHEC. (OCA File 13/45)*
- ❖ *One chart recommended that a child needed a CBC (Complete Blood Count) and a PPD (tuberculosis screening) but these were not done at the CHEC (they were done 4 months later). (OCA File 62/217)*

Conclusion/Recommendation

Overall, the OCA is impressed by the thoroughness of the evaluations done by the CHEC providers. More often than not, children received evaluations and services as outlined in the CHEC RFQ. However, there were missed opportunities to immunize and screen children. Although touched upon previously, the OCA reiterates the need for all available medical information to accompany the child to the CHEC as well as involvement of family. This will result in more comprehensive evaluations and better outcomes.

6. Follow-up

Practice Parameter

National Recommended Practice Parameter

AAP standards call for a follow-up assessment 30 days after the comprehensive health assessment. This serves multiple purposes including assessing “goodness of fit” between the child or adolescent and foster parents, identifying issues that may have surfaced since the child or adolescent has entered foster care, and is a time to update, refine, and reinforce treatment plan.¹⁷ For example, inadequate weight gain in a young child often is the first sign of foster parent-child mismatch. Because of the multiple environmental and social issues that can adversely impact a child in foster care’s health and development, the AAP recommends more frequent preventive pediatric visits. The schedule for a child in foster care should be: monthly visits up to six months of age, every two months between six and 12 months, every three months between one and two years, and semiannual visits beyond two years of age through adolescence. Primary care physicians may need to schedule additional visits on a case-by-case basis.¹⁷

CHEC Practice Parameter

The CHEC provider is to perform a post-assessment case conference with the foster parent and DYFS caseworker encompassing findings, need for referral or follow-up, and education regarding the significance of these findings. A Plan of Care with summation and priorities is to be completed within 14 calendar days of the evaluation. A Health Care Coordinator at each site is responsible for ensuring that each child receives ongoing primary health care services including EPSDT examinations, blood lead testing, and well-child care including immunizations.¹⁴ The Medical Plan for OCS uses the EPSDT program as the framework for preventive health care for children in DYFS custody.¹⁵ This would call for visits at two to four days, one month, two months, four months, six months, nine months, 12 months, 15 months, 18 months, 24 months, and then annually.

Findings

The CHEC identified multiple problems in the areas evaluated. (Appendix, Tables 8 & 9) The most prevalent medical conditions diagnosed at the CHEC, listed below in Table 2, were: (1) dental/oral health (53.7%); (2) delayed screenings (50 %); (3) delayed or unknown immunizations (40.7%); (4) skin/dermatologic (38.9%); and (5) vision/hearing (29.6%).

There was inadequate follow-up for children’s identified medical, developmental, and mental health problems in the sample. This audit revealed that 2.2 percent of children received follow-up care for all CHEC diagnoses, 75.6 percent of children received follow-up care for some CHEC diagnoses, and 22.2 percent of children received no follow-up care for their CHEC diagnoses within the review period. (Appendix, Table 11)

Table 2.

Diagnostic Category

	By Child (n = 54)	
	f	%
Dental/Oral Health	29	53.7
Screening, Delayed	27	50.0
Immunizations, Delayed/Unknown	22	40.7
Skin/Dermatologic	21	38.9
Vision/Hearing	16	29.6

There were also numerous instances of children leaving the CHEC without having been linked to a primary care provider. For example, the OCA auditors found CHEC reports forwarded to identified physicians in only 35 (70%) of the audit sample. (Appendix, Table 4)

❖ *A sixteen-year-old girl received a CHEC exam on 2/17/05. The adolescent had a history of a positive PPD test. A CHEC doctor recommended an x-ray as follow-up. DYFS' six month regional review documents of June 2005 do not indicate that the x-ray ever took place. (OCA File 37/120)*

Conclusion/Recommendation

Follow-up was not consistent for children who received a CHEC. The “one shot deal” of the current CHEC system in New Jersey is sub-optimal. A child comes into contact for one day with a provider who has never met him/her. The child then leaves that exam and never sees that provider again. If the current system remains in place, the OCA recommends that all children leave the CHEC exam with a scheduled visit with a primary care provider within 30 days or sooner, depending on “urgent” needs, if any. A medical home needs to be established quickly for both the resource parent and the child’s sake. This audit revealed far too many instances of important issues not receiving appropriate, if any, follow-up.

The child entering out-of-home placement should be promptly given a medical home, staffed with a primary care physician and other key health care providers with skills in caring for this population. The system should support the child continuing care within this medical home throughout his/her stay in foster care, and possibly beyond. The provider/patient/family relationship is a very important one. The success of this relationship can greatly improve health outcomes as patients and families are more likely to follow recommendations or seek health care when a trusting relationship exists. This is not going to happen in the current system despite caring, competent providers.

7. Coordination of Care

Practice Parameter

National Recommended Practice Parameter

Coordination of care is repeatedly mentioned by experts in foster care as the key to good outcomes. CWLA Standards suggest that a unit specifically responsible for the goal of assuring the receipt of quality health services, a Health Services Management Unit, be created at each organizational level and be vertically integrated (see Standard 4.5 for extensive list of responsibility).¹⁹ The Georgetown University critical components also recommend responsibility for coordination of health care be assigned to a specific person or unit of persons.¹⁸ The AAP devotes an entire chapter to the concept of health care management. In this model, health care management is the responsibility of the child welfare agency, but it is a function that requires medical expertise. The functions include information gathering, systematic communication and coordination of care among medical personnel, casework staff, and foster and birth parents as well as an advocacy role to ensure that children and adolescents receive all necessary health, mental health, and developmental services in a timely manner. “Health care management is the mechanism for integrating health and social services planning in a way that enhances health outcomes, well-being, and permanency for this most vulnerable and needy population.”¹⁷

CHEC Practice Parameter

The CHEC RFQ describes a designated “Health Care Coordinator” who is to provide coordination of medical, developmental, and mental health services. The Coordinator’s responsibilities include:

1. Researching and obtaining prior medical records and health information;
2. Ensuring that each child receives ongoing primary health care services including:
 - a. EPSDT examinations;
 - b. blood lead testing; and
 - c. well-child care including immunizations;
3. Ensuring that children receive all recommended services linked to the Division of Developmental Disability, Preschool Handicapped programs, Special Child Health Services and/or other school-based resources;
4. Facilitating communication between a child’s foster parent, DYFS case management staff, the primary care provider, mental health professionals and the HMO care manager and specialists as appropriate; and
5. Assisting with the coordination of any needed Medicaid transportation services through the Medical Assistance Customer Centers (MACCs)

in Essex County and Hudson County, and the local Board of Social Services in the remaining counties.¹⁴

Findings

The audit revealed an overall lack of care coordination. Responsibility for this function is diffuse, spread among DYFS caseworkers, the HMOs, DYFS CHEC liaisons, DYFS nurses, and resource parents, leaving a lack of clarity and accountability to the detriment of the child. Untimely CHECs and CHEC Final Reports, poor familial participation, whether resource or birth, inadequate data management, and inadequate follow-up all contributed to fragmented care.

