

## **ASSESSMENT OF THE HEALTH STATUS OF A SAMPLING OF CHILDREN IN FOSTER CARE**

### **Scope of the Assessment**

In September 2004, the Office of the Child Advocate (“OCA”) undertook an assessment of the New Jersey Department of Human Services’ (“DHS”) coordination of health care for a statistically relevant sample of children in out of home placements under the supervision of the Division of Youth and Family Services (“DYFS”) through four of its offices: the Camden North and Central District Offices and the Monmouth North and South District Offices. The OCA selected the Camden District Offices pursuant to ongoing monitoring efforts related to our investigation into the systemic child protection lapses identified earlier this year within the Jackson Report<sup>1</sup>. The OCA selected the Monmouth District Offices because of our understanding that those offices have taken initiative with reform efforts relative to coordinating foster children’s medical care. This report reflects the OCA’s findings from the assessment and measures the progress the State has made in establishing a continuum of coordinated medical care for foster children, as promised in two Corrective Action Plans submitted to the OCA in response to the Jackson Report, and as required by the Child Welfare Reform Plan.<sup>2</sup>

### **OCA Jurisdiction**

The independent Office of the Child Advocate 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

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<sup>1</sup> In February 2004, the Office of the Child Advocate released a preliminary report entitled “JACKSON INVESTIGATION: An Examination of Failures of New Jersey’s Child Protection System and Recommendations for Reform.”

<sup>2</sup> “A New Beginning: The Future of Child Welfare in New Jersey,” June 9, 2004.

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.”

### **Data Collection**

To conduct this assessment, the OCA reviewed and examined medical information in a random sampling of foster children’s case files within two counties: Camden and Monmouth. To that end, the OCA requested from DYFS the identification (KC) numbers of all children in out-of-home care in each of the aforementioned district offices between September 2003 and September 2004. DYFS identified 424 KC numbers: 117 from Camden North; 114 from Camden Central; 73 from Monmouth North; and 120 from Monmouth South. From this, the OCA selected a statistically relevant 12.5 percent random sampling of children’s files. The total universe of the review encompassed 53 KC numbers and 82 children, as multiple children were bundled within one KC number in 20 instances. The range of ages for all reviewed children was one month to eighteen years of age. Of the 53 DYFS KC files reviewed, 15 were from Camden North; 19 from Camden Central; 7 from Monmouth North; and 12 from Monmouth South. The sampling consisted of 41 girls, 40 boys, and one child whose gender was unidentifiable in the file.

The OCA obtained the assistance of Latham & Watkins LLP pro bono to gather and analyze the relevant data.<sup>3</sup> This review included:

- Pre-placement exams conducted in 2003-2004;
- Annual exams and well-visits;
- Acute care/sick-child visits;
- School records;
- Medically fragile care reports (e.g. special needs day care);

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<sup>3</sup> Latham & Watkins LLP was retained by the OCA pro bono to assist with the 2003-2004 Jackson investigation.

- Behavioral health assessments and reports; and
- Immunization records.

The OCA created a uniform assessment instrument modeled upon the Universal Child Health Record, endorsed by the New Jersey Department of Health and Senior Services, the American Academy of Pediatricians, and the New Jersey Academy of Family Physicians. The OCA tool, a copy of which is appended, collected information in six categories, as follows:

- (I) Identification Information: KC Number, District Office, Gender, and Date of Birth
- (II) Pre-Placement Information: Date(s) of Exam(s), Date(s) of Placement(s), Site and Time of Exam(s), Height, Weight, Temperature, Blood Pressure, Injuries/Marks Noted, Other Information Noted
- (III) Immunizations: Was Immunization Record in File?, Was Date of Next Immunization Noted?, Notes
- (IV) Preventive Health Screens (Hgb/Hct, Lead, TB, Hearing, Vision, Dental, Developmental, Scoliosis): Date Screened, Record Value, Notations
- (V) Ongoing Care: Date, Head Circumference (if child less than two years old), Blood Pressure (if child over three years old), Behavioral/Mental Health Needs, Equipment Needs, Medical Conditions Noted, Medications/Treatment Noted, Follow Up Required/Provided, Other Information Noted
- (VI) Conclusion (Completed by OCA Staff): Was child's health care coordinated? Does it appear that providers had access to child's prior medical records? Does it appear that providers accessed prior or contemporaneous collateral records (i.e. birth records, other relevant information) to substantiate previously, or allegedly, diagnosed medical conditions?

