

New Jersey Office of the Child Advocate

Health Matters:

A STUDY OF THE COMPREHENSIVE HEALTH EVALUATION FOR CHILDREN (CHEC) PROGRAM

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OFFICE OF THE CHILD ADVOCATE

Joseph Suozzo, Esq., First Assistant

Maria McGowan, Deputy Director of Welfare and Health Policy Monitoring

Nicole Hellriegel, M.P.A., Assistant Child Advocate

Nancy Parello, Senior Child Advocate

Elizabeth Wood, Assistant Child Advocate

Alison Zuvich, Assistant Child Advocate

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Executive Summary

This report, “Health Matters: A Study of the Comprehensive Health Evaluation for Children (CHEC) Program”, the second put forth by the Office of the Child Advocate (OCA), examines how well the Department of Children and Families (DCF), through the CHEC program, is identifying and addressing the health care needs of children. Through a statistically significant sample of 80 child-specific CHEC reports and DYFS case files, the OCA’s study indicated that although the strengths of the CHEC program lie primarily in the expertise and commitment of professionals who serve at-risk children at the CHEC sites, many improvements are still necessary to ensure children are receiving appropriate and timely medical and mental health assessments and continuous follow-up care.

Many children who enter an out-of-home placement have already been exposed to circumstances that may have undermined their chances for healthy development. In response to the well-documented, significant medical and mental health needs of the foster care population, in 2004 the State of New Jersey began utilizing the CHEC program. The CHEC is intended to assist in the identification and provision of health services for children under the supervision of the Division of Youth and Family Services (DYFS) and residing in out-of-home placement.

The CHEC model offers great promise to identifying and meeting the health-related needs of children initially entering out-of-home care. The program is rooted within demonstrated best practice concepts, which promote full integration of all health and mental health domains into a comprehensive evaluation of the child early on in their initial placement into substitute care. All CHEC sites perform an invaluable service by gathering, assessing and documenting critical health information on behalf of the child and prepare this information for those individuals who are responsible for that child. Additionally, through this program, newly acute and/or chronic health issues are identified for the child, treatment is given and/or a plan for addressing the child’s needs is created. The CHEC program provides the opportunity for children in out-of-home care to experience improved health outcomes, and this service is an integral part of identifying and meeting their health needs.

Overall Findings:

This study demonstrates that children in the NJ child welfare system have significant health and mental health needs while in out-of-home placement. Over three-quarters of the children in the sample were identified as having at least one health-related need as a result of receiving the CHEC evaluation. Similarly, at least one mental health need was identified as a result of the CHEC evaluation for over half of the children in the OCA sample. Clearly, the CHEC program is working to identify key health and mental health issues in this vulnerable population and provides a critically needed service.

Yet the OCA estimates that less than one-third of all children initially entering DYFS out-of-home placement in 2006 received a CHEC evaluation. When CHEC evaluations are performed, children do not receive this service within the intended 30-day timeframe. Additionally, when evaluations are performed, few children receive complete and timely follow-up to services and treatment recommended by the CHEC sites, and full caregiver participation at the appointment is inconsistently occurring.

Other concerns related to variations among the CHEC sites in how CHEC findings are shared with interested parties, how CHEC services are provided at each site, as well as the timeliness and formats of CHEC final reports and Plans of Care. It was identified that no central system or policies exist

within DYFS for gathering, organizing and regularly updating information pertinent to a child's health history, treatment or status, and important medical information is not routinely and consistently shared with, or available to, CHEC provider sites. Integration of the CHEC model into DYFS case practice has been less than optimal

Further, DYFS lacks a functional system for quality review and improvement of CHEC services, including the collection and assessment of relevant data. State oversight of this essential and critical program has been inconsistent at best. Throughout the nearly three years the CHEC program has been operational, gaps have existed in maintaining a necessary State-sponsored system for this monitoring program.

Meeting the health needs of children while they are in the State's care is fundamental. Children deserve the opportunity to grow and develop to their fullest potential. The OCA has provided recommendations for enhancing the delivery of health services and will continue to advocate for needed reforms and improved outcomes for children, because health matters.

Acknowledgements

The OCA recognizes that the State of New Jersey is incredibly fortunate to have its current CHEC provider resources. These skilled and dedicated professionals work tirelessly to meet the needs of children in the State's care. Their contributions in the daily work they perform are invaluable to children, families, DYFS and to all New Jersey residents. The OCA recognizes and commends them for their efforts. Special thanks go to the CHEC sites for their assistance, information and insights in helping prepare this report.

The OCA also extends its appreciation to Department of Children and Families Commissioner, Kevin M. Ryan and his staff for their cooperation and assistance with this project. Additionally, the OCA acknowledges the efforts of DYFS field staff as they work to meet the needs of children and families. They face many challenges as they carry out their responsibilities and are to be commended for their efforts to protect children. Their work is greatly appreciated.

Lastly, the OCA wishes to thank our team of reviewers who utilized their remarkable skills and experiences to assess each child's case and to inform the OCA on findings. Their work on this project provided valuable insights into areas of strength within the CHEC model and areas needing improvement.

Introduction

Health care and mental health care for children under the supervision of DYFS and residing in out-of-home placement is considered by the OCA to be among the most critically urgent areas of needed reform within New Jersey's child welfare system. Providing for and ensuring that children in State custody receive appropriate services to identify, diagnose, treat and monitor health and mental health needs is fundamental. Children under DYFS supervision and in foster care or other out-of-home placements rely on DYFS to ensure that their safety, permanency and well-being needs are addressed. The OCA is committed to ensuring that necessary reforms are made within the NJ child welfare system to improve overall outcomes for children in the State's care and that priority is given to identifying and meeting the health, developmental and mental health needs of these children.

This report, "Health Matters", is the Office of the Child Advocate's (OCA) second study of the Comprehensive Health Evaluation for Children (CHEC) program within the State of New Jersey, Department of Children and Families (DCF), Division of Youth and Family Services (DYFS). The first OCA review of the CHEC model was completed in December 2005.

The following 2007 OCA report examines how DCF is addressing the health, developmental and mental health needs of children in out-of-home placement through the CHEC program and is based on the OCA's study of a scientific sampling of child-specific CHEC reports and DYFS case files. It provides an in-depth analysis of the physical, developmental and mental health of children receiving CHEC evaluations, makes note of strengths and areas which require attention and systemic improvement and makes recommendations for enhancing the overall delivery of health services to children under DCF/DYFS supervision.

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."

Children's Rights, Inc., a national child welfare advocacy organization, filed a class action lawsuit against the State in 1999, after it determined that legal action was the only means to bring about urgently needed reform. The suit cited "severe systemic problems in the NJ child welfare system that jeopardized the health and safety of over 60,000 children from every county in NJ, including over 11,000 children in DYFS custody."¹ Also included were allegations that the State's child welfare agency was failing in its responsibility to provide a coordinated system of health and mental health assessment and treatment services to children in out-of-home placement, despite the fact that the State was required by federal and state law to do so. Instead, children in foster care and other out-of-home placements were found to have unmet health and mental health needs while under DYFS supervision,

¹"A court-enforceable Reform Plan was part of the settlement agreement. In October 2005, the independent panel monitoring the reforms found that the State was making "seriously inadequate progress" toward meeting mandated reforms. After talks between the parties broke down in mid-November, Children's Rights sought to hold the State in contempt of court and requested that the system be taken over by a receiver. Since then, Governor Jon S. Corzine has created a separate Cabinet-level children's agency, the Department of Children and Families, to prioritize the needs of abused and neglected children, and appointed former Child Advocate, Kevin Ryan as Commissioner in January 2006. On July 18, 2006, the court approved a Modified Settlement Agreement that focuses the reform effort on caseloads, training, services, safety and adoptions." Children's Rights. "Legal Cases: New Jersey: Charlie and Nadine H. v. Corzine, No. 99-3678, U.S. District Court, The District of New Jersey, Case Summary." <http://www.childrensrights.org>

despite the fact experts in the fields of health and child welfare consider this population of children to have significant pre-existing health and mental health issues.²

In 2003, a landmark settlement agreement was reached between Children's Rights and the State of New Jersey. With this agreement came the State's promise to completely overhaul its child welfare system, resulting in the development of a comprehensive, court-enforceable plan of unprecedented magnitude. Included in the State's plan was a commitment and detailed action plan to reform the management of children's health and mental health needs; however this section of the larger scale plan was only partially implemented, and the State fell short in prioritizing the health related needs of children in its care.

In late 2004, the State implemented a consultative model for the comprehensive assessment and coordinated delivery of health care services for children under the supervision of DYFS and in foster care, a program called the Comprehensive Health Evaluation for Children, or CHEC. By late fall of 2004, five CHEC sites serving ten counties were identified to initiate the CHEC program. While two additional sites were later added, these additional programs have very limited capacity.

Despite commitments in 2004 -2006 from prior Department of Human Services (DHS)³ leadership to develop additional provider resources to serve children in the remaining counties for the provision of CHEC services, no additional sites were added. Hundreds of children enter the State's care each month and are in need of health-related services. Unfortunately, a plan to ensure that all children entering out-of-home placement receive a CHEC exam was not built into the model at the time of creation. A sound, logical plan for building that capacity has not yet been implemented.

An insufficient pool of provider resources to assess the health and mental health needs of children in all counties entering out-of-home placement has not been the only identified area of concern regarding the CHEC program. Significant findings in the 2005 OCA CHEC report⁴ reflected inadequate follow-up of identified medical, developmental and mental health related diagnoses for children who received a CHEC evaluation. In that first OCA evaluation of the CHEC program, only a very small number of children received complete follow-up care for identified needs.⁵ Additionally, the gathering of the child's medical records and information pertaining to the child's health by DYFS local offices prior to the CHEC evaluation was deemed to be inadequate. A centralized health record or system for collecting important health records was found to be lacking.

² For example, research cited by Caring Communities, Health Resources and Services Administration (HRSA) and the United States General Accounting Office (GAO) advise that children in foster care, "Have the poorest physical and mental health in the nation; may have increased exposure to multiple risks, which increases the likelihood of poor outcomes; and are over represented in the mental health system."

Caring Communities for Children in Foster Care. "Why Care About Children in Foster Care?"
<http://www.peatc.org/FosterCare/index.htm>.

³ On July 11, 2006, Governor Corzine signed legislation to create the Department of Children and Families (DCF), the state's first Cabinet-level department focused solely on child and family welfare. Prior to this landmark legislation, child protection services fell within the purview of the NJ Department of Human Services.

⁴ Office the Child Advocate. 2005. "Needs and Assets Assessment of the Comprehensive Health Evaluation for Children (CHEC) Program."

⁵ 2005 OCA CHEC report cited evidence of complete follow-up of health and mental health recommendations in only 2.2% of children in the sample.

The CHEC Model

The CHEC is one component of the overall continuum in the identification and provision of health services for children under the supervision of DYFS and residing in out-of-home placement. The assessment is intended to occur early on for children in out-of-home placement.⁶ Initiated in 2004, the basic concept of the CHEC was rooted within a consultative model that provided children entering foster care with a timely, flexible, culturally sensitive and comprehensive assessment of their physical health, mental and behavioral health and developmental needs. The initial program requirements called for this assessment to be scheduled within 10 days of placement and completed within 30 days of the child's initial entry into out-of-home care.