- *A seven-month-old girl received a CHEC on March 31, 2005. Her CHEC doctor noted a concern that the infant was sharing her nebulizer with a foster sibling. The resource family ultimately went on vacation, leaving the infant without access to a nebulizer. (OCA File 26/89)*
- *A sixteen-year-old boy received a CHEC on April 19, 2005. He had extensive health issues, for which CHEC staff made numerous recommendations, with most having been followed-up. Problematic, however, is the fact that this child entered a detention center and the caseworker noted that the facility nurse had no knowledge of the child's health issues and later called the caseworker for information. The child had a history of unexplained loss of consciousness and the CHEC doctor recommended that the child be prohibited from participating in contact sports. (OCA File 34/114)*
- *A five-and-one-half-year-old girl received a CHEC exam on February 7, 2005. Case notes indicate the child's caregiver made multiple requests for Medicaid coverage for the child. The child underwent a sleep study for which the caregiver received a bill. The DYFS caseworker erroneously advised the caregiver to call the hospital billing department to apply for Charity Care, despite the fact that the child qualified for Medicaid. (OCA File 65/186)*

Conclusion/Recommendation

The OCA concludes that no single entity or person has been tasked with the ultimate responsibility for coordinating health care for children in out-of-home placement. Within the CHEC RFQ and OCS' Medical Plan, roles are described for HMO care managers, DYFS nurses, and Health Care Coordinators at the CHEC sites as well as other stakeholders.^{14, 15} There is some overlap in these duties and the OCA feels that different individuals responsible for the child's care have the same confusion that was experienced by the OCA auditors. All of these individuals play important roles, and many are doing a fine job. However, there is a lack of coordination that translates into duplication or omission of needed services for the children. The current system where children see multiple providers from pre-placement to CHEC to primary care contributes to this disjointed care.

Coordinated health care requires a clearly identified individual or team to manage care and be accountable to children in out-of-home placement. Teamwork is undoubtedly required. Each child needs to have a medical home. As the system matures, opportunities should be found to centralize as many services as possible in the medical

home, including where appropriate the pre-placement exam, the CHEC, and follow-up/primary care. The medical home must be linked to DHS through a structured communication system and DHS, in turn, should build information systems to track the health needs of, and services for, children individually and in the aggregate.

8. Monitoring/Evaluation

Practice Parameter

National Recommended Practice Parameter

Health outcomes for children should be tracked; family, child, and provider satisfaction should be assessed; and cost effectiveness should be examined. Improvements are then made based on the results of this monitoring system.¹⁸ The AAP provides information that quality assessment and improvement programs must include the following components at the health care professional and health care management levels: process for identifying issues, assessment to determine compliance with standards, action plans, follow-up of action plans, and reporting of findings.¹⁷

CHEC Practice Parameter

The CHEC RFQ calls for the CHEC providers to establish and maintain a Quality Improvement Committee for evaluating and measuring clinical outcomes, including quality improvement plans. These outcomes must be internally evaluated and analyzed on a quarterly basis and the committee is to report to DMAHS on a quarterly basis to ensure continued monitoring and program evaluation. A Continuous Quality Improvement Process (“CQI”) that uses numerous methodologies is described in OCS’ Medical Plan. Included is an internal CQI process to “track pre-placement exams and CHEC exams for timeliness of emergency removal and planned removals. CHEC sites to develop database and to send data electronically to DYFS. Tracking the treatment plans will identify the timeliness and answer the question was the appointment met.”¹⁵

Findings

The OCA found there to be no systematic process for the monitoring or evaluation of CHEC. Data is gathered by the CHEC sites and the DYFS Medical Director as to the number of CHECs completed. However, this does not address or begin to evaluate the CHEC process or outcomes. This audit is the first quantitative assessment of CHEC.

Conclusion/Recommendation

Currently, quality improvement processes are not in practice. The OCA recommends that DHS implement the commitments made in both the OCS Medical Plan and the CHEC RFQ. Monitoring and evaluation are essential to ensuring the intended outcomes of an implemented program.

III. CONCLUSIONS AND RECOMMENDATIONS

The development of the CHEC program by DHS affirms that a critical component of a coordinated and quality health care continuum for children in out-of-home placement is a timely, accurate, and thorough evaluation of a child's health status. Information gained through such an evaluation is baseline – it lays a foundation for care and provides a backdrop against which to measure change. DHS should maximize the potential value of the evaluation and its impact on a child's health by updating and standardizing forms, developing an information system capable of maintaining, tracking, and aggregating health information and by mandating key stakeholder participation at the evaluation.

Evaluation alone is not enough. A child must be seamlessly linked to a medical home, with an identified health care provider (likely both medical and mental health) at the time of removal. Ideally, a single doctor or practice group would perform the pre-placement exam, CHEC, and provide follow-up care. Provider continuity would offer a semblance of stability in the often tumultuous life experienced by children in out-of-home placement. Indeed, a commitment by the State to forge relationships between health providers and children is the cornerstone of quality care.

The OCA is sensitive to the fact that the mechanics of building a physical and mental health care delivery system are complex – the process takes time, buy-in, and commitment. Much less complicated is the concept that must drive the architecture and construction of such a system: the child must be at the center of all decision-making. Each and every policymaker, caseworker, resource person, and health provider needs to envision what it would be like to be the child going through the process. The following observation is instructive:

*One of the most important pieces to remember is that many of us cannot possibly understand what life entails for these children. For some children, medical visits can be the scariest aspect of the foster care experience. A physical exam can be awkward or embarrassing for any child. But it can be especially scary to a child who has never been on an examination table under bright lights and absolutely traumatic for a child who has been sexually abused. We all must do everything possible to ease that trauma.*²¹

The OCA has outlined within this report ideas to improve the health care delivery system for children in out-of-home placement from a child-centered perspective.²² One action step necessary to breathe life into these ideas has already begun. The OCS and the OCA have jointly convened a work group comprised of DHS and DHSS decision-makers, including leadership of OCS and DMAHS; the New Jersey Chapter of the American Academy of Pediatrics; RDTC leadership; Federally Qualified Health Center (FQHC) leadership; and Medicaid HMOs. The primary goal of the group is to solution build to improve health care for these children.

Endnotes

1. Office of the Child Advocate, *Jackson Investigation: An Examination of Failures of New Jersey's Child Protection System and Recommendations for Reform* (February 2004).
2. Office of the Child Advocate, *Assessment of the Health Status of a Sampling of Children in Foster Care* (November 2004).
3. DHS' commitment to establish a comprehensive continuum of care is also memorialized in two Corrective Action plans submitted to the OCA by DHS in response to the OCA's *Jackson Investigation* report, which were reaffirmed in subsequent Quarterly Updates, and in the New Jersey Child Welfare Reform Plan, James E. McGreevey et al. *A New Beginning: The Future of Child Welfare In New Jersey* (June 9, 2004).
4. Issues outlined in the February 2004 Report and unrelated to coordinated medical care have been addressed by the Department of Human Services in its Corrective Action Plans and through the commitments outlined in the Child Welfare reform Plan. As such, this report is squarely focused upon the Department's commitments regarding coordination of health services for children in its care, and concludes the OCA's investigative work related to the *Jackson Report*.
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14. New Jersey Department of Human Services, "Request for Qualifications, Health Services for Children Newly Placed in Foster Care: Comprehensive Health Evaluations for Children (CHEC)" (September 2004).
15. New Jersey Department of Human Services, "Health Plan for the Office of Children's Services" (March 2005).