## **Findings-**

### a. Quality of File Information Available for Audit

The OCA requested that DYFS provide all health related information for the selected children between September 2003 and September 2004, though many files included information prior to September 2003.<sup>4</sup> In general, the audited health records contained scattered documentation from various sources, and were devoid of any meaningful synthesis or interpretation of medical history and conditions. No systematic record keeping process appears to be in place to distinguish among pre-placement exams, annual check-ups, psychological and psychiatric exams, and educational records, including child study team reviews. There was no evidence in this review that DYFS systematically tracks foster children's access to health care through insurance utilization, either through Medicaid's fee-for-service program or the Medicaid health maintenance organizations.

### b. Pre-Placement Examinations

Although DHS requires medical examinations for all children prior to an out-of-home placement under the supervision of DYFS, the files reveal a lack of standardization as to content. Generally, significant disparities and inconsistencies existed among healthcare providers' methods of assessing health and recording information. Typically, pre-placement exams included physical observations for bruising and injuries, and measurements for height, weight, blood pressure, and body temperature. However, 35 percent of all reviewed pre-placement exams featured only three of these four measurements, twenty-six percent of pre-placement exams included only two

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<sup>4</sup> Several files were dominated by assessments of parents for drug dependence, social stability and parental fitness, including psychological and psychiatric evaluations. None of this information had been requested.

measurements, and 9 percent of the exams, nearly one in ten, featured no measurements at all. The records generally evidenced perfunctory assessments, not meaningful physical health evaluations. This was particularly true when the same child required an exam more than once within a short period of time. For example, scars and other permanent body marks were sometimes noted during one exam, but not during subsequent exams occurring shortly thereafter.

Illegible and incomplete notes, names, and dates featured prominently in the files. Despite the fact that the DYFS pre-placement exam form clearly requests the assessor to indicate the date, time and location of the exam, 35 of 53 files omitted at least some of that information. Health history was rarely recorded – especially when a provider used the DYFS form to guide the exam – and inquiries concerning sexual history (when appropriate), social and emotional well-being, diet, and educational development were generally not assessed.

DHS included among its Child Welfare Reform accomplishments as of September 23, 2004, that it had “[r]educed reliance on emergency rooms for children entering foster care by establishing a network of pediatricians to conduct medical evaluations.”<sup>5</sup> Of the 109 pre-placement exams included in this review, for which a location was provided, 59, or 54 percent, were conducted in emergency room facilities.<sup>6</sup> Of the 59 emergency room exams, 39 noted the time of the exam.<sup>7</sup> We noted 90 pre-placement examinations that

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<sup>5</sup> Listing Child Welfare Reform Accomplishments, appended to Commissioner Davy’s testimony before the Assembly Budget Committee, September 23, 2004.

<sup>6</sup> This review neither confirms nor contradicts DHS’s representation on the diminished utilization of emergency room facilities for pre-placement examinations because the review was limited to four district offices in two counties, whereas DHS made a representation as to statewide utilization. The OCA intends to conduct a comprehensive, statistically relevant, statewide audit of pre-placement examinations in 2005.