This initial consultative CHEC model was developed to provide a "snapshot" of a child's health, mental health and dental status, and provide comprehensive recommendations for medical, mental health and dental follow-up. The model provides evaluations by a clinical team, on one day, at one site. The original CHEC sites were not designed to serve as the child's medical home for the provision of ongoing care and services, although the ability to do so was a possibility for three of the original CHEC sites.⁷ Linkage to a medical home and subsequent delivery of needed treatment and follow-up services was designed to occur concurrently or shortly thereafter in the office of the primary care physician selected by the child's resource parent. Ideally, the new primary care physician was to receive a copy of the CHEC evaluation from DYFS and/or the CHEC site.

A designated Health Care Coordinator for children receiving CHEC evaluations was to be established at each site to provide coordination of information and services in collaboration with the child's identified DYFS caseworker, caregiver, primary care provider, Health Maintenance Organization (HMO) care manager, and as necessary, all mental health providers and specialists. Unfortunately, support for CHEC site coordinators was not provided by the State, and a functional system to ensure needed follow-up of identified issues and treatment recommendations was never implemented.

The components of the original CHEC model are in keeping with the provisions set forth through Early Periodic Screening, Diagnostic and Treatment (EPSDT).⁸ Included in the original framework for the CHEC are the following services:⁹

⁶ Current NJ law and DYFS Policy requires all children initially entering out-of-home placement to have a pre-placement health exam to assess their current health status, detect acute and chronic health needs and provide needed urgent treatment.

⁷ The sites that had the capacity to serve as the child's medical home were Audrey Hepburn, Dorothy B. Hersh and Jersey Shore University Medical Center.

⁸ The Early Periodic Screening, Diagnostic, and Treatment (EPSDT) program provides comprehensive health services for infants, children, and adolescents enrolled in Medicaid. Under federal regulations, states are given some flexibility in determining the periodicity or timing of the health visits and screenings, but the content of screening services is mandated by law to include the following: Comprehensive health and developmental history, including a developmental assessment of physical and mental health; Comprehensive physical examination; Immunizations, based on the current approved Advisory Committee on Immunization Practices schedule; Laboratory tests, including mandatory lead screening; vision, hearing, and dental screening; and health education and anticipatory guidance.

Centers for Medicaid & Medicare Services, U.S. Department of Health & Human Services. "Medicaid Early & Periodic Screening & Diagnostic Treatment Benefit: EPSDT Benefits." December 2005.

http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/02_Benefits.asp#TopOfPage.

⁹ Additional services may be provided based on the child's presenting needs and risk factors.

New Jersey Department of Human Services. 2004. "Legal Notice-Request for Qualifications (RFQ) for the Comprehensive Health Evaluation for Children (CHEC)."

- Comprehensive health and developmental history;
- Developmental assessment;
- Comprehensive, unclothed, head-to-toe physical examination including vision and hearing screening, dental inspection and nutritional assessment;
- Age-appropriate immunizations;
- Blood lead testing, risk assessment for lead poisoning and family education for children ages 6 months to 6 years;
- Laboratory and other diagnostic tests, including a complete blood count (CBC), Mantoux tuberculin test (PPD to include follow-up reading in 48-72 hours), urinalysis, and any other tests that may be appropriate and medically necessary, including testing for HIV, and Hepatitis B and C;
- Screening for pregnancy, when appropriate, screening for sexually transmitted diseases and routine gynecologic and urologic care, including PAP smear, wet mount, and other gynecological cultures when appropriate, and testing for GC and Chlamydia (if clinically indicated);
- When appropriate, screening for substance abuse, which may include: urine toxicology screening and/or use of the CRAFFT substance abuse screening tool;
- Age-appropriate health education and guidance to caregivers and children, including anticipatory guidance;
- Referral for further diagnosis and treatment or follow-up of all abnormalities which are treatable/correctable or require maintenance therapy;
- 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;
- Comprehensive mental health assessment, in accordance with the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters for the Psychiatric Assessment of Infants and Toddlers and Practice Parameters for the Psychiatric Assessment of Children and Adolescents, including a review of individual/family history; strengths and needs assessment; medical and developmental needs; review of school performance, including results of child study team evaluations, previous developmental testing, school classification; mental health history; mental status evaluation; interview with the caregiver, child and DYFS worker
- Age-appropriate psychometric testing;
- Age-appropriate neuro-developmental assessments utilizing age-appropriate developmental screening tools; assessment of cognitive functioning according to Gessell Standards; referral to Early Intervention Services for children under 3 years old and referrals to other specialists;
- Referrals for mental health/behavioral health services and additional testing as needed; and
- Post-assessment case conferences with the foster parent and DYFS caseworker (by phone or fax) encompassing developmental, physical and mental health findings, need for referrals or follow-up, and education regarding the significance of these findings.

The CHEC program was rolled out in 2004 through the efforts of five provider sites, comprised at the time of New Jersey's four Regional Diagnostic and Treatment Centers for Abuse and Neglect (RDTCs) and a satellite location of an RDTC. The RDTC sites are already familiar with working with DYFS as these providers serve children who are victims of abuse, neglect and/or family violence. The RDTCs were able to provide CHEC services for 10 counties in the State, leaving 11 counties not

served by CHEC programs.¹⁰ After approximately one year of operation, 2 additional CHEC sites were added. These new sites provide limited services in three additional counties (See *Table 1*).

Table 1: Current CHEC Sites

Provider	Counties Served
Audrey Hepburn Children’s House (Hackensack)	Bergen Morris Passaic
Metropolitan RDTC -Newark Beth Israel Medical Center (Newark)	Essex
CARES Institute (Stratford)	Camden Gloucester
Dorothy B. Hersh Child Protection Center (New Brunswick)	Middlesex Somerset
Jersey Shore University Medical Center (Neptune)	Monmouth Ocean
Liberty Child & Adolescent Health Services (Jersey City) - operational in August 2005	Hudson
AtlantiCare (Atlantic City)- operational in October 2005	Atlantic Cape May

Counties without a current CHEC site or CHEC site coverage through 2006 are highlighted in *Table 2* below:

Table 2: Counties without Coverage

2006 Uncovered Counties
Burlington
Cumberland
Hunterdon
Mercer
Salem
Sussex
Union
Warren

CHEC providers bill the Department of Human Services, Division of Medical Assistance (DMAHS-Medicaid) directly for Medicaid reimbursement. To date, CHEC sites are reimbursed a \$670 bundled rate for completing a physical exam, mental health assessment, and an age-appropriate neuro-developmental screen. Immunizations, and diagnostic testing, including lab and other screenings are billed to Medicaid separately at the established Medicaid fee-for-service rates.

¹⁰ Children residing in counties without an identified site can utilize a site in another county, if there is provider availability to see the child. Significant backlogs exist within particular counties and CHEC sites, and there is evidence that children wait several months to be seen for a CHEC assessment.

Currently, DYFS local office case work staff schedule a child for a CHEC evaluation. DYFS policy requires the child's caseworker to schedule a CHEC evaluation within 10 days of initial out-of-home placement. Most CHEC sites require the local DYFS office referring the child for the evaluation to complete a referral form prior to the child's visit. Additionally, a form exists within the DYFS Policy Manual for field staff to formally request a CHEC evaluation. The DYFS CHEC RFQ made assurances that medical records and background information would be provided by DYFS to the CHEC providers prior to the child's CHEC evaluation. Significant variation exists in what is actually provided by DYFS to the CHEC sites. DYFS has not developed a standardized and documented system for gathering and disseminating medical records to the CHEC sites.

There are also differences in whether a CHEC site will proceed with an evaluation without the necessary records and information. All require DYFS and the caregiver to provide whatever information is currently known. Differences exist in the reporting templates utilized by the CHEC sites for their preliminary and final reports, and in the dissemination of these reports to interested stakeholders responsible for the child.¹¹ However, all CHEC sites are required to forward the Final Report and Plan of Care with accompanying documentation of needed referrals and services to the DYFS local office caseworker responsible for the child. Timeliness for providing these reports also varies by site. All CHEC sites require proof of a valid Medicaid number prior to providing a CHEC evaluation.

Inherent in the current consultative CHEC program is the availability of site clinicians to provide education, anticipatory guidance,¹² and case conferencing of findings about the child to the child's caregiver, DYFS caseworker, and to the child. Built into the CHEC model is meaningful clinical time spent with individuals responsible for the child. This process assists caregivers and other stakeholders with gaining enhanced knowledge of the child and his/her health-related and treatment needs. Having this knowledge and understanding of the child potentially minimizes trauma for the child, reduces the rate of multiple placements, assists and prepares the caregiver, eases the child's transition into care and ensures that the child's needs are met.

The core values rooted within the consultative Comprehensive Evaluation for Children model provide a promising approach to meeting the physical, mental and behavioral health needs of children entering out-of-home placement. Ideally, this service provides a point-in-time evaluation of the child's medical, developmental and mental health history, as well as a thorough assessment and diagnosis of acute and chronic medical, developmental and mental health issues. Immunizations are updated, diagnostic tests and assessments are performed, and/or referrals and recommendations for necessary follow up services are made by the CHEC provider. Clinicians spend a significant amount of time providing education and guidance to DYFS staff and the caregiver, as well reporting on information pertaining to the child's overall health status and treatment needs through verbal and written reports and a Plan of Care.¹³

¹¹ The original proposal called for Final Reports and Plans of Care, with summation and priorities for follow-up care to be provided to the foster parent (Plan of Care only), DYFS caseworker, CHEC site care coordinator, HMO care manager, primary care provider, mental health provider and any other specialists involved in the child's care within 14 calendar days of evaluation.

¹² Anticipatory guidance, a provision of EPSDT services, is information and education given to the caregiver by the treating provider to promote health and well-being.

¹³ A "Plan of Care" defines the individual's health issues, services/treatment/referrals provided at the visit or needed with an identified time-frame for implementation.

This study confirms that many of these evaluations are less than optimal as critical information is not routinely provided by DYFS to the CHEC sites. Further, completeness of evaluations is hindered when the caregiver does not accompany the child for the evaluation. Incomplete information concerning the child's health results in missed opportunities to appropriately immunize a child, or conversely, can lead to over-immunization with repeated vaccines. A lack of health information may also result in missed diagnoses, identification of allergies as well as adverse reactions to prescribed medications.

New Jersey Children in Out-of-Home Placement **An Overview**

Each year, thousands of New Jersey children are placed by DYFS into out-of-home care. These settings include placement with a resource parent, including a relative or family friend caregiver or traditional foster parent. Other placement types include group homes, shelter care, residential treatment facilities, or an independent living arrangement. The specific reasons children are placed out-of-home vary considerably; primarily however, placement occurs due to some type of parental abuse and/or neglect, parental absence or parental inability to provide care. No matter what the reason for placement or the placement type, the removal of a child from their family or other caregiver and subsequent out-of-home placement is an undeniably traumatic event for the child.