16. New Jersey Department of Human Services, Office of Children's Services, "Medical Issues in the Child Welfare System" (June 7, 2005) Website: <http://www.state.nj.us/humanservices/ocs/index.html>.
17. AAP District II Task Force on Health Care for Children in Foster Care. *Fostering Health: Health Care for Children and Adolescents in Foster Care*. 2nd Edition. American Academy of Pediatrics, 2005.
18. Georgetown University Child Development Center. *Meeting the Health Care Needs of Children in the Foster Care System. Framework for a Comprehensive Approach: Critical Components*. Washington, DC: Georgetown University Child Development Center, 2002.
19. Child Welfare League of America. *Standards for Health Care Services for Children in Out-of-Home Care*. Washington, DC: Child Welfare League of America; 1988.
20. New York State Office of Children and Family Services. *Working Together. Health Services for Children in Foster Care*, 2004.
21. Bilchik, Shay, "Pediatricians Should Ensure Foster Children Get Needed Care," AAP News (March 2005).
22. Related to audit findings, the OCA will perform a separate assessment of New Jersey's Early Intervention System to ensure that the children in the State's care who are between birth to age three are equipped with the resources necessary to maximize their development.

APPENDIX

1. DEMOGRAPHICS

1.1 Age (n = 45)¹

Descriptives (in years: .08 = 1 mo.)			Frequencies (f, in number of children)			
Mean (M)	Median (Mdn)	Range	Age Bracket	f	%	Total %
6.29	4.48	[.06 – 16.48]	3 wks – 6 mos.	10	22.2	22.2
			7 mos. – 3 yrs.	9	20.0	42.2
			3 yrs, 6 mos. – 6 yrs.	7	15.6	57.8
			6 yrs, 6 mos. – 12 yrs.	9	20.0	77.8
			12 yrs, 7 mos. – 16 yrs, 6 mos.	10	22.2	100

1.2 Gender (n = 54)

			Ethnicity (n = 53)	
	f	%		
Male	29	53.7	African-American	24
Female	25	46.3	Caucasian	15
			Latino	4
			Mixed Ethnicity	4
			(Caucasian & Latino)	(3) ²
			(Latino & African-American)	(1)
			Unknown	4
			Asian-American	2

1.3 Geographical Distribution

By DYFS District Office (n = 52)			By Exam Site (n = 54)	
DO	f	%	Site	
Bloomfield	1	1.9	Cares	9
Burlington	3	5.8	Hepburn	12
Camden Central	1	1.9	Hersch	7
Camden East	1	1.9	JSMC	13
Camden North	2	3.7	NBIMC	13
East Orange	1	1.9		
Gloucester	2	3.7		
Hudson	1	1.9		
Mercer	1	1.9		
Monmouth North	1	1.9		
Monmouth South	4	7.4		
Morris	5	9.3		
Newark 1	1	1.9		
Newark 2	5	9.3		
Newark 3	2	3.7		
Ocean	10	18.5		
Passaic Central	3	5.6		
Passaic North	1	1.9		
Perth Amboy	2	3.7		
Somerset	1	1.9		
Union East	1	1.9		
Union West	2	3.7		
Unknown	1	1.9		

¹ Sample size (n) varies throughout, as data was not available for all participants in the case of each analysis.

² Note: throughout values listed in parentheses and italics are subsets of the last set of values in ordinary typeset above.

2. REASONS FOR OUT-OF-HOME PLACEMENT

Primary Factor (n = 54)

Type	f	%
Any Abuse or Neglect	44	81.5
Abuse	15	27.8
(Physical)	(11)	20.4
(Sexual)	(4)	7.4
Neglect	20	37.0
(Physical)	(13)	(24.1)
(Emotional)	(1)	(1.9)
(Medical Neglect)	(2)	(3.7)
(Neglect Unspecified)	(4)	(7.4)
Other	9	16.7
(Child Welfare Assessment)	(2)	(3.7)
(Grandparents Unable to Care)	(2)	(3.7)
(No Prenatal Care)	(2)	(3.7)
(Abandonment)	(1)	(1.9)
(Mental Illness)	(1)	(1.9)
(Parental Substance Abuse)	(1)	(1.9)

Secondary Factors (n = 54)

Type	f	%
Any Other Factors	30	55.6
Parental Substance Abuse	13	24.1
Poverty/Homelessness	6	11.1
Domestic Violence	5	9.3
Mental Illness	2	3.7
Other	4	7.4
(Child Behavioral)	(1)	(1.9)
(Home "Deplorable")	(1)	(1.9)
(Placed for Adoption)	(1)	(1.9)
(Unspecified)	(1)	(1.9)

3. TIMELINESS OF CHEC EXAMS

3.1 Time between Placement³ and Referral (in days)

Site	n	M	Mdn	Range
Cares	0 ⁴	n/a	n/a	n/a
Hepburn	6	27.7	13.0	[3 – 96]
Hersch	5	21.6	13.0	[6 – 48]
JSMC	13	28.3	18.0	[0 – 85]
NBMIC	6	16.0	16.5	[1 – 31]
Overall	30	24.6	15.0	[0 – 96]

3.2 Time between Referral and Exam (in days)

Site	n	M	Mdn	Range
Cares	0	n/a	n/a	n/a
Hepburn	12	13.3	8.5	[0 – 63]
Hersch	7	26.1	21.0	[7 – 46]
JSMC	13	35.0	41.0	[3 – 76]
NBMIC	11	23.7	19.0	[7 – 59]
Overall	43	24.6	18.0	[0 – 76]

3.3 Time between Placement and Exam (in days)

Site	n	M	Mdn	Range
Cares	4	24.3	24.5	[0 – 48]
Hepburn	6	44.3	29.0	[15 – 104]
Hersch	5	39.6	27.0	[1 – 89]
JSMC	13	61.5	65.0	[15 – 88]
NBMIC	7	46.0	43.0	[10 – 89]
Overall	35	48.1	43.0	[0 – 104]

3.4 Time between Exam and Report (in days)

Site	n	M	Mdn	Range
Cares	0	n/a	n/a	n/a
Hepburn	12	12.8	15.5	[0 – 31]
Hersch	7	10.7	7.0	[0 – 31]

³ All children entering placement prior to 12/1/04 were regarded as having entered placement on that date for the purposes of these analyses.

⁴ The CHEC form employed at Cares did not include a field for referral or report date; hence no timeliness data is reported for those categories in which referral or report date were a boundary.

JSMC	13	25.5	7.0	[0 – 120]
NBMIC	12	34.5	38.0	[0 – 61]
Overall	44	22.2	14.0	[0 – 120]

4. PERSONS RECEIVING CHEC REPORT

Report Destination (n = 50)

Individual	f	%
DYFS		
Caseworker	44	88.0
Nurse: Primary	45	90.0
Additional	1	2.0
Supervisor	43	86.0
Regional Coordinator	4	8.0
Addtl DYFS Staffperson	2	4.0
Caregiver	40	80.0
Physician	35	70.0
Medicaid Coordinator	4	8.0
Other	14	28.0
(Unspecified: Named, no affiliation)	(6)	(12.0)
(Unspecified: No name given)	(5)	(10.0)
(Unspecified: Illegible)	(1)	(2.0)
(Nursing Coordinator)	(1)	(2.0)
(Office of Quality Assurance)	(1)	(2.0)

5. INDIVIDUAL(S) SUPPLYING HISTORICAL MEDICAL INFORMATION AT CHEC

Historian (n = 54)

Single Historian	f	%	Age (in years: .08 = 1 mo.)		
			M	Mdn	Range
Foster Parent – resource (FP-res)	9	16.7	1.5	0.4	[.06 – 5.5]
Caseworker (CW)	7	13.0	5.3	5.2	[.16 – 11.0]
Foster Parent – relative (FP-rel)	5	9.3	2.7	2.7	[.08 – 5.7]
Patient (Pat)	4	7.4	15.6	16.4	[13.0 – 16.7]
Birth Parent (BP)	1	1.9	2.6	2.6	n/a
Other (total)	4	7.4	1.8	1.5	[.16 – 4.0]
Unknown	3	5.6			
Godmother	1	1.9			