<sup>7</sup> Of these, 16 occurred between 9 a.m. and 5 p.m., 11 occurred between 5 p.m. and 9 p.m., and 12 occurred between 9 p.m. and 8 a.m..

had occurred in 2004 after DHS announced a plan to reduce reliance on emergency rooms for foster children. Of these, 41 exams, representing 46 percent, took place in emergency rooms.

c. DYFS Recordkeeping, Coordinated Care and Continuity: Ongoing Care, Immunizations, and Preventative Screens

Because of the lack of standardization in the type of health information sought as children enter placement, the variable quality of health records maintained for children during out of home placements supervised by DYFS, and the lack of centralized record-keeping, it is difficult for DYFS caseworkers to track and coordinate a foster child's care. For example, immunization records were available in only 30 of the 53 files assessed. Of the 20 KC numbers that included sibling groups or children within the same family, all featured substantive disparities in the depth and breadth of information collected for different children. Ensuring a child's enrollment in school appeared in some instances to provide DYFS with its only evidence of the child's access to health care. For example, one file noted DYFS' concern regarding a foster family that had not taken the children to a doctor in over a year. This concern was allayed, however, by the family's assertion that the children received physical examinations at school in order to participate in sports. The file neither contained evidence that the physicals had occurred nor contained written documentation of the examinations' findings. Several files reflected foster families' frustration with their inability to locate doctors and dentists who accept Medicaid.

Mental health service providers' reports and evaluations were better documented than physical health service providers. For example, psychiatric evaluations are typed and thorough, while the records of physical exams appear cursory, inconsistent and often

illegible. At least 10 files contained notations about physical exams that were illegible to the point that an overall evaluation of the file was extremely difficult.

Medically fragile children, especially those receiving care in medical day care facilities, benefited from a professional charged to coordinating their care among multiple providers and specialists. Nine of the 82 children reviewed were clearly designated as medically fragile. Documentation for these children was the most detailed and complete and, their records generally revealed exemplary care.

### **Systemic Observations**

DHS recently announced developments concerning medical care for children in foster care. On October 12, 2004, DHS announced that DYFS will begin automatic enrollment of foster children into Medicaid HMOs beginning early next year. Approximately 3,800 foster children have been voluntarily enrolled in an HMO by their foster parents, and another 4,000 are not yet enrolled. DHS also reported four exemptions that would allow a foster parent to “opt out” of automatic enrollment: (1) a foster parent who is currently using a doctor, who does not participate in one of the designated HMOs, may continue medical care with that same doctor; (2) emergency placements and all Special Home Service Providers that care for medically fragile children will be exempt; (3) foster parents who have established their own network of doctors for their foster children (i.e. primary doctors who coordinate with specialists) are exempt; and (4) a child would be exempt from using a Medicaid HMO if he were forced to move to a new home and a participating doctor were not in close proximity to that home. Since these exemptions are broad, the successful implementation of auto-

enrollment as a strategy to provide health care for foster children will not negate the need for DHS to deploy a comprehensive health care utilization tracking system.

As recently as October 13, 2004, the OCA learned that DHS has hired its Medical Director. This progress should result in much-needed leadership, accountability and standardization of care. DHS also intends to further reduce its reliance on emergency rooms as venues for pre-placement physicals, which could minimize the trauma and upheaval for children headed for new out-of-home placements. To that end, DHS should continue to expand the resource pool of pediatricians available to serve children.

DHS intends to rely on the Comprehensive Health Evaluation for Children (CHEC) system as a key strategy to achieve coordinated medical care for foster children.<sup>8</sup> The CHEC system uniquely focuses on the delivery of comprehensive, coordinated health services<sup>9</sup> in a timely, flexible and culturally sensitive manner within 30 days of out-of-home placement, mindful of the unique needs<sup>10</sup> of foster children. CHEC services include Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services<sup>11</sup>;

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<sup>8</sup> DHS issued a Request for Qualifications (RFQ) to which responses were due by September 30, 2004. Per the RFQ, notification of qualified providers and implementation will take place after October 15, 2004. *Legal Notice State of New Jersey, Department of Human Services, Request for Qualifications (RFQ), "Comprehensive Health Evaluations for Children (CHEC)"* p. 3.