According to the American Academy of Pediatrics (AAP), children in foster care have much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays, and poor school achievement than their peers from similar socioeconomic backgrounds.¹⁴ Additionally, the AAP has identified that, "Greater numbers of infants and young children with increasingly complicated and serious physical, mental health, and developmental problems are being placed in foster care."¹⁵ The American Academy of Child and Adolescent Psychiatry (AACAP) reports as many as 85% of children who enter foster care are estimated to evidence some type of emotional disorder and/or substance use problem.¹⁶ Additional research by the Urban Institute confirms that, "Children in the child welfare system are more likely to have behavioral and emotional problems than children living with their parents and even compared to children living in high-risk parent care."^{17 18}

The following provides point in time data on children residing in out-of-home placement based on available information from the Department of Children and Families,¹⁹ (unless otherwise noted):

¹⁴ American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependant Care. 2002. "Health Care of Young Children in Foster Care". *Pediatrics*, 109(4): 536-541.

¹⁵ American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependant Care. 2002. Health Care of Young Children in Foster Care." *Pediatrics*, 109(4): 536-541.

¹⁶ American Academy of Child & Adolescent Psychiatry. 2007. "Policy Statements: AACAP/CWLA Foster Care Mental Health Values Subcommittee."

¹⁷ Kortenkapm, K., & Ehrele, J. 2002. "The Well-Being of Children Involved with the Child Welfare System: A National Overview." *Urban Institute*, An Urban Institute Program to Assess Changing Social Policies. Series B, No. B-43.

¹⁸ "High risk parent" in this research refers to single parent, low-income (income less than 200 percent of the federal poverty level) families.

¹⁹ New Jersey Department of Children and Families. 2007. "DYFS Demographics."
<http://www.state.nj.us/dcf/home/childdata/dyfsdemo/>.

- ❖ As of January 2007, there were approximately 53,698 children under the supervision of DYFS, New Jersey's child protection agency;
- ❖ As of March 2007, there were approximately 10,369 children in DYFS out-home placement; approximately 84%, or 8,669 of these children reside in relative, family friend or traditional foster care settings;
- ❖ Approximately 6,966 children entered DYFS out-of-home placement in 2006;
- ❖ Approximately 7,737 children left out-of-home placement in 2006;²⁰
- ❖ Of the total number of children residing in out-of-home placement in March 2007, 52% are male and 48 % are female;
- ❖ As of March 2007, the ages of children in out-of-home placement are as follows:
 - 23% are 2 years old and under
 - 15% are 3-5 years old
 - 16% are 6-9 years old
 - 12% are 10-12 years old
 - 17% are 13-15 years old
 - 12% are 16-17 years old
 - 3% are 18 years and older
 - In 2% of cases, the age of the child is unknown to DCF
- ❖ Nearly 40% of children in foster care are under 6 years old;
- ❖ In 2006, approximately 67% of children were placed by DYFS within 10 miles of their own home;
- ❖ Children remain in DYFS out-of-home placement an average of 11 months;²¹
- ❖ 40% of children experienced three or more foster care placements compared to 42% of children nationally;²² and
- ❖ Nearly 25% of children in DYFS out-of-home placement are from Essex County (2,512), followed by Camden County (835), and Union County (831). See *Table 3* for the breakdown of children in placement by county.

²⁰ This number does not necessarily reflect the same children who entered placement during that same time period.

²¹ New Jersey Department of Children and Families. 2007. "Coordinated Health Care Plan for Children in Out-of-Home Placement." http://www.state.nj.us/dcf/DCFHealthCarePlan_5.22.07.pdf.

²² Kids Are Waiting. 2007. "Key Facts: New Jersey." The Pew Charitable Trusts. <<http://kidsarewaiting.org/reports/factsheets/?StateID=NJ>>.

Based on National 2004 AFCAR data.

Table 3: Children in Out-of-Home Placement

County	# of Children in Placement March 2007	% Statewide
Atlantic	292	3%
Bergen	468	5%
Burlington	418	4%
Camden	835	8%
Cape May	162	2%
Cumberland	349	3%
Essex	2,512	24%
Gloucester	266	3%
Hudson	669	6%
Hunterdon	66	1%
Mercer	453	4%
Middlesex	640	6%
Monmouth	594	6%
Morris	199	2%
Ocean	590	6%
Passaic	465	4%
Salem	204	2%
Somerset	145	1%
Sussex	97	1%
Union	831	8%
Warren	114	1%
STATE WIDE TOTALS	10,369	

Materials and Methods Utilized

In 2006, 6,966 children were initially placed by DYFS into out of home care. Approximately 1,969 children received a CHEC evaluation during 2006.²³ To initiate this study, the OCA subpoenaed, evaluated and analyzed medical and mental health records for a sample of children in out-of-home placement who received a CHEC evaluation between April 1, 2006 and June 30, 2006. DCF and the CHEC sites identified 521 children²⁴ who received a CHEC assessment during this time period. The OCA selected a statistically significant random sample of approximately 15 percent of this population, or 80 children. Another random sample of 20 children (an over-sample) who received CHEC evaluations was selected to serve as substitute files in the event there was a need to replace a case in the original sample. Some cases from this over-sample were utilized for training the review team prior to the start of the study.

During this project, it was necessary to replace three cases from the original sample. Each substitute case was representative of a child who was of the same age range and received an assessment at the same CHEC site, as the case that was replaced, to ensure consistency of the original relevant sample.

²³ The total universe of children who were eligible to receive a CHEC evaluation in 2006 varies. There are children who were placed in the later part of 2005 who received a CHEC in 2006. Additionally, there are children who were placed in the later part of 2006, who were subsequently eligible to receive a CHEC in early 2007.

²⁴ DCF originally identified 549 children who met these criteria. Upon OCA review, discrepancies were identified between DCF's data and data provided to the OCA by the CHEC sites. OCA used the baseline of 521 children, from which a statistically relevant sample was drawn.

Additionally, for the purposes of completing the project, the OCA obtained:

- Final CHEC reports and Plans of Care for evaluations conducted between April 1, 2006 and June 30, 2006 for the identified children from the CHEC sites;
- Complete DYFS files for all children reviewed by the OCA in this sample through March 2007;
- All medical information contained in DYFS case files, as provided to the OCA by DCF, for the selected children through March 2007; and
- Current information contained in the DYFS Service Information System (SIS).²⁵

The OCA developed and utilized a uniform assessment instrument to conduct the study. This Review Tool collected information in the following categories:

- **Demographic Information:** gender, race, date of birth, date of exam, reasons for and number of out-of-home placements, placement type, prior DYFS history, exam site;
- **History:** person accompanying child to CHEC and length of relationship with child, identified medical provider, Medicaid coverage status, identified previous illnesses and surgeries, known family history, immunization status, mental health history, educational profile, DCF provision of health records to the CHEC site, pre-placement exam information, timeliness of the exam, frequency of appointments kept.
- **Findings of CHEC Exam and Plan of Care:** identification of specific physical, developmental, and behavioral/mental health concerns, areas assessed, recommendations, distribution of the preliminary CHEC findings and final report by the CHEC site; and follow-up as indicated by review of the CHEC record and DYFS file.

The OCA assembled a review team comprised of specialists in the fields of pediatric medicine and child welfare to review documents and complete the Review Tool. Training on the tool was provided to the team prior to the study, which included a step-by-step review of the tool and an accompanying instructional guide.

Cases were randomly assigned²⁶ to the four members of the review team.²⁷ Each reader was instructed to submit the case for a second read if the facts of the case raised specific concerns or missing information made it difficult to complete the Review Tool. Twelve cases met one of these criteria. An additional eight cases were randomly chosen for a second review, making a total of 20 cases which received a second read. Immediate concerns regarding the health and or safety of the child were identified in five cases. The OCA specifically followed-up with DCF on these individual cases prior to the completion of the Review Tool.

²⁵ The DYFS Service Information System was the previous system used by DYFS for case-related information. As of 8/07, the state implemented an updated automated system for the collection of case information, tracking and case management. (NJSPIRIT system).

²⁶ The original random sample included 2 separate sibling groups, each consisting of 3 siblings. These sibling groups were randomly assigned as a unit because sibling information is collected as a unit by DYFS.

²⁷ The number of cases read by each team member was as follows: Reader (1) read 17 cases, Reader (2) read 24 cases, Reader (3) read 17 cases, and Reader (4) read 22 cases.

It should be noted that in several key areas, the tool specified to the reviewer which file source to utilize for the collection of information. Specifically, the tool instructed reviewers to refer to the child's DYFS file and/or CHEC file in order to complete the question or section. Some sections of the tool required the reviewer to answer the same set of questions by 1) reviewing the DYFS file and 2) reviewing the CHEC file. This was done to identify potential gaps in the provision of health-related information by DYFS to CHEC providers and conversely, by the CHEC provider to DYFS staff/caregiver.

The following report reflects the OCA's findings and evaluates the progress DCF has made in utilizing the CHEC program to establish a continuum of coordinated medical care for children in out-of-home placement.

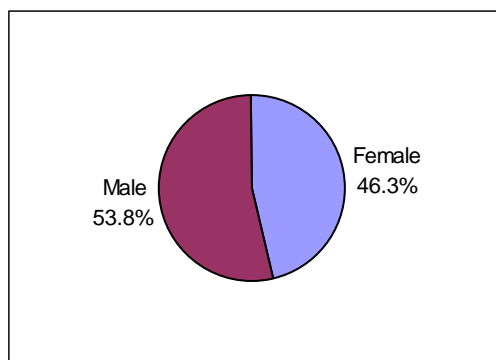
2007 Health Matters: A Study of the CHEC -Results

Demographics of Sample Cases

Gender of Children

The OCA's study utilized a random sampling of New Jersey children identified by DYFS as residing in out-of-home placement. Demographically, the study's findings closely mirrored both State and national trends. As evidenced by the Child Welfare League of America (CWLA), roughly 53% of children, nationwide, in out-of-home care in 2004 were male and roughly 46% were female.²⁸ As depicted in *Chart 1*, 53.8% of the cases within the review were male, while 46.3% were female.

Chart 1:
Gender of Children
n = 80



Age of Children

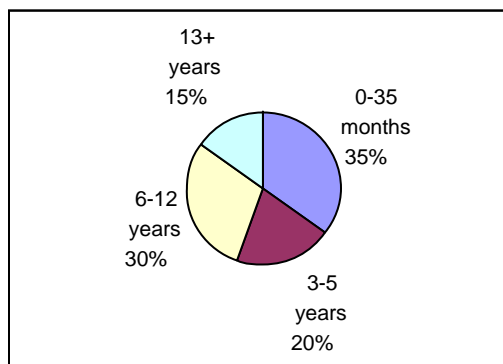
The National Center for Children in Poverty found that young children, under the age of five, are both the fastest growing segment of the foster care population, and are also the most at-risk for medical problems and unhealthy development. Given the special needs of this population, and the fact that they

²⁸Child Welfare League of America. 2006. "Special tabulation of the Adoption and Foster Care Analysis Reporting System." Washington, DC.

may remain in care twice as long as older children, it is not surprising that they comprise the largest cohort of out-of-home children.²⁹ The OCA's study also found that the majority of children within the sample were under the age of five. *Chart 2* reveals that 55%, over half of children within the sample were under the age of five, with 35% between 0 and 35 months of age. Only 15% of children in the sample were aged 13 and older.