Multiple Historians

Historians	f	%	Historians	f	%
CW & Pat	6	11.1	CW, Pat, & Other	1	1.9
CW & FP-res	4	7.4	FP-rel & CW	1	1.9
FP-res & Pat	2	3.7	FP-rel & Pat	1	1.9
FP-res, CW, & Pat	2	3.7	FP-rel & Other	1	1.9
BP & FP-res	1	1.9	FP-res & Other	1	1.9
BP & CW	1	1.9	FP-rel, CW, & Other	1	1.9
BP & Pat	1	1.9	FP-rel, Pat, & Other	1	1.9

6. CHEC REPORT HISTORICAL RECORD REVIEW

6.1 Category

	Up to Date		Delayed		No Records		No Indication in CHEC	
	f	%	f	%	f	%	f	%
Immunizations	32	59.3	10	18.5	9	16.7	3	5.6
	Evidence of		No Evidence of		No Records		No Indication in CHEC	
	f	%	f	%	f	%	f	%
Dental Care	11	20.4	12	22.2	8	14.8	23	42.6
Allergies	6	11.1	34	63.0	9	16.7	5	9.3
Hospitalizations	11	20.4	24	44.4	9	16.7	10	18.5
ER Visits	7	13.0	13	24.1	13	24.1	21	38.9
Injuries	7	13.0	24	44.4	10	18.5	13	24.1
	Normal		Abnormal		No Records		No Indication in CHEC	
	f	%	f	%	f	%	f	%
Behavior & Development	11	20.4	15	27.8	5	9.3	23	42.6
Growth & Nutrition	25	46.3	4	7.4	2	3.7	23	42.6

6.2 Provision of Family Medical History (n = 54)

	Via Narrative		Via Family History Form	
	f	%	f	%
Yes	13	24.1	1	1.9
No	9	16.7	34	63.0
Incomplete	12	22.2	0	0
No Indication in CHEC	19	35.2	19	35.2

7. HMO ENROLLMENT

HMO Enrollment Status (n = 54)

Plan Status	f	%
Single Plan	26	48.1
Single Plan with Coverage Gaps	5	9.3
Change in Plan	6	11.1
Plan(s) with Exemptions	9	16.7
Unknown	4	7.4

8. CHEC DIAGNOSIS CODE

Physical/ Medical

<u>Category</u>	<u>Code</u>
Allergies	1
Dental/ Oral Health	2
ENT	3
Gastrointestinal (GI)	4
Growth/ Nutrition	5
Gynecologic	6
Injury	7
Neurologic	8
Ophthalmologic	9
Orthopedic	10
Respiratory	11
Skin/ Dermatologic	12
Vision/ Hearing	13
Immunizations, Delayed/ Unknown	14
Screening, Delayed	15
Screening, Abnormal	16

Mental Health/ Behavioral

<u>Category</u>	<u>Code</u>
Attachment Disorder (AD)	17
Attention-Deficit Hyperactivity Disorder (ADHD)	18
Conduct Disorder (CD)	19
Depression	20
General Mental Health	21
Oppositional Defiant Disorder	22
Post-Traumatic Stress Disorder (PTSD)	23
Suicide Risk/ Ideation	24

Developmental/ Academic

<u>Category</u>	<u>Code</u>
Developmental Delay/ Disability	25
General Academic Functioning	26
Learning Disability	27
Prenatal Drug Exposure	28

Other	29
Excluded Diagnoses	30

9. DIAGNOSES BY CHILD

Diagnosis by Child (n = 54)

Diagnostic Category	Frequency by Child	As Percentage (Rank)
Physical/Medical (Dx code)	52	96.3
Allergies (1)	4	7.4
Dental/Oral Health (2)	29	53.7 (1)
Ear Nose & Throat, ENT (3)	6	11.1
Gastrointestinal, GI (4)	5	9.3
Growth/Nutrition (5)	9	16.7
Gynecologic (6)	2	3.7
Injury (7)	4	7.4
Neurologic (8)	7	13.0
Ophthalmologic (9)	3	5.6
Orthopedic (10)	8	14.8
Respiratory (11)	14	26.0
Skin/Dermatologic (12)	21	38.9 (4)
Vision/Hearing (13)	16	29.6 (5)
Immunizations, Delayed/Unknown (14)	22	40.7 (3)
Screening, Delayed (15)	27	50.0 (2)
Screening, Abnormal (16)	10	18.5
Mental Health/Behavioral (Dx code)	33	61.1
Attachment Disorder, AD (17)	3	5.6
Attention-Deficit Hyperactivity Disorder, ADHD (18)	1	1.9
Conduct Disorder, CD (19)	0	0
Depression (20)	4	7.4
General Mental Health (21)	25	46.3
Oppositional Defiant Disorder, ODD (22)	1	1.9
Post-Traumatic Stress Disorder, PTSD (23)	4	7.4
Suicide Risk/Ideation (24)	0	0
Developmental/Academic (Dx code)	37	68.5
Developmental Delay/Disability (25)	15	27.8
General Academic Functioning (26)	15	27.8
Learning Disability (27)	2	3.7
Prenatal Drug Exposure (28)	9	16.7
Other (Dx code)	10	18.5
Other (29)	8	14.8
Excluded Diagnoses (30)	3	5.6

10. OVERALL RATES OF ILLNESS

Prior to CHEC (n = 54)

1 Dx		2 Dx		3 Dx		4 Dx		5 Dx		6+ Dx	
f	%	f	%	f	%	f	%	f	%	f	%
34	63.0	21	38.9	16	29.6	8	14.8	4	7.4	3	5.6

At CHEC Exam (n = 54)

1 Dx		2 Dx		3 Dx		4 Dx		5 Dx		6+ Dx	
f	%	f	%	f	%	f	%	f	%	f	%
48	88.9	45	83.3	44	81.5	38	70.4	30	55.6	25	46.3

11. FOLLOW-UP RATES

11.1 Overall Follow-Up Rates (n = 45)

Mean Rates from Aggregate Data (merged medicaid & DYFS data)

Yes	No	N/A	Unk
32.0	58.8	3.0	6.3

11.2 Follow-Up by Child (n = 45)

Category	Mean Rates from Medicaid Data		Mean Rates from DYFS Data	
	Frequency	Percentage	Frequency	Percentage
All Dx follow-up	1	2.2	1	2.2
Some Dx follow-up	31	68.9	34	75.6
No Dx follow-up	13	28.9	10	22.2