<sup>9</sup> The scope of services encompassed by CHEC includes, but is not limited to, obtaining prior medical records and health information and when applicable education records; linkage to ongoing Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services; linkage to Medicaid managed care providers; HMO care managers and facilitation of transfer of care; transportation services; and linkage to the Division of Developmental Disabilities, Schools, Preschool Handicapped programs, Special Child Health Services and/or other school-based resources. RFQ, pp. 5-7. See "Sample Flow Chart of Comprehensive Health Services for Child in New Out-of-Home Placement" attached as Appendix A.

<sup>10</sup> "Limited physical or mental health history may be available to the health care provider. In some cases, the available historical information may be limited to the child's name, date of birth, reason for placement and any acute problems identified during the pre-placement examination. Health care providers must be aware that children entering foster care may lack appropriate immunizations, may have untreated dental needs, communicable diseases or other acute illnesses, may suffer from mental and/or behavioral health issues, and may have poorly controlled or undiagnosed chronic conditions." RFQ, p. 3.

<sup>11</sup> EPSDT services include, but are not limited to, comprehensive health and developmental history; developmental assessment; unclothed head-to-toe physical exam including vision and hearing screening, dental inspection and nutritional assessment; age-appropriate immunizations; blood lead testing, risk assessment and family education from the ages of 6 mos. to 6 years; laboratory and other diagnostic tests;

screening, when appropriate, for pregnancy and sexually transmitted diseases, and routine gynecologic and urologic care; provision of a comprehensive mental health evaluation including screening in accordance with the American Academy of Child and Adolescent Psychiatry (AACAP), substance abuse screening and age-appropriate psychometric testing; and referrals for further diagnosis and treatment or follow-up of all abnormalities which are treatable/correctable.<sup>12</sup>

In addition to the wide breadth of services set forth in the State's vision of the CHEC system, there are equally promising coordination, monitoring and evaluation components. For example, CHEC entities are expected to employ designated Health Care Coordinators to coordinate developmental, medical and mental health services; schedule assessments; provide documentation required for court proceedings; complete required DYFS documentation; facilitate communication between a child's foster parents, DYFS case management staff, the primary care provider, mental health professionals and the HMO care manager and specialists as appropriate; and assist with transportation services.<sup>13</sup> CHEC providers are similarly expected to establish and maintain a Quality Improvement Committee for evaluating and measuring clinical outcomes. On a quarterly basis, the Committee must report to the Division of Medical Assistance and Health Services (DMAHS) within DHS to ensure continued monitoring and evaluation. Furthermore, the DYFS Medical Director will be responsible for establishing and maintaining a CHEC Advisory Committee for the purpose of producing prospective,

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age-appropriate health education and guidance to children and caregivers; referral for further diagnosis and treatment or follow-up of all abnormalities which are treatable/correctable or require maintenance therapy; and referral to the Special Supplemental Food Program for Women, Infants and Children (WIC) for children under five years of age and pregnant or lactating women.

<sup>12</sup><sup>12</sup> Providers of CHEC services will be reimbursed on a fee-for-services basis at an all-inclusive rate of \$670, with the caveat that laboratory, diagnostic tests, immunizations, and gynecological services are billed separately. RFQ at p. 10.

concurrent, and retrospective analysis of the CHEC delivery system and providing recommendations to the State on a quarterly basis.

**Next Steps**

The coordination of comprehensive, quality health care represents a sea change for DHS and DYFS, medical providers, foster children and their families. Developing the infrastructure necessary to achieve this change requires partnership, communication and evaluation. As part of the monitoring process and in accordance with our statute, the OCA intends to undertake the following next steps: (i) assess statewide the content, quality and location of pre-placement examinations for foster children in 2005; and (ii) monitor the Department's implementation of CHEC to ensure that quality and uniformity exist statewide with regard to comprehensive screening assessments, delivery of follow-up care, and meaningful quality assurance measures.

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<sup>13</sup> RFQ at p. 8.