This finding is significant because younger children require more frequent well-child visits and immunizations, testing for elevated blood lead levels, and Early Intervention-related services, which are critical for detecting and addressing developmental delays and special needs. Monitoring a child's vision and hearing, growth, cognitive development, and nutrition is particularly important during the early stages of childhood, given the windows of opportunity that exist to provide interventions and treatments to improve health outcomes.

Chart 2:
Age of Children
n = 80



Race of Children

Of the 80 children in the sample, 15% were identified as white (non-Hispanic) and 21.3% were identified as Hispanic.³⁰ Over half of the children within the sample were identified as black. This closely mirrors March, 2007 DYFS demographics wherein 53% of children in DYFS out-of-home placements were identified as black/African-American.³¹ *Chart 3* depicts the OCA's findings regarding the breakdown of children represented in the review by race:

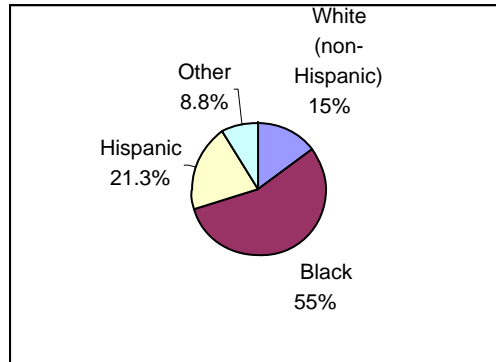
²⁹ Dicker, S., Gordon, E. and J. Knitzer. 2002. "Improving the Odds for the Healthy Development of Young Children in Foster Care." NY: National Center for Children in Poverty.

³⁰ 8.8 percent of the children within the review were also identified as "other." While some of these children were inter-racial, the races of 3 children were unable to be determined through the review of DYFS and CHEC files.

³¹ DCF provides a disclaimer on their website which indicates that due to reliance on the Statewide Information System (SIS), statistical information on race and ethnicity may be limited.

New Jersey Department of Children and Families. 2007. "DYFS Demographics." <<http://www.state.nj.us/dcf/home/childdata/dyfsdemo/>>

Chart 3:
Race of Children
n = 80



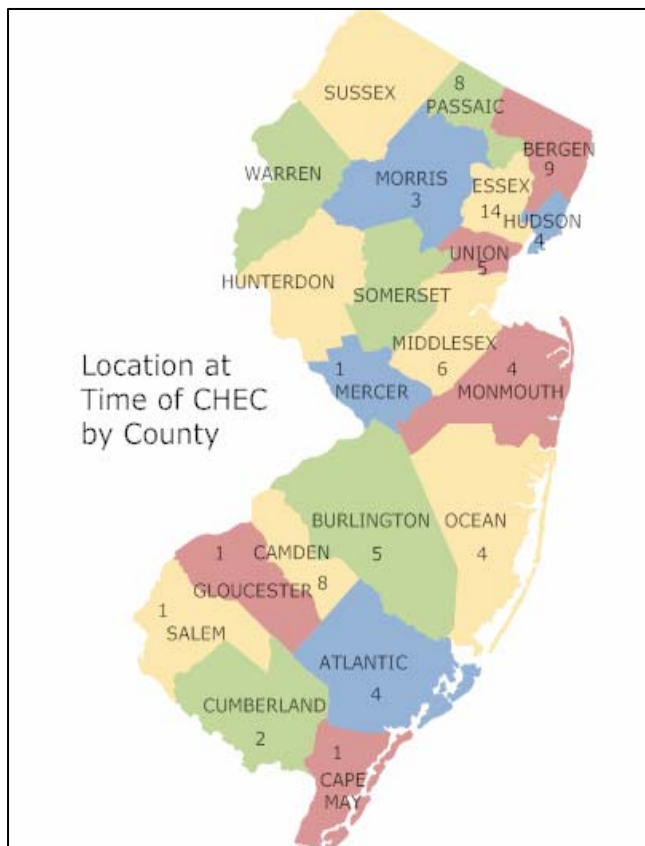
Child's County of Placement

The OCA's study found that while children resided in placements throughout New Jersey at the time of their CHEC evaluation, the largest numbers of children were identified as residing within Essex County (17.5%), followed by Bergen County (11.3%), Camden County (10%) and Passaic County (10%). This pattern of distribution is similar to recent (March 2007) DYFS data which reflects that 24% of children in DYFS out-of-home placement were residing in Essex County, followed by 8% in Camden County. Frequencies of child placement in the OCA review, by county, can be seen in *Chart 4*.³²

This information is significant as it points to indicators of high volume areas and those where gaps in provider resources exist. This is helpful in determining where additional resources must be added to ensure all children entering placement receive a CHEC evaluation. Children residing in counties without a CHEC site were either not represented or were in decreased proportion in this sample.

³² New Jersey Department of Children and Families. 2007. "DYFS Demographics." <<http://www.state.nj.us/dcf/home/childdata/dyfsdemo/>>

***Chart 4:
Child's Location at Time of
CHEC Study by County***

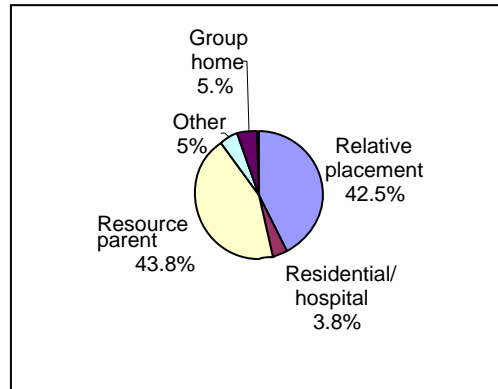


Child's Placement Type

Out-of home care refers to a wide-variety of different kinds of placements, including children placed in traditional foster care settings, with relatives or family friends, in residential treatment facilities, shelter care, group homes or independent living. While the individualized decisions to remove a child from their home to protect them is dependent on numerous factors in accordance with state and federal laws, the fundamental reason for removal from a parent or other caregiver is to ensure the safety and protection of the child by placement in an appropriate setting where they can continue to receive the care and attention necessary to promote their safety and well-being. At the time of the CHEC evaluation, 35 (43.8%) of the children in the OCA sample were residing with a traditional resource/foster parent and 34 (42.5%) were residing in a relative or family friend placement.³³ (See Chart 5)

³³ For the purposes of the study, relative placement constituted placement with a birth family member or a family friend. "Other" type of placement included two children placed in shelters, one child placed with a birth mother in a residential program for adolescents and their children, and one child in a mentor home.

Chart 5:
Child's Placement Type
n = 80



Child's Number of Placements

Federal standards guiding child welfare practice define placement stability as the child having two or fewer moves within a consecutive 12-month period.³⁴ Longitudinal studies conducted by the Children and Family Research Center (CFRC) at the University of Illinois, associates placement instability and placement disruptions with poorer outcomes. This research cites that, “Children with four or more moves were significantly more likely to convey depressive attitudes, express less happiness with their current home, and feel a weaker sense of belonging than children with fewer movements. Frequently moved children were more likely to have their placement disrupt and less likely to be adopted. With each move, the odds of finding permanence decreased 25%.”³⁵

The OCA collected data on the number of reported out-of-home placements in two ways. First, the OCA utilized the child’s CHEC file to identify this information. Second, a review of the child’s DYFS file, including current information identified on the DYFS SIS system was used.

Based on the information within the child’s DYFS file, the study found that 29 children (36.3%) experienced just one out-of-home placement prior to the CHEC evaluation, whereas 28 children (35.2%) experienced 3 or more placements. One child within the sample experienced 12 out-of-home placements prior to their CHEC evaluation.

However, upon review of the child’s CHEC file, half, or 40 children (50%) were identified as experiencing one out-of-home placement prior to the evaluation and 16 children (20.3%) were described as having 3 to 10 prior out-of-home placements. These discrepancies reflect the OCA’s concern that CHEC providers are not consistently receiving the basic information they need to thoroughly assess the child.

Given the profound impact of placement instability on children experiencing multiple placements, providing evaluating clinicians with accurate information to assess the child’s physical health and

³⁴ United States Department of Health and Human Services, Administration for Children and Families. 2006. “Children’s Bureau: Achieving Outcomes Related to Placement Stability and Appropriate Placements for Young Children in Foster Care.” <http://www.acf.hhs.gov/programs/cb/pubs/cwo03/chapters/chapterfour2003.htm>.

³⁵ Testa, M.. 2003. “Instability in Foster Care.” Urbana, IL: Children and Family Research Center.

developmental status, as well as their behavioral/emotional/mental health needs, is critical to developing appropriate treatment plans for improving overall well-being outcomes. (See Charts 6 and 7)

Chart 6:
Total Prior Out-Of-Home Placements per DYFS File
n = 80

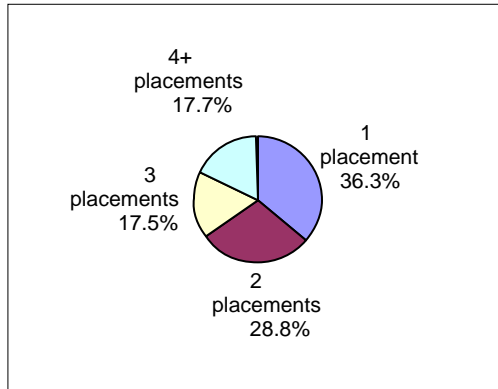
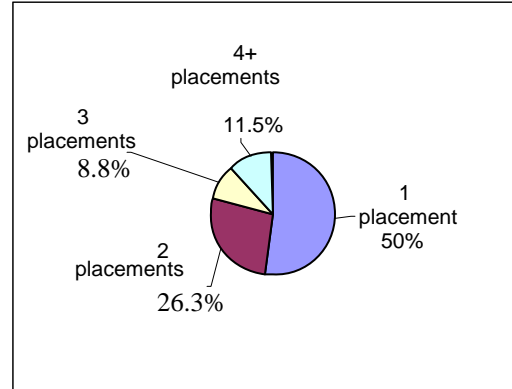


Chart 7:
Total Prior Out-Of-Home Placements per CHEC File
*n = 80**



**For three cases, the total number of prior out-of-home placements could not be determined.*

Occurrence and Recurrence of Child Maltreatment

Data generation and evaluation on child maltreatment are areas of keen interest for child welfare agencies and others in the child welfare field. Knowledge of why children enter out-of-home placement and the abuse/neglect they have suffered assists child protection agencies in developing strategies for prevention and in developing a coordinated response to serving high-risk families.