11.3 Follow-Up by District Office (n = 43)

District Office	Mean Rates from Medicaid Data					Mean Rates from DYFS Data				
	Yes	No	N/A	Unk	n	Yes	No	N/A	Unk	n
Bloomfield	0	100	0	0	1	25.0	75.0	0	0	1
Burlington	20.0	80.0	0	0	3	18.9	81.1	0	0	3
Camden Central	14.3	85.7	0	0	1	28.6	71.4	0	0	1
Camden East	0	100	0	0	1	71.4	28.6	0	0	1
Camden North	0	100	0	0	2	7.1	92.9	0	0	2
East Orange	0	100	0	0	1	0	100	0	0	1
Gloucester	70.8	29.2	0	0	2	45.8	54.2	0	0	2
Hudson	75.0	25.0	0	0	1	25.0	75.0	0	0	1
Mercer	57.1	42.9	0	0	1	42.9	57.1	0	0	1
Monmouth South	50.5	49.5	0	0	3	45.0	55.0	0	0	3
Morris	41.7	58.3	0	0	5	51.3	48.7	0	0	5
Newark 2	27.0	65.0	0	8.0	5	17.0	75.0	0	8.0	5
Newark 3	28.3	46.7	0	25.0	2	28.3	46.7	0	25.0	2
Ocean	38.0	43.3	5.0	13.7	5	21.0	60.3	5.0	13.7	2
Passaic Central	33.9	58.9	0	7.1	2	41.2	52.7	0	7.1	2
Passaic North	35.7	35.7	28.6	0	1	28.6	42.9	28.5	0	1
Perth Amboy	15.5	60.7	15.5	8.3	2	29.8	46.4	15.5	8.3	2
Somerset	100	0	0	0	1	100	0	0	0	1
Union East	42.9	14.3	42.9	0	1	28.6	28.6	42.9	0	1
Union West	31.3	62.5	0	6.3	2	18.8	75.0	0	6.3	2
Unknown	36.4	45.5	9.1	9.1	1	27.3	54.5	9.1	9.1	1
Overall	34.1	57.8	3.2	4.9	43	31.5	60.4	31.2	4.9	43

11.4 Follow-Up by Exam Site (n = 45)

District Office	Mean Rates from Medicaid Data					Mean Rates from DYFS Data				
	Yes	No	N/A	Unk	n	Yes	No	N/A	Unk	n
Cares	24.0	76.0	0	0	9	29.2	70.8	0	0	9
Hersch	44.7	38.8	14.1	2.4	7	34.0	49.5	14.1	2.4	7
Hepburn	44.5	49.9	3.4	2.1	11	39.5	54.9	3.4	2.1	11
JSMC	43.2	45.4	0	11.4	6	38.8	49.8	0	11/4	6
NBIMC	19.0	68.4	0	12.6	12	16.7	67.1	0	16.3	12
Overall	33.5	57.7	3.0	5.8	45	30.4	59.8	3.0	6.8	45

11.5.1 Follow-Up by Demographic Information

By Age	Mean Rates from Medicaid Data					Mean Rates from DYFS Data				
	Yes	No	N/A	Unk	n	Yes	No	N/A	Unk	n
3 wks – 6 mos.	41.0	52.9	6.1	0	7	38.7	55.2	6.1	0	7
7 mos. – 3 yrs.	25.7	74.3	0	0	5	24.2	75.8	0	0	5
3 yrs, 6 mos. – 6 yrs.	53.6	41.0	4.3	1.1	8	44.0	50.6	4.3	1.1	8
6 yrs, 6 mos. – 12 yrs.	26.5	61.0	0	12.5	8	26.0	61.5	0	12.5	8
12 yrs, 7 mos. – 16 yrs, 6 mos.	32.9	52.4	4.5	10.2	10	28.0	57.3	4.5	10.2	10
Overall	36.5	54.8	3.2	5.5	38	32.4	58.8	3.2	5.5	38

11.5.2. Gender

	Mean Rates from Medicaid Data					Mean Rates from DYFS Data				
	Yes	No	N/A	Unk	n	Yes	No	N/A	Unk	n
Male	34.4	58.3	1.8	5.5	24	34.8	57.9	1.8	5.5	24
Female	32.7	58.1	4.7	4.5	20	26.6	62.9	4.7	5.8	20
Overall	33.6	58.2	3.1	5.1	44	31.1	60.2	3.1	5.6	44

11.5.3. Ethnicity

	Mean Rates from Medicaid Data					Mean Rates from DYFS Data				
	Yes	No	N/A	Unk	n	Yes	No	N/A	Unk	n
Af-Am	34.9	54.8	4.4	6.0	20	27.2	62.5	4.4	6.0	20
Asian-Am	38.9	61.2	0	0	2	72.2	27.8	0	0	2
Caucasian	39.2	52.2	2.6	6.0	13	30.2	61.2	2.6	6.0	13
Latino	14.0	77.9	2.9	5.4	5	32.6	54.1	2.9	10.4	5
Other	31.0	69.0	0	0	4	31.0	69.0	0	0	4
Overall	33.6	58.2	3.1	5.1	44	31.1	60.2	3.1	5.6	44

11.6 Total EI Referral (n = 19)

f	%	f	%
10	52.6	4	40.0

EI Referrals with Follow-Up (n = 10)

12. Diagnoses and Follow-Up by Child

ID	Previous Dx	CHEC Dx	Follow-Up	
			Med	DYFS
2/3	1: Possible G6PD Deficiency (16)	1: Delayed Immunizations (14) 2: Possible G6PD Deficiency (16) 3: Possible Hearing Impairment (13) 4: Developmental Delay (25)	1: N 2: N 3: N 4: N	1: N 2: N 3: N 4: N
3/12	1: Asthma (11) 2: URI (11) 3: Speech Delay (25)	1: Asthma (11) 2: URI (11) 3: Speech Delay (25) 4: Temper Tantrums (21) 5: Anemia, nutritional (5)	1: N 2: N 3: N 4: N 5: N 6: N	1: N 2: N 3: N 4: N 5: N 6: N
4/13	None	1: Gastroesophageal Reflux (4) 2: Hypertonia (8)	1: N 2: N	1: N 2: Y
5/19	1: Prenatal Drug Exposure (28)	1: Perianal Rash (12) 2: Seborrheic Dermatitis (12) 3: Prenatal Drug Exposure (28)	1: N/A 2: N 3: N	1: N/A 2: N 3: N
6/20	1: Speech Delay (25) 2: Diarrhea (4)	1: Developmental / Speech Delay (25) 2: Macrocephaly (8) 3: Dental (2) 4: At risk for Obesity (5) 5: Screening: hearing related to speech delay (13) 6: Abnormal social/emotional dev (21)	1: N 2: N 3: N 4: N 5: Y 6: N	1: Y 2: N 3: N 4: N 5: Y 6: N
7/23	1: Hepatitis C Exposure (16) 2: Gastroesophageal Reflux (4) 3: No HIV Screening Results (15)	1: Hepatitis C Exposure (16) 2: Hepatomegaly (4) 3: Microcephaly (8) 4: Developmental Delay (25) 5: Gastroesophageal Reflux (4) 6: Vision Screening (13) 7: Hearing Screening (13) 8: Head Ultrasound (15) 9: Liver/Spleen Ultrasound (15)	1: Y 2: Y 3: N 4: Y 5: N 6: N 7: N 8: N 9: Y	1: Y 2: Y 3: Y 4: Y 5: Y 6: N 7: N 8: Y 9: Y
8/26	1: Prenatal Drug Exposure (28) 2: Tremors (8) 3: Right Upper Extremity Weakness (8)	1: Prenatal Drug Exposure (28) 2: Hypertonia (8) 3: Gastroesophageal Reflux (4)	1: Y 2: Y 3: Y	1: Y 2: Y 3: Y
10/32 ¹	None	1: Delayed Immunizations (14) 2: Bilateral hip click (10) 3: Diaper Rash (12)	1: N 2: N 3: N	1: Y 2: N 3: Y
11/36	Missing	1: Prenatal Drug Exposure (28) 2: URI (11) 3: Teething (2) 4: Screening: CBC, Pb (15)	1: N 2: N 3: N 4: Y*	1: N 2: N 3: N 4: Y*
13/45	None	1: Delayed Immunizations (14) 2: URI (11) 3: Screening: CBC, Pb, Sickle (15)	1: N 2: N 3: Y	1: N 2: N 3: N
15/49	None	1: Headaches (8) 2: Anger Issues (21) 3: Vision, needs glasses (13) 4: Unknown Immunization Status (14) 5: Possible Scoliosis (10) 6: Routine Dental Care (2) 7: Screenings: CBC, Cholesterol, PPD, UA (15) 8. General Academic Functioning (26)	1: N 2: N 3: N 4: N 5: N 6: N 7: Y* 8.	1: N 2: Y 3: N 4: N 5: N 6: N 7: Y* 8.
16/50 ²	1: Premature birth (29) 2: Failure to thrive (5) 3: Inappropriate Feeding (5) 4: Apnea of prematurity (29) 5: Hyperbilirubinemia (29) 6: RDS (11) 7: Cephalohematoma (29)	1: Premature birth (29) 2: Apnea of Prematurity (29) 3: Respiratory Distress Syndrome (29) 4: Possible Retinopathy of Prematurity (9) 5: Diaper Rash (12) 6: Umbilical hernia (4)	1: Y 2: Y 3: Y 4: Y 5: N 6: N	1: Y 2: Y 3: Y 4: Y 5: N 6: N
18/61	none	1: Puncture wound (7) 2: Delayed Immunizations (14) 3: Routine Dental Care (2) 4: Screenings: CBC, Pb, PPD (15)	1: N 2: Y 3: Y 4: Y*	1: N 2: N 3: N 4: Y*
19/62	1: Asthma (11)	1: Asthma (11) 2: Dental Routine Care (2) 3: Screenings: CBC, PPD+ (15)	1: Y 2: N 3: Y	1: N 2: N 3: Y