The recurrence of maltreatment among children in the child welfare system is particularly important to gauging the overall effectiveness of the child welfare agency’s related services and interventions. The US Department of Health and Human Services (DHHS), Administration on Children, Youth and Families (ACYF), Children’s Bureau, requires states receiving federal grants to regularly report to ACYF on case-level data to identify individual state and national trends in child maltreatment.^{36 37} ACYF matches this data to established indicators for child safety and well-being. This data is further utilized to establish how states conform to federal and state plan requirements in accordance with federal and state law. Additionally, the data reported by each state assists the federal government in determining future areas in need of measurement.³⁸

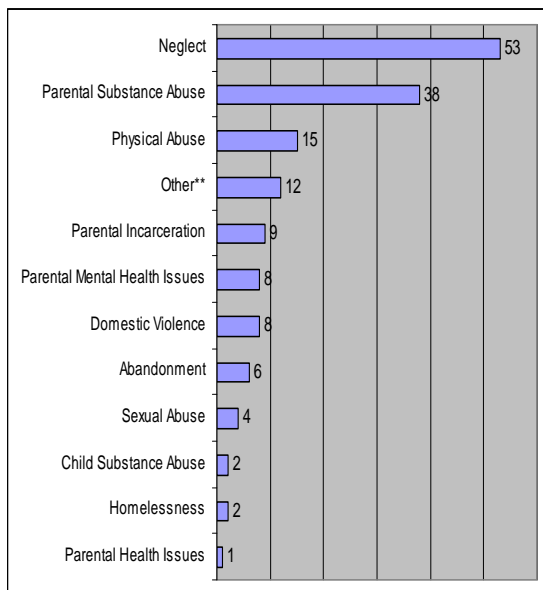
³⁶ In accordance with the Child Abuse Prevention and Treatment Act (CAPTA) of 1988, and amended in 1996, ACYF utilizes the National Child Abuse and Neglect Data System (NCANDS) to collect, analyze and report on data by child protection agencies.

³⁷ CAPTA law provides states with federal funding for programs serving children who are abused/neglected. These awards may be used to assist states in intake and assessment; screening and investigation of abuse/neglect reports; improving risk and safety assessment protocols; training child protection staff and mandated reporters; and improving services to disabled infants with life-threatening conditions.

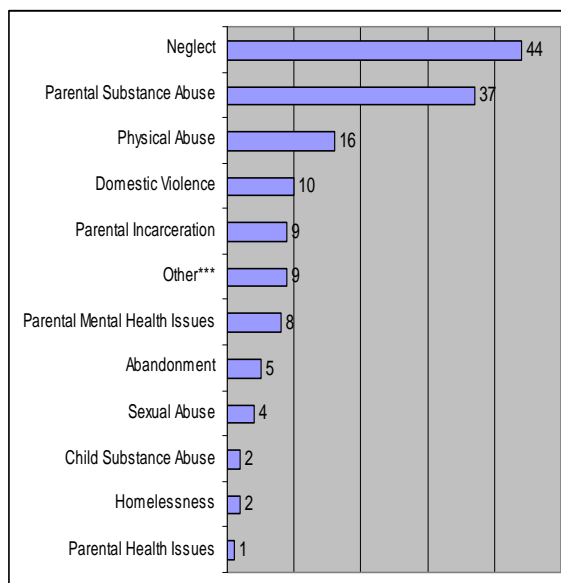
³⁸ The Child and Family Service Review (CFSR) is a process established through the Federal Register by the DHHS, Children’s Bureau to monitor State child welfare programs. Effective March 25, 2000, States are assessed for substantial conformity to identified requirements for child protection; foster care and adoption services; family preservation, family support and independent living services. Recently, the CFSR process added recurrence of child maltreatment and maltreatment in foster care to its data measures.

The OCA’s study identified that the majority of children removed from their home had multiple reasons for out-of-home placement, although reasons differed somewhat between DYFS and CHEC files. (See Graphs 1 and 2) Per the review of DYFS files, 58 children (72.5%) were reported to have had multiple reasons for placement. The majority of children were removed due to neglect (53 children, or 66.3%), parental substance abuse (38 children, or 47.5%) and physical abuse (15 children, or 18.8%). A review of CHEC files indicated that 51 children (63.7%) had multiple reasons for placement; the most commonly cited reasons being neglect (44 children, or 55%), parental substance abuse (37 children, or 46.3%) and physical abuse (16 children, or 20%).

Graph 1:
*Reason for Placement per DYFS File**



Graph 2:
*Reason for Placement per CHEC File***



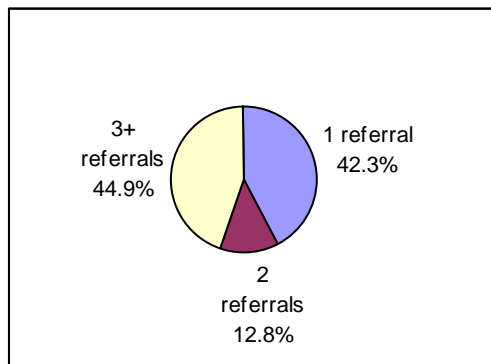
**58 children had multiple reasons for placement, per DYFS file.*

***51 children had multiple reasons for placement, per CHEC file.*

****These reasons include children witnessing abuse of other household members, parental cognitive limitations, charges of sexual abuse against a parent not involving the child in question and familial illness.*

The OCA study revealed that while 10 children (12.5%) had 2 referrals to DYFS, the majority, (46 children, 57.5%), had 3 or more DYFS referrals alleging caregiver abuse and/or neglect or other concerns prior to their CHEC evaluation. This alarming number reflects the prevalence of an established DYFS history for the majority of these children prior to their removal and suggests potentially higher incidents of alleged child maltreatment prior to DYFS ultimately removing children from their caregiver. (See Chart 8) Of note, one child within the review was found to have had 27 prior DYFS referrals.

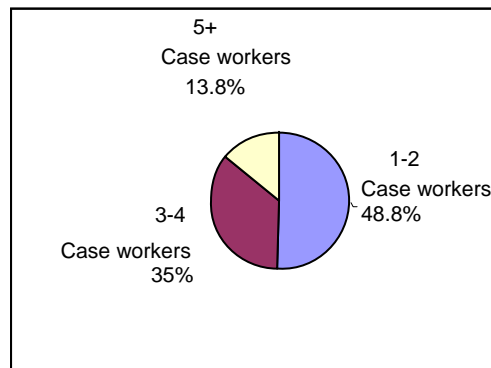
Chart 8:
DYFS Referrals Prior to CHEC
n = 80



Number of DYFS Workers Assigned

According to the Child Welfare League of America, “The issue of staff turnover is perhaps the most important problem facing front-line service delivery in child welfare.”³⁹ Each time a transition or change in caseworker occurs, opportunities increase for loss of information and further lack of consistency in a child’s life. Additionally, there is an increased risk for missing opportunities for timely follow-up on needed services and activities. This study revealed that 71 children (88.8 %) had at least 2 caseworkers⁴⁰ prior to the time of the CHEC evaluation, with one child noted to have had 10 caseworkers. (See Chart 9)

Chart 9:
Number of DYFS Caseworkers Prior to and Including Time of CHEC
*n = 80**



**There were 2 cases where the total number of previous case workers could not be determined.*

DYFS continues to work toward decreasing staff turnover rates and establishing lower caseloads for its field staff and has seen success in this area. The OCA acknowledges and supports these efforts.

³⁹ Child Welfare League of America. 2001. “Finding Better Ways Conference Presentation Recap: Traumatic Stress, Turnover and Peer Support in Child Welfare.” <http://www.cwla.org/programs/trieschman/2001fbwPhilHowe.htm>.

⁴⁰ As of 2004, DYFS transitioned to an overall system that separates out child protection investigations from servicing ongoing cases. Investigations of abuse/neglect allegations are performed by Investigative Workers and if opened for services, the children and families in these cases are transitioned to a permanency worker for ongoing services/supervision.

However, issues created during transitions and staff turnovers underscore the need for an organized system to deliver recommended health, developmental and mental health services to children in out-of-home placement. The risk that children will fall through the cracks in these situations is far too great.

Medical Home

In a July 2002 Policy Statement, the American Academy of Pediatrics (AAP) defines the concept of a medical home for infants, children and adolescents as, “Accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them.”⁴¹

All children in DYFS out-of-home placement are covered by NJ Medicaid. Over the years, many NJ-based health care providers have shifted their practice of accepting traditional Medicaid fee-for-service and now participate in Health Maintenance Organization (HMO) networks that also serve Medicaid managed care clients. In 2004, DYFS mandated that children in out-of-home placement be enrolled in a participating Medicaid HMO to facilitate access to scarce Medicaid services for children in out-of-home placement. The HMO covering the child’s care is contractually responsible for identifying a provider to meet the specific need of the child, even if that means the child receives the service from an out-of-network provider.

Resource parents are permitted to choose a Medicaid HMO for the child in their home from five managed care networks presently operating in New Jersey. DYFS practice requires the resource parent to choose the child’s Medicaid HMO and enroll the child within 60 days of initial entry into their home. If the resource parent does not choose an HMO for the child within this timeframe, or requests an exemption to HMO enrollment, the child is auto-assigned into an HMO plan. The auto-assignment process presents many challenges to ensuring a medical home is provided.

Beginning in 2004, children in out-of-home placement enrolled in a Medicaid HMO are assigned HMO care managers to ensure they are progressing through their treatment plans. HMO Care Managers provide varying levels of care management depending upon an enrollee’s particular clinical needs.⁴² Children in DYFS out-of-home placement enrolled in Medicaid HMOs are automatically designated as requiring Level 2 care management. The State made this decision to provide a high level of care management given the fact that this population of children was identified as being at high risk for adverse medical outcomes.

According to the Department of Human Services, Division of Medical Assistance and Health Services, as of July 2007, there were approximately 7,439 children in out of home placement enrolled in DYFS Medicaid. Approximately 5,796 of these children were in a Medicaid managed care plan. A total of 390 of the 7,439 children were identified as having an exemption from enrollment in managed care and their health needs are addressed through the Medicaid fee-for-service system.

⁴¹ American Academy of Pediatrics. 2002. “Medical Home Initiatives for Children with Special Needs Project Advisory Committee.” *Pediatrics*, 110(1): 184-186.

⁴² Non-DYFS Medicaid recipients may also receive care management services, although the level of care management is based solely on the identified clinical needs of the patient.

The level of success achieved by the decision to move all children in DYFS out-of-home placement into Medicaid managed care has not been measured in this study. However, the findings below clearly demonstrate that the process to enroll children in Medicaid managed care and ensure a medical home for children is another area where significant improvements are needed.

Enrollment in Medicaid HMO

Only 23 (28.8%) of the 80 children within the scope of the OCA’s study were identified as enrolled in Medicaid Managed Care at the time of the CHEC evaluation. There were 57 (71.3%) children for whom there was no evidence on enrollment into Medicaid managed care at the time of their CHEC (See Chart 10) Of the children who were enrolled in a Medicaid managed care plan, 8 (34.8%) were enrolled in Horizon NJ Health; 7 (30.4%) in AmeriGroup; 4 (17.4%) in AmeriChoice; 3 (13.8%) in University Health Plan; and 1 child (4.3%) was enrolled in Health Net. (See Chart 11)

OCA reviewers looked for documentation in the child’s DYFS and CHEC file that there was a plan in place for enrollment into Medicaid managed care, given the fact that the child’s CHEC evaluation may have occurred prior to the 60-day enrollment window. For 19 (33.3%) of the 57 children who were not already enrolled, a plan for enrollment was in place. For the remaining 37 children (64.9%) identified as not enrolled, a plan for enrollment was not documented.

This evidence points to the need for DCF to develop and implement, as well as monitor and track the process for managed care enrollment. DYFS field staff need to ask resource parents about their choice for the child’s health insurance plan, ensure the child is enrolled and offer supports as needed to the child’s caregiver in this process. Children must be able to readily access health providers to ensure their health is routinely evaluated and treatment services are provided. Resource parents and other caregivers require DYFS support and guidance in this area.