		4: Latent Tb (16) 5: Reading Skills (21)	4: Y 5: N	4: Y 5: N
20/63	None	1: Diaper Rash (12) 2: Dry Skin (12)	1: N 2: N	1: N 2: N
21/68		1: Jaundice (29) 2: Possible Heart Murmur (16) 3: Possible Sacral Dimple (16) 4: Oral Thrush (2) 5: Diaper Rash (12) 6: Seborrheic Dermatitis (12) 7: Prenatal Drug Exposure (28)	1: N 2: N 3: N 4: N 5: N 6: N 7: N	1: N 2: N 3: N 4: Y 5: N 6: N 7: N
22/69	1: Prenatal Drug Exposure (28) 2: Torticollis (10)	1: Prenatal Drug Exposure (28) 2: Abrasion to Central Palate (7) 3: Torticollis (10)	1: N 2: N 3: N	1: N 2: N 3: N
23/73 ³	1: Cerumen impactions recurrently (3) 2: Nocturnal Enuresis (25)	1: Penile Nodule (29) 2: Cerumen Impaction (3) 3: Failed Hearing Screening (13) 4: Dental Caries (2) 5: Nocturnal Enuresis (25) 6: Mental Health (21) 7: General Academic Functioning (26)	1: N 2: N 3: N 4: N 5: N 6: N 7: N	1: Y 2: Y 3: N 4: Y 5: Y 6: Y 7: N
26/89 ⁴	1: Reactive Airway Disease (11)	1: Facial weakness, Subdural Hematomas (8) 2: Diaper Rash (12) 3: Seborrheic Dermatitis (12) 4: Reactive Airway Disease (11) 5: Serous otitis media (3) 6: Development, monitoring (25)	1: N 2: N 3: N 4: N 5: N 6: N	1: N 2: N 3: N 4: Y 5: N 6: N
27/103	1: Oppositional behavior (22) 2: Femur Fracture (10)	1: Oppositional Defiant Disorder (22) 2: Routine Gynecologic Care (6) 3: Routine Dental Care (2) 4: Immunization, Hep B (14) 5: Screenings: CBC, Hep, HIV, UA (15) 6: Abnormal Screen: UA (16) 7: General Academic Functioning (26)	1: Y 2: N 3: Y 4: Y 5: Y 6: 7: N	1: Y 2: N 3: N 4: N 5: N 6: 7: N
28/104	1: Prenatal Drug Exposure (28) 2: Neonatal Abstinence Syndrome (29)	1: Prenatal Drug Exposure (28) 2: Neonatal Abstinence Syndrome (29) 3: Diaper Rash (12) 4: Screenings: Hearing, Hep, HIV, Newborn (15)	1: N 2: N 3: Y 4: Y(?)	1: Y 2: Y(?) 3: N 4: N
29/105	1: Reactive Airway Disease (11) 2: Bronchiolitis (11) 3: Ear Infection (3)	1: Reactive Airway Disease (11) 2: Diaper Rash (12) 3: Food Allergy (1) 4: Delayed Immunizations (14) 5: Attachment Disorder Risk (17)	1: N 2: Y 3: N 4: N 5:	1: N 2: N 3: Y 4: N 5:
31/109	1: Physical Abuse (29) 2: Head Injury (7) 3: URI (11) 4: Prenatal Drug Exposure (28)	1: Prenatal Drug Exposure (28) 2: URI (11) 3: Diaper Rash (12) 4: Screenings: HIV, Pb (15) 5: Screening Abnormal: CBC (16) 6: Delayed Immunizations (14)	1: N 2: N 3: N 4: N 5: 6: N	1: Y 2: N 3: N 4: Y 5: 6: N
32/110	1: Otitis Media (3) 2: Acute Gastroenteritis (4)	1: Delayed Immunizations (14) 2: Speech Delay (25) 3: Attachment Disorder (17) 4: Cognitive Delay (25)	1: Y* 2: Y 3: N 4: Y	1: Y* 2: N 3: N 4: N
33/111	1: Fine Motor Delay (25)	1: Urgent need for therapy (21) 2: General Academic Functioning (26) 3: Dental (2) 4: Screenings: CBC, HIV, Pb, UA (15)	1: Y 2: Y 3: Y 4: Y*	1: Y 2: Y 3: N 4: Y*
34/114	1: Syncope (29) 2: Mild Sinus Arrhythmia (29) 3: Asthma (11)	1: Loss of Consciousness (Hx, 29) 2: Asthma (11) 3: Single testicle (29) 4: Lordosis/Kyphosis/Scoliosis (10)	1: Y 2: Y 3: N 4: Y	1: Y 2: Y 3: N 4: N