Chart 10:
Evidence of HMO Enrollment
n = 80

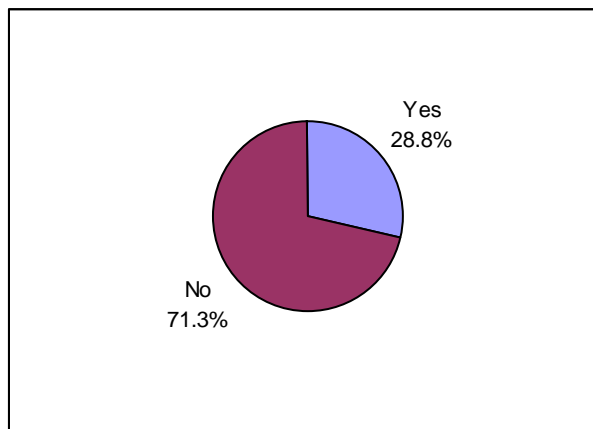
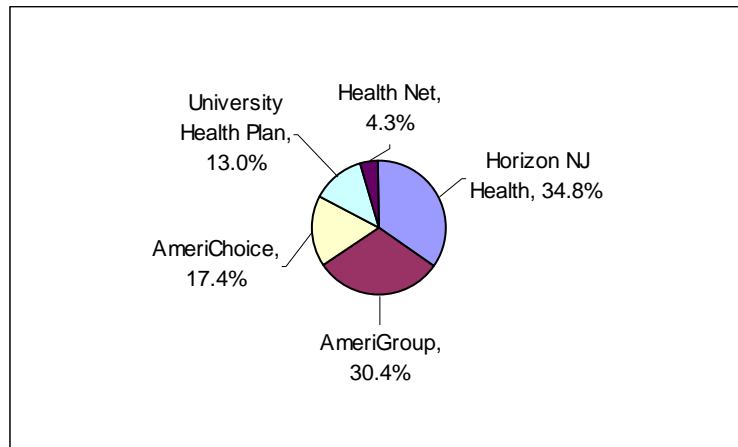


Chart 11:
HMO Enrollment by Type
n = 23



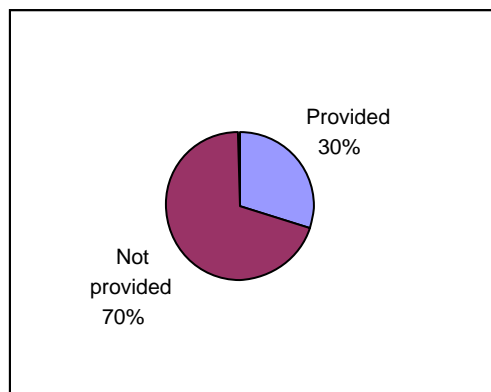
Primary Care Provider

At the time of the CHEC evaluation, a primary care provider was identified for 70 children (87.5%) in the OCA sample. For 9 children (11.3%) in the study, there was no evidence that a medical home was identified. This result is encouraging and suggests that DYFS or the resource parent, (or both) are working to ensure that a medical home is identified for the child. Additional supports and education around the managed care enrollment process can ensure that unnecessary changes in the child’s provider do not occur and caregivers receive needed support to ease confusion.

However, based on a review of the child’s DYFS file, the OCA found that documentation regarding the child’s most recent appointment with a health provider was noted in the DYFS record for only 24 (30%) of the 80 children reviewed. For nearly three-quarters of the children in the study (56 children, 70%), OCA reviewers could find no documentation that the child received a well visit to a physician, despite the fact that the OCA reviewed information within the child’s DYFS record through March 2007. This suggests that while DCF may assert that children in out-of-home placement have access to and are regularly seeing a primary care provider for routine care,⁴³ and while DCF’s data is encouraging, there is evidence that this information is not routinely tracked, monitored and documented by DYFS case work staff, and highlights the need for improvement in this area. (See Chart 12)

⁴³ In the proposed May 2007, DCF health model, DCF cites that “beginning in December 2006, (DCF) began analysis of two statistically significant, random samples of DYFS children to understand more about their health care needs and access to services. One of those studies revealed that 92% of the children in the sample (238 of 260) had documented evidence of having received an annual medical exam.

Chart 12:
Documentation of Most Recent Visit with Health Provider
n = 80



Pre-Placement Medical Exams:

NJ law and DYFS policy require children initially entering out-of-home placement to receive a pre-placement medical exam.⁴⁴ The purpose of the exam is for a health practitioner to examine the child just prior to out-of-home placement and document and assesses the presence of acute and chronic health issues, injuries, contagious disease and urgent treatment needs. These exams help establish a baseline regarding the child’s identified health status and information obtained during this exam is to be shared by DYFS with the child’s identified caregiver.

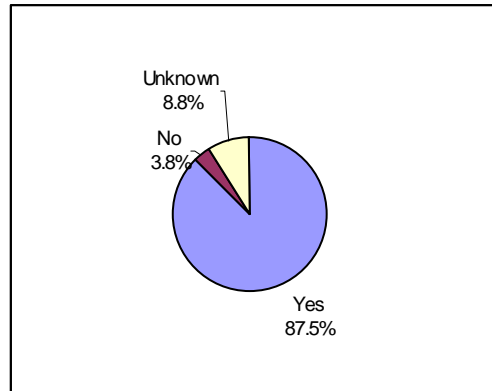
As part of the overall Modified Settlement Agreement, DCF has made a commitment to ensure children receive a pre-placement examination and to provide these exams in settings other than hospital emergency rooms. By December 2006, DYFS was to “provide pre-placement assessments to children entering out-of-home care to the best of its ability.”⁴⁵

Based upon reviews of DYFS and CHEC files, it was determined that 70 children (87.5%) received a pre-placement exam prior to their most recent out-of-home placement. For 3 children (3.8%), reviewers noted that a pre-placement exam did not occur. For 7 children (8.8%), OCA reviewers were not able to determine if an exam occurred due to the absence of this information in the child’s DYFS case file. (See Chart 13)

⁴⁴DYFS Field Operations Casework Policies and Procedures Manual. 803.4. Pre-Placement Assessment (Health). 6-29-2007; “A pre-placement assessment (health) is required for all children initially entering foster care (N.J.A.C. 10:122D-2.5), or any out of home placement (i.e., beginning a placement episode). The only exception is when children are entering placement from a medical setting (e.g., a newborn going into foster care).This policy applies to all DYFS staff, including after-hours emergency workers (Special Response Unit Workers, or SPRU).”

⁴⁵ New Jersey: Charlie and Nadine H. v. Corzine No. 99-3678 U.S. District Court; Modified Settlement Agreement

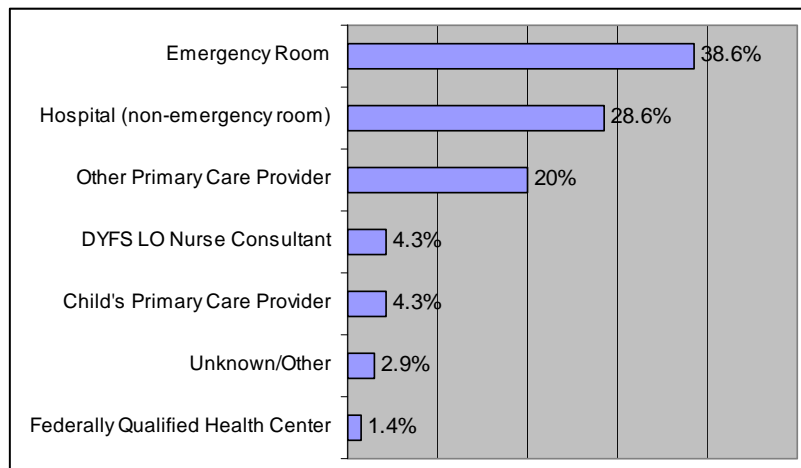
Chart 13:
Completion of Pre-Placement Exam
n = 80



While DYFS appears to be making strides to ensure children receive needed pre-placement exams, there was evidence that information pertaining to the child's pre-placement examination was not part of the child's overall DYFS file. This, coupled with the fact that OCA reviewers noted an overall disorganization of key health information in the child's DYFS file, further underscores the need for an organized system of gathering and maintaining health-related information within the child's DYFS record. Missing or incomplete health information within the child's DYFS case record, and the lack of an electronic system to document key health issues, treatment needed and treatment received, significantly increases the likelihood that health needs will go undiagnosed and untreated.

For 27 children in the study (38.6%), pre-placement exams took place in the hospital emergency room. Another 20 children (28.6%) received a pre-placement exam in a non-emergency room, hospital setting. For these 20 children, it is likely that the child was a newborn discharged at birth from the hospital, or was hospitalized just prior to out-of-home placement. For 14 children (20%), pre-placement exams occurred at a physician's office that was not the identified primary care physician of the child at the time of the pre-placement. (*See Graph 3*)

Graph 3:
Location of Pre-Placement Exam
n = 70*



**n=70; 10 children either had no evidence of a pre-placement exam in their records or it was determined that a pre-placement did not occur.*

Pre-placement exams are critically important in the overall continuum of providing health care services to children in out-of-home placement. In addition to establishing baseline information regarding the child's current health status as they enter out-of-home care, for many children entering the child welfare system with pre-existing gaps in receiving timely and regular health appointments, this exam may be their first opportunity to receive health services. Currently, the State has not established a process to ensure that pre-placement exams provide all needed baseline information to DYFS, nor is there an identified process to evaluate the overall quality of the assessment provided.

Further, DYFS does not have a system to identify and document the overall findings of the child's pre-placement exam, other than placing a completed form regarding the exam in the DYFS record. Since there is no integration of these findings by DYFS into any formal data system tracking information on the child, it subsequently follows that there is no way to aggregate data on the overall presenting needs of this population as they enter out-of-home care.

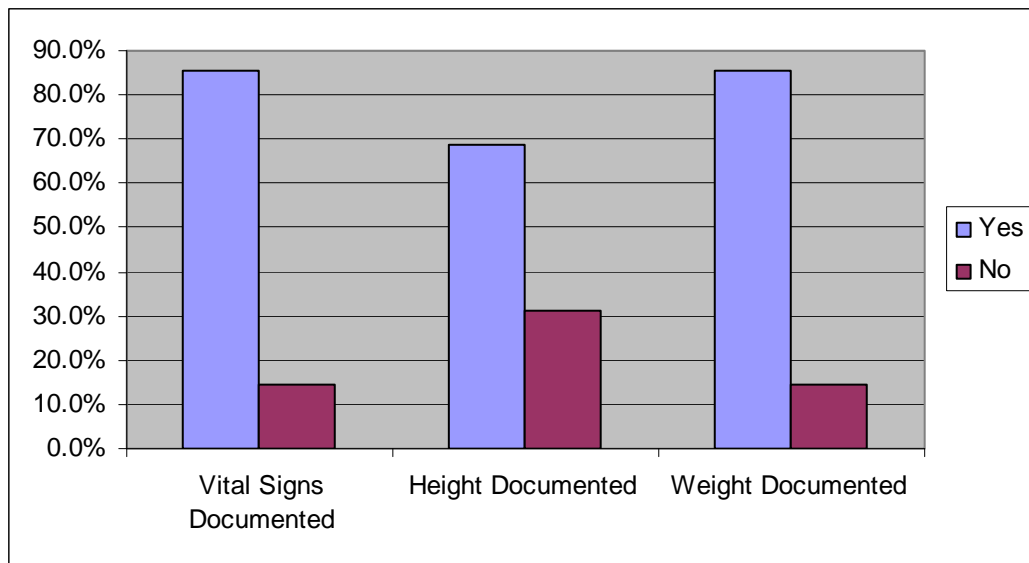
Based on the fact that pre-placement exams are the first component of the health care services children receive while in DYFS out-of-home placement, information gleaned from this exam can be critical to appropriately meeting the child's emergent health needs. Coupled with the fact that these pre-placement exam results can provide CHEC clinicians with baseline information on the child's health status at the time of placement, the OCA determined it was critically important to take a closer look at the health screenings children receive during their pre-placement exam. Based on the information documented on the child's DYFS pre-placement examination form (DYFS Form 11-2), the OCA review team was asked to identify evidence that the child received the following assessments:

- The child's vital signs were taken; heart rate, respiratory rate and body temperature;
- The child's height and weight were measured;
- For children ages three years and older, the child's blood pressure was taken; and,
- For children ages two years and under, the child's head circumference was measured.