		5: Short Stature (5) 6: Arachnoidactyly (29) 7: Acne (12) 8: Food Allergy (1) 9: STD risk (29) 10: Vision Problems (13) 11: Prominent Right Chest (29) 12: Urgent need for therapy (21) 13: Academic Problems (26) 14: Screenings: HIV, RPR (15)	5: NA 6: Y 7: NA 8: NA 9: N 10: N 11: NA 12: Y 13: N 14: N	5: NA 6: N 7: NA 8: NA 9: Y 10: N 11: NA 12: N 13: N 14: Y
35/115 ⁵	None	1: Underweight (5) 2: Failed Hearing Screening (13) 3: Dental Cavities (2) 4: Psychological problems (21) 5: Screenings: CBC, Chem, Pb, Sickie, UA (15) 6: PPD needs follow-up	1: N 2: N 3: N 4: Y 5: N 6: N	1: N 2: N 3: N 4: Y 5: N 6: N
36/188	None	1: Delayed Immunizations (14) 2: URI (11) 3: Eczema (12) 4: Routine Dental Care (2) 5: Routine Vision Care (13) 6: Failed Hearing Screening (13) 7: Screenings: CBC, Pb, UA (15) 8: Screening: PPD (15) 9: General Mental Health (21) 10: Hypopigmentation (11)	1: N 2: Y 3: N 4: N 5: N 6: N 7: Y* 8: N 9: 10:	1: Y 2: N 3: N 4: N 5: N 6: N 7: Y* 8: Y 9: 10:
37/120	None	1: Sexual Abuse (Hx, 30) 2: Screening: X-ray f/u for +PPD (16) 3: Routine Dental Care (2) 4: Post-Traumatic Stress Diagnosis (23) 5: Substance Abuse (21)	1: Y 2: N 3: N 4: 5:	1: Y 2: N 3: Y 4: 5:
39/126	1: Down's Syndrome (25) 2: Compensated Hypothyroidism (29) 3: Imperforated Anus (29) 4: Abuse and Neglect (30) 5: Malnutrition (5) 6: Zn Deficiency (5)	1: Down's Syndrome (25) 2: Malnutrition (5) 3: Hypothyroidism (29) 4: Chronic Constipation (4) 5: Hearing Evaluation (13) 6: Vision Evaluation (13) 7: Screen for AtlantoAxial Instability (10) 8: Screenings: CBC, HIV, Pb, STD, UA...(15) 9: Routine Dental Care (2) 10: Physical Abuse (Hx, 30) 11: General Academic Functioning (26)	1: N 2: Y 3: N 4: Y 5: Y 6: N 7: N 8: Y* 9: ? 10: NA 11: N	1: Y 2: N 3: N 4: Y 5: N 6: N 7: N 8: Y* 9: ? 10: NA 11: N
40/128 ⁶	1: Chicken Pox (29) 2: Fractured Right Lower Leg (10) 3: Trauma to Left Elbow (10)	1: Elbow Trauma (10) 2: Failed Hearing Screening (13) 3: Failed Vision Screening (13) 4: Delayed Immunizations (14) 5: Dental Health (2) 6: Depression (20) 7: Screenings: CBC, Chem, PPD, Sickie, UA...(15)	1: Y 2: N 3: N 4: Y* 5: ? 6: N 7: Y*	1: N 2: N 3: N 4: Y* 5: ? 6: Y 7: Y*
41/133	1: Prenatal Drug Exposure (28)	1: Prenatal Drug Exposure (28) 2: Hearing Evaluation (13)	1: Y 2: N	1: N 2: N
42/145 ⁷	1: Possible Language Delays (25) 2: Obesity (5) 3: Intermittent Asthma (11) 4: Malocclusion of Teeth (2)	1: Routine Labs (15) 2: Obesity (5) 3: Malocclusion of Teeth (2) 4: Asthma (11) 5: Speech Delay (25) 6: Behavioral / Psych (21) 7: Screening: UA (15)	1: Y* 2: N 3: N 4: Y 5: N 6: Y 7: Y*	1: Y* 2: N 3: N 4: N 5: N 6: Y 7: Y*
43/147	1: Obesity (5) 2: Borderline Blood Pressure (29)	1: Morbid Obesity (5) 2: Substance Abuse (21) 3: Sexual Activity, no STD screen (15) 4: Routine Dental Care (2) 5: Behavioral / Psych (21) 6: General Academic Functioning (26)	1: Y 2: ? 3: NA 4: N 5: N 6: N	1: Y 2: ? 3: NA 4: N 5: N 6: N
44/156	1: Sexual Abuse (30) 2: Family Dysfunction (30) 3: Caries (2) 4: Seasonal Rhinitis (3)	1: Delayed Immunizations (14) 2: Dental Caries (2) 3: Acne (12) 4: Sexual Abuse (30) 5: Education / Academic (26)	1: N 2: N 3: NA 4: N 5: N	1: N 2: Y 3: NA 4: Y 5: N

		6: Behavior (21) 7: Screenings, CBC, HIV, PPO, RPR, Sickle...(15)	6: N 7: Y*	6: N 7: Y*
45/164 ⁸	1: Ringworm (12) 2: Dental Caries (2) 3: Dry Skin (12) 4: Delayed Immunizations (14)	1: Ringworm (12) 2: Dental Caries (2) 3: Dry Skin (12) 4: Delayed Immunizations (14) 5: Risk of Attachment Disorder (17) 6: Developmental (25) 7: Screenings: CBC, EP, HIV, Pb, PPD (15)	1: N 2: Y 3: NA 4: Y* 5: NA 6: NA 7: Y*	1: N 2: N 3: NA 4: Y* 5: NA 6: NA 7: Y*
46/166	1: Premature Birth (29) 2: Transient Tachypnea (29) 3: Prenatal Drug Exposure (28) 4: Family Dysfunction (30)	1: Prenatal Drug Exposure (28) 2: Neonatal Drug Withdrawl (29) 3: Premature Birth (29) 4: Screening: CBC, HIV (15)	1: N 2: N 3: N 4: Y*	1: N 2: N 3: N 4: Y*
47/169	None	1: Dental Caries (2) 2: Keratosis Pilaris (12) 3: Injury (7) 4: Delayed Immunizations (14) 5: Delayed Screening PPD (15) 6: Enuresis (21) 7: Psych / Mental Health (21) 8: General Academic Functioning (26)	1: N 2: N 3: N 4: N 5: N 6: NA 7: N 8: N	1: N 2: N 3: N 4: N 5: N 6: NA 7: N 8: N
48/173	None	1: Obesity (5) 2: General Academic Functioning (26) 3: Delayed Screenings: CBC, PPD, UA (15) 4: Delayed Immunizations (14) 5: Routine Dental Care, problems noted (2) 6: Psych / Mental Health (21)	1: N 2: N 3: N 4: N 5: N 6: N	1: N 2: N 3: N 4: N 5: N 6: N
49/174	1: Possible Autism (25)	1: Possible PDD (25) 2: Hyperactivity (18) 3: Clubfoot Surgery (10) 4: URI (11) 5: Elevated Blood Pressure (16) 6: Immunizations (14) 7: Routine Dental Care (2) 8: Screenings: CBC, Pb, PPD (15)	1: N 2: N 3: N 4: N 5: N 6: N 7: N 8: N	1: N 2: N 3: N 4: N 5: N 6: N 7: N 8: N
50/178	1: Diabetes (29) 2: DKA (29) 3: Varicella (29) 4: Possible Transient Tachypnea (29)	1: Diabetes (29)	1: Y	1: Y
51/180	1: No Prenatal Care (29) 2: Aspiration w/ Tachypnea (29) 3: Prenatal Drug Exposure (29) 4: Neonatal Drug Withdrawl (29)	1: Prenatal Drug Exposure (29) 2: Neonatal Drug Withdrawl (29) 3: Eczema (12) 4: Heart Murmur (16) 5: Immunizations (14)	1: ? 2: ? 3: N 4: Y 5: N	1: ? 2: ? 3: N 4: N 5: N
52/185 ⁹	1: Seizures (8)	1: Vision Deficit (13) 2: Hand Tremor (8) 3: Knee Pain (10) 4: Acne (12) 5: Routine Dental Care (2) 6: Possible PTSD (23) 7: General Academic Functioning (26)	1: N 2: N 3: N 4: N 5: N 6: N 7: N	1: N 2: N 3: N 4: N 5: N 6: Y 7: N
53/188 ¹⁰	1: Asthma (11)	1: Bug Bites (12) 2: Substance Abuse (21) 3: Foot Pain, gun shot wound (7) 4: Asthma (11) 5: Behavior (21) 6: Delayed Immunizations (14) 7: Routine Dental Care (2) 8: Abnormal Screen for White Blood Count (16) 9: PTSD (23) 10: General Academic Functioning (26) 11: Screening: CBC, PPD, Tox, UA (14)	1: ? 2: N 3: N 4: ? 5: Y 6: N 7: Y 8: ? 9: Y 10: ? 11: N	1: ? 2: ? 3: ? 4: ? 5: N 6: N 7: N 8: ? 9: N 10: ? 11: N
56/195	1: Major Depressive Disorder (20)	1: Depression (20) 2: PTSD (23) 3: Gynecologic Problems (6) 4: Anemia (15) 5: Vision Problem (13) 6: Delayed Immunization (14)	1: Y 2: Y 3: Y 4: Y 5: Y 6: N	1: Y 2: Y 3: N 4: N 5: Y 6: N