The results of this review highlighted variations in the services children receive at pre-placement exams. For example, vital signs were noted as taken for 60 of the 70 children (85.7%) who received pre-placement exams. Yet for 10 children (14.3%), there was no documented evidence of vital signs.

For only 48 of the 70 children (68.6%) (See Graph 4), height was documented, yet weight was documented for 60 of the 70 children (85.7%). In children for whom a blood pressure check was age-appropriate, (3 years of age and over, n = 45) there was evidence that 34 children (75.6%) received a blood pressure check. In children for whom a head circumference measurement was necessary, (children 2 years of age and younger, n = 25) only 13 children (52%) were measured. (See Charts 14 and 15)

Graph 4:
Percentage of Children Receiving Vital Signs Measurements at Pre-placement Exam
*n = 70**



*n=70; 10 children had no evidence of a pre-placement exam.

Chart 14:
Blood Pressure Documented at Pre-Placement Exam
*n = 45***

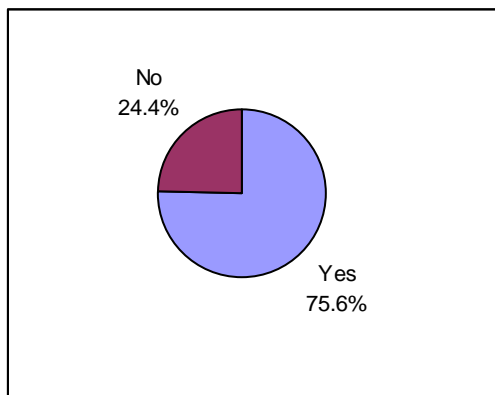
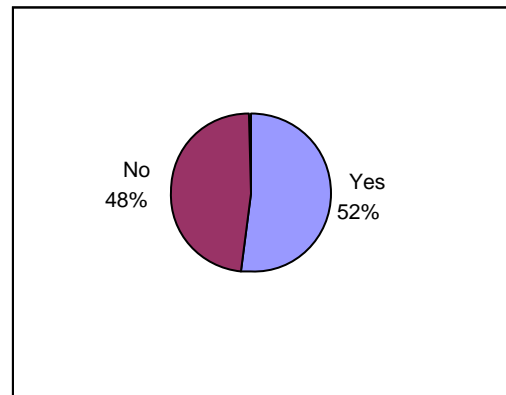


Chart 15:
Head Circumference Documented at Pre-Placement Exam
*n = 25****



**n=45; 35 children had no evidence of a pre-placement exam or were 3 years of age and younger.

***n=25; 55 children had no evidence of a pre-placement exam or were older than age 2.

Pre-Placement Exam Information to CHEC Sites

DYFS policy requires caseworkers to attach a copy of the child's pre-placement exam form (DYFS Form 11-2) to the request for obtaining a CHEC evaluation for the child. Information obtained at the pre-placement exam is then reviewed by the CHEC provider and utilized to more thoroughly assess and report on the child's health status. Based on information obtained in the child's DYFS record and CHEC file, the OCA determined that the child's pre-placement exam information was provided to the CHEC site for 47 (67.1%) of the 70 children identified as receiving a pre-placement exam. This information was not provided to the CHEC site for 23 (32.9%) children who received an exam. In the original CHEC RFQ, DYFS advised potential CHEC respondents that information on the child's health status is often unknown given the many circumstances surrounding the placement. Information from a pre-placement exam is one tangible piece of documentation DYFS has regarding the health status of the child, provided there was compliance with state law and policy and an exam was obtained. DYFS compliance with these policies and the impact non-compliance has on the quality and thoroughness of the CHEC evaluation is of significant concern.

The OCA stresses that pre-placement exams are an important aspect of identifying and meeting the health needs of children initially entering out-of-home placement. Equally important is the need to implement a process that evaluates services provided and quality of exams, evidences that follow-up of identified treatment needs has occurred, ensures communication of vital information to caregivers and treatment providers, in addition to evaluating the timeliness of examination and collecting information to establish key demographic data. The OCA will consider conducting a review of pre-placement exams in the future, and encourages DCF to establish a measurable system for regularly evaluating its pre-placement exam process.

The Health of Children in Out-of-Home Placement

All children, regardless of age, socio-economic status or current living situation, require continued well-child care, immunizations and treatment for acute and chronic illnesses through an established medical home. However, children in out-of-home placement are at increased risk for developing complex health, mental health and developmental concerns, and thus require even more attention. Numerous studies have evaluated the health status of children in out-of-home placement. National experts in child welfare cite the following findings regarding the health and mental health of these children:

“Physical health problems affect 30 to 40% of children in the child welfare system. These include delayed growth and development, HIV infection, neurological disabilities, malnutrition and asthma. Mental health problems are particularly widespread. Experts estimate that between 30 and 85% of youngsters in foster care have significant emotional disturbances. Adolescents living with foster parents or in group homes have about four times the rate of serious psychiatric disorders as those living with their own families.”⁴⁶

⁴⁶ National Resource Center for Family Centered Practice and Permanency Planning at the Hunter College School of Social Work. 2007. “Child and Adolescent Health and Mental Health Care.” http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/child-and-adolescent-health-care.html.

The OCA’s review sought to determine the health status of the identified children within the sample. The following areas were examined:

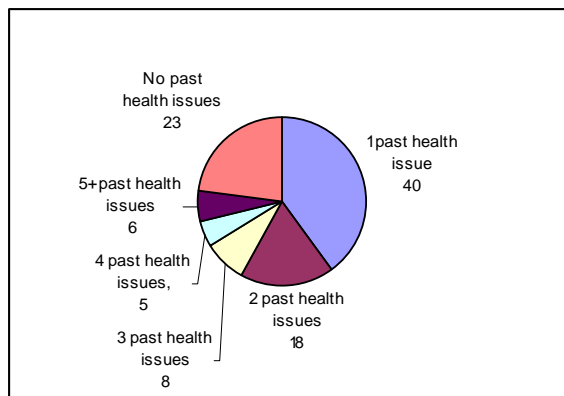
- Evidence of pre-existing health issues prior to the CHEC exam;
- Evidence of health issues post-CHEC exam;
- Identification of newly identified health issues and prevalence of diagnoses;
- Evidence of immunizations;
- Evidence that lead screenings were performed;
- Evidence of pre-natal drug exposure;
- Evidence that vision and hearing screenings were performed;
- Evidence of dental screens;
- Evidence of nutritional/growth assessments performed;
- Evidence that mental health assessments were performed.

Knowledge regarding the needs and presenting status of children as they enter the State’s child protection system is invaluable to policy makers and administrators in determining strategies and resources for providing services. Similar to national research findings, the OCA’s study identified that children entering out-of-home placement have significant pre-existing health related needs and have additional health needs identified through the CHEC evaluation process. It is imperative that DCF develop and implement a system for routinely capturing and analyzing this information as they develop additional placement and service resources, as well as programs and policies to serve this population. Additionally, timely implementation of this system will greatly assist DCF in preparing to comply with future phases of the Modified Settlement Agreement.⁴⁷

Pre-Existing Health Issues: DYFS File

Based upon a review of each child’s individual DYFS file, 57 (71.3%) of the 80 children in the OCA sample evidenced a history of previous health issues prior to their out-of-home placement. Of these children, the most frequent past health issues noted were asthma (16 children, or 20%), allergies (11 children, or 13.8%) and non-inflicted injury (10 children, or 12.5%). It is important to note that 37 children (46.2%) had more than one identified pre-existing health issue. (See Chart 16)

Chart 16:
Number of Children with Pre-Existing Health Issues per DYFS File
n = 80

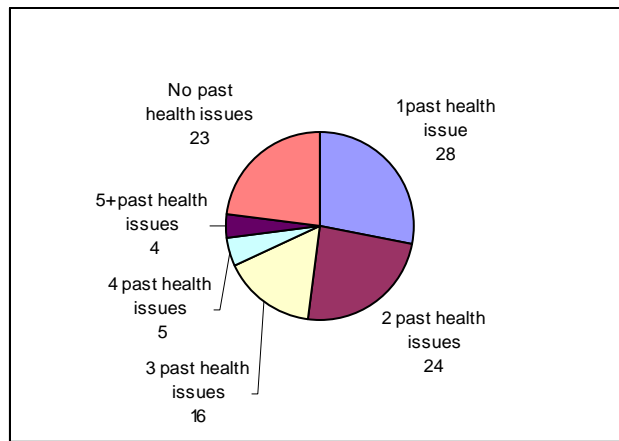


⁴⁷ Within the Modified Settlement Agreement, by June 2009 and thereafter, DCF is to “Regularly evaluate the needs of children in custody and their families. The State shall develop placements and services consistent with the findings of these needs assessments.”