		7: Allergy (1) 8: Screening: Varicella Titre (15)	7: ? 8: N	7: ? 8: N
57/199	unknown	1: Aggressive Behavior (21) 2: General Academic Functioning(26) 3: Immediate Dental Care (2) 4: Depression (20)	1: N 2: N 3: N 4: N	1: Y 2: N 3: N 4: N
58/203 ¹¹	none	1: Speech Delay (25) 2: Dermatitis (12) 3: URI (11) 4: Delayed Immunizations (14) 5: Hearing Evaluation (13) 6: Routine Dental Care (2) 7: Screenings: CBC, Pb (15) 8: Behavioral Problems (21)	1: N 2: N 3: ? 4: Y* 5: N 6: N 7: N 8: N	1: ? 2: ? 3: ? 4: Y* 5: N 6: N 7: N 8: N
61/210	1: Conduct Disorder (19) 2: Depression (20) 3: Suicide Risk/Ideation (24) 4: Truancy (30) 5: Psychiatric Hospitalization (21) 6: Seasonal Allergies (1) 7: Eczema (12) 8: Right Wrist Fracture (10) 9: Pneumonia (11) 10: General Academic Functioning (26)	1: General Academic Functioning (26) 2: Behavior / Psych (21) 3: Vision (13) 4: Seasonal Allergies (1) 5: Eczema (12) 6: Overdue Dental Care (2)	1: N 2: Y 3: ? 4: ? 5: ? 6: N	1: N 2: Y 3: ? 4: ? 5: ? 6: N
65/186	1: Eczema (12)	1: Eczema (12) 2: Behavior (21) 3: Screening (15) 4: Routine Dental Care (2) 5: Psych / Mental Health (21)	1: N 2: N 3: N 4: N 5: Y	1: N 2: Y 3: N 4: N 5: Y
66/212	1: Sleep Apnea (3) 2: Adenoidal & Tonsillar Hypertrophy (3) 3: Eczema (12) 4: Mild Asthma (11) 5: Umbilical Hernia (4)	1: Possible Obstructive Sleep Apnea (3) 2: Adenoidal & Tonsillar Hypertrophy (3) 3: Eczema (12) 4: Asthma (11) 5: Delayed Immunizations (14) 6: Ear Pain (3) 7: Speech Delay / Communication Skills (25)	1: N 2: N 3: N 4: N 5: Y* 6: Y 7: N	1: N 2: N 3: N 4: N 5: Y* 6: N 7: N
67/22	1: Learning Disability (27) 2: Language Disorder (25)	1: Learning Disability (27) 2: Language Delay (25) 3: Urgent Dental Caries (2) 4: URI (11) 5: Hearing (13) 6: Vision (13) 7: Screenings: CBC, Pb, Fragile X, Hep, HIV, UA (15) 8: Ptosis (9) 9: Deviated Nasal Septum (3) 10: Psych / Mental Health (21)	1: Y 2: Y 3: Y 4: ? 5: Y 6: Y 7: Y* 8: Y* 9: Y 10: Y	1: N 2: N 3: Y 4: ? 5: N 6: N 7: Y* 8: Y* 9: N 10: N
68/136 ¹²	none	1: Language Delay (25) 2: Otitis Media (3) 3: General Mental Health (21) 4: Developmental Delay (25)	1: Y 2: Y 3: NA 4: Y	1: Y 2: N 3: NA 4: Y
69/33		1: Ophthalmology (9) 2: Anxiety/Depression (20) 3: Anger (21) 4: Possible Learning Disability (27)	1: ? 2: N 3: N 4: N	1: ? 2: N 3: N 4: N
70/9	none	1: Morbid Obesity (5) 2: Psych/Mental Health (21) 3: General Academic Functioning (26)	1: ? 2: N 3: N	1: ? 2: N 3: N

Legend: Diagnoses and Follow-Up by Child

***: Administered at CHEC**

[Blank Space]: No Information Known

(?): Inconclusive

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- ¹ 10/32: The attending CHEC doctor provided the child's resource parent with a prescription for diaper cream and the resource parent was unable to fill it because the child did not have a Medicaid card. However, the resource parent purchased an over the counter ointment to treat the child's diaper rash.
- ² 16/50: SHSP foster home followed recommendations post CHEC (4/27/05-6/2/05) but care interrupted when baby returned to maternal grandmother ("MGM") 6/05 because MGM asserted doctor is "too far" from MGM's home. MGM asserted she would find care closer to her home.
- ³ 23/73: Child saw PsyD once pre-CHEC and once post-CHEC. 6/14 DYFS case note indicates BF contacted Value Options for community services for son on 5/11. 6/21 DYFS case note indicates CW having difficulty contacting BF to set up in-home counseling and mentor for child. 6/28 DYFS case note indicates CW spoke with BF who reported that Value Options had not yet been to home to begin therapy. CW to "look into it."
- ⁴ 26/89: DYFS case note indicates child is on Pulmicort but questionable if child is sharing nebulizer with foster sibling. [CHICA 05448]
- ⁵ 35/115: CDC, Chem, Pb, Sickie, and UA screening were completed at the CHEC.
- ⁶ 40/128 possibly over-immunized. Received Td booster at 4/15/05 CHEC (per CHEC Final Report) and another Td booster on 6/18/05 (per Medicaid encounter data).
- ⁷ 42/145: HIV screen could not be performed at CHEC because a DYFS worker did not accompany child to exam and a DYFS "Consent to Screen for HIV" was not submitted.
- ⁸ 45/164: Despite CHEC doctor noting "dental cavities/bottle rot" as an "urgent" health need for follow up, neither DYFS case file nor Medicaid encounter data indicates child ever saw a dentist. Medicaid data indicates that a prescription was filled for PolyVit/Flouride. CHEC recommended child be referred to EI in three months, with resource mother and DYFS nurse designated as the parties responsible for coordination. The OCA audit exclusive of time frame in which child should have been referred. Similarly, CHEC recommended that DYFS refer child to RDTC psychologist at age three for evaluation for possible attachment disorder. Child was not yet three during the period of the OCA audit.
- ⁹ 52/185: DYFS case file indicates child's individual therapy was interrupted because child was diagnosed as needing a female therapist. Records do not indicate that therapy resumed.
- ¹⁰ 53/188: Medicaid data indicates child went to a Partnership for Children provider and was diagnosed was Attention Deficit/Non-Hyperactivity Disorder. Records do not indicate treatment.
- ¹¹ 58/203: Child received DTAP #2, IPV #2, HBV #2, & MMR #1 at the CHEC exam. She required DTAP #3, IPV #3, and HBV #3 within four to six weeks. Medicaid data indicates that child only received one of these immunizations. CHEC recommended that child receive routine dental care. Records do not indicate that child saw a dentist. Medicaid data indicates a prescription and refills for a multivitamin with fluoride.
- ¹² 68/136: CHEC recommended monitoring child for several months for possible reactive attachment disorder and referring to therapy if needed. The OCA audit exclusive of time period during which child would have been referred to therapist.