Pre-Existing Health Issues: CHEC File

A review of each child’s individual CHEC file indicated that CHEC sites identified past health issues for 57 (71.2%) of the children seen. The most common past health issues identified were asthma (18 children, or 22.5%), environmental risk factors (15 children, or 18.8%) and allergies (14 children, or 17.5%). However, at the time of their CHEC evaluation, well over half of the children (49 or 61.2%) had two or more identifiable previous health issues. This means that CHEC clinicians more readily uncovered and documented the prevalence of health issues than had been previously recognized and/or documented by others involved with the child. (See Chart 17)

Chart 17:
Number of Children with Pre-Existing Health Issues per CHEC File
n = 80

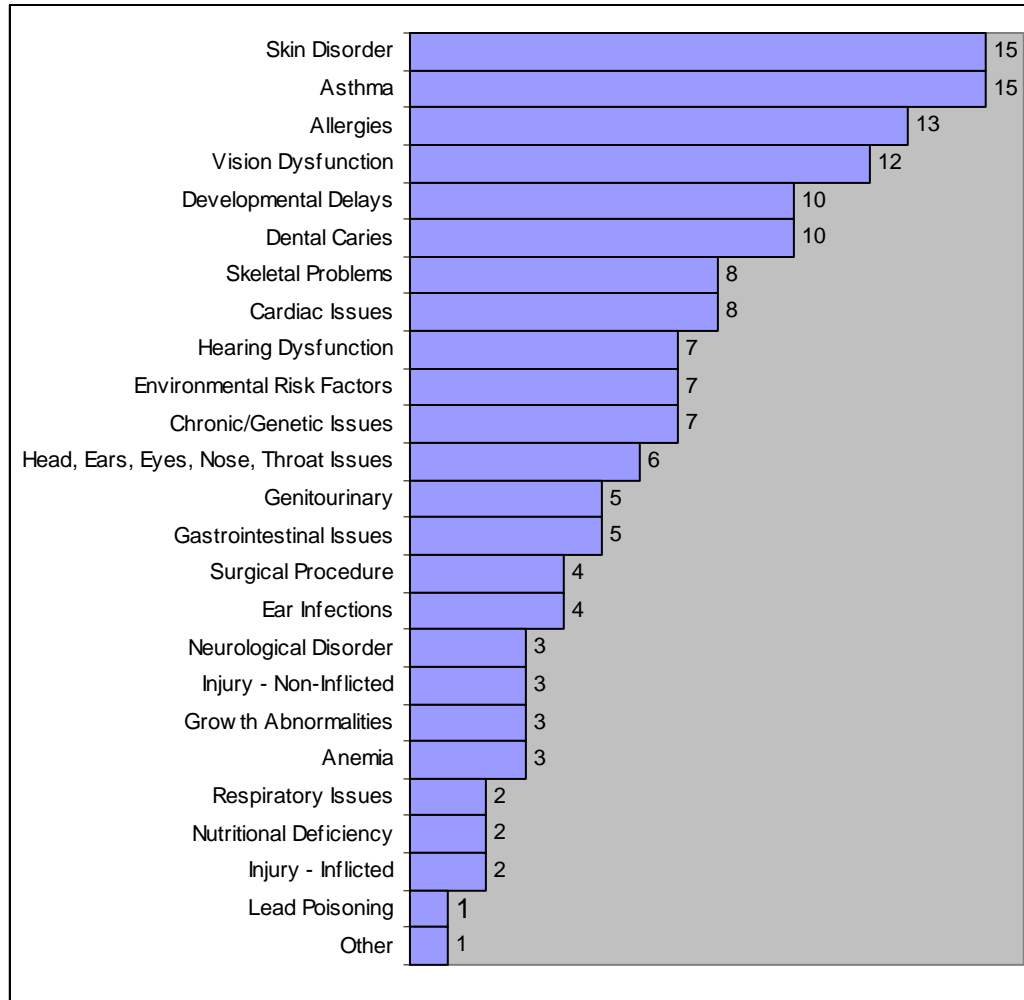


Child Health Issues Identified by CHEC

While obtaining historical medical information is imperative to properly assess, plan for and treat children in out-of-home placement, the CHEC evaluation is intended to identify and treat all acute and chronic health issues, as well as provide referrals and recommendations for follow-up care. The OCA’s review of CHEC files revealed that over three-quarters, or 78.8%, of all children had at least one acute and/or chronic health issue identified at their CHEC evaluation. This is especially significant since this percentage is greater than the presence of past health issues, as identified by the child’s DYFS and CHEC files. This indicates the prevalence of newly recognized health issues that may not have been identified without the CHEC evaluation.

A breakdown of the health issues identified at the CHEC evaluation, by diagnosis, can be seen in *Graph 5*, below. The most frequently diagnosed health issues within the sample of 80 children were 15 children with identified skin disorders (18.8%), 15 children with asthma (18.8%), 13 children with allergies (16.3%) and 12 children with vision dysfunctions (15%). Information concerning the follow-up children received for these identified health issues is discussed in a later section of this report.

Graph 5:
Frequency of Health Issues Identified at CHEC*
*n = 63***



**Note: 16 children had 2 identifiable health issues, 15 children had 3 identifiable health issues, 10 children had 4 identifiable health issues, and 4 children had 5 or more identifiable health issues. As stated, this information is vitally important when considering the development of health and service-related resources and in recruiting and developing caregiver resources to meet the needs of children entering out-of-home placement.*

***There were 17 children the CHEC identified as not having any current acute or chronic health needs.*

Immunizations

Immunization is one of the most effective ways to protect the human body against infectious disease and is an essential part of ensuring overall health and well-being. Although determining the specific types and number of past immunizations a child has may be difficult, many children entering out-of-home placement are likely to be incompletely immunized.⁴⁸ The CHEC evaluation provides the opportunity for the child’s immunization record to be reviewed and necessary immunizations given to

⁴⁸ American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependant Care. 2002.” Health Care of Young Children in Foster Care.” *Pediatrics*, 109(3): 536-541.

the child at this appointment. This ensures the child is up-to-date on immunizations and allows for the much-needed documentation of the child’s immunization status.

The OCA study found that while 39 (48.8%) children were up-to-date on their immunizations upon arrival for their CHEC evaluation, 28 (35%) were delayed, 9 (11.3%) children had immunization records that were unavailable,⁴⁹ and 3 (3.8%) had no previous immunization records. (See Chart 18)

While vaccines were not given to 33 (41.3%) children evaluated, as they were not needed,⁵⁰ vaccines were given to 26 (32.5%) children at the time of their CHEC evaluation and these children were brought up-to-date on their immunizations. Although this is encouraging, vaccines were not given to 15 (18.8%) children reviewed for reasons unknown, despite the fact they were not up-to-date at the time of the CHEC evaluation. Necessary vaccines were not administered to 4 children (5%) as the vaccines were unavailable to the CHEC site from the Vaccines for Children (VFC) program.⁵¹ The immunization status for 2 children (2.5%) after the CHEC evaluation was unknown. (See Chart 19)

Chart 18:
Immunization Status Pre- CHEC
n = 80

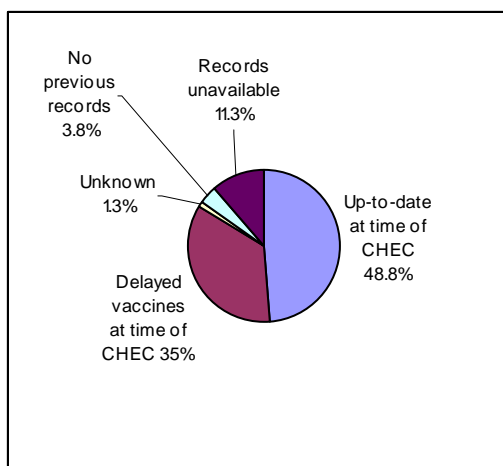
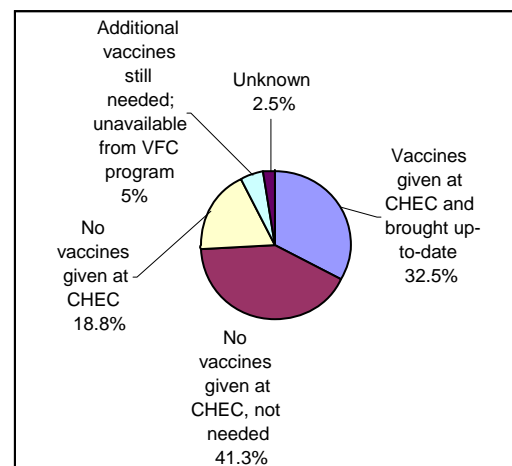


Chart 19:
Immunization Status Post-CHEC
n = 80



The administration of needed immunizations is a required component of EPSDT, as well as the CHEC RFQ. It is concerning to the OCA that there were 15 children who did not receive immunizations at their CHEC evaluation, despite the fact that they were indicated. It is not known if the program was unable to give the child a vaccine due to an extenuating circumstance (such as the child’s physical and/or mental health status) during the exam, or due to an undocumented shortage of a vaccine or a practice at the particular site for not administering needed immunizations. Variations such as this in the provision of basic care must be addressed through a regular review and assessment of services. The

⁴⁹ “Unavailable immunization records” refers to the fact that an immunization record existed, either in paper or electronic form, but was unavailable to the CHEC provider at the time of the child’s CHEC evaluation.

⁵⁰ “Immunizations Not Needed” refers to situations where the child was up-to date for that immunization or the child’s age was out of the recommended age range when a particular immunization is medically indicated.

⁵¹ VFC helps families of children who may not otherwise have access to vaccines by providing free vaccines to doctors who serve them. VFC is administered at the national level by the Centers for Disease Control (CDC) through the National Immunization Program. CDC contracts with vaccine manufacturers to buy vaccines at reduced rates.

OCA strongly recommends that DCF work with its current CHEC sites to develop and implement a system for review, communication and quality measurement.

Lead Screening

Lead poisoning, or the presence of elevated levels⁵² of lead in the body, is a serious and potentially life-threatening problem. Research emphasizes that, “Lead exposure is harmful to the developing brain and nervous system of fetuses and young children.”⁵³ Recent studies have demonstrated that the harmful effects of lead may even occur at concentrations below the current designated level of concern of 10µg/dL.⁵⁴ Additionally, exposure to lead contributes to behavior problems, learning disabilities, and lowered intelligence scores, underscoring the importance of conducting lead screening for all children. New Jersey law (Public Law 1995 ch328 and N.J.A.C. 8:51A) mandates that all children between the ages of 6 months to 6 years be screened for lead, preferably at 12 months and again at 24 months of age. Children over 24 months, who have never been tested, or whose blood lead levels are unknown, should also be screened. Blood lead testing is also a requirement of EPSDT. The current CHEC model requires that all children who fall within the age range of 6 months to 6 years receive a blood lead test, if previous results of two tests are not known.

Based on the OCA’s study, 39 children (49%) were within the identified age range for lead screening (between the ages of 6 and 72 months) at the time of their CHEC evaluation.⁵⁵ The OCA encountered difficulties in locating evidence of previous lead screens in the documentation contained within the child’s DYFS file. However, based on OCA’s review of CHEC files, CHEC sites were able to determine the presence of at least some evidence of previous lead testing for 17 of the 39 children (43.6%), who were within this age criteria at the time of their CHEC evaluation. These results indicated the presence of previous elevated levels for 2 children. For the remaining 22 children identified as being within this age range, a review of the CHEC files could not determine that the CHEC was able to establish if prior lead screen was completed.

Further review of CHEC files found that 14 of the 39 children (35.9%) identified as within the age range for recommended lead screening received this test at the CHEC site. There were 9 children (23%) identified by the CHEC site as not requiring a lead screening⁵⁶ and another 8 children (20.5%) who were referred to an outside lab for the screen. For 8 children (20.5%), OCA reviewers could not determine a reason explaining why a lead screening was not performed. (*See Chart 20*)

The OCA’s study found that of the available results of the lead screenings performed at the CHEC sites, all were identified to be within the normal range. However, given the serious dangers and consequences associated with lead poisoning and its risks to the developing young child, the OCA strongly encourages DCF and CHEC sites to partner together to develop and implement clear policy

⁵² Blood lead levels are considered elevated when readings are at and above 10 ug/dL(micrograms per deciliter).

⁵³ Roper, W.L., et al. 1991. “Preventing Lead Poisoning in Young Children: A Statement by the Centers for Disease Control and Prevention.” U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. <http://www.cdc.gov/nceh/lead/publications/books/plpyc/contents.htm>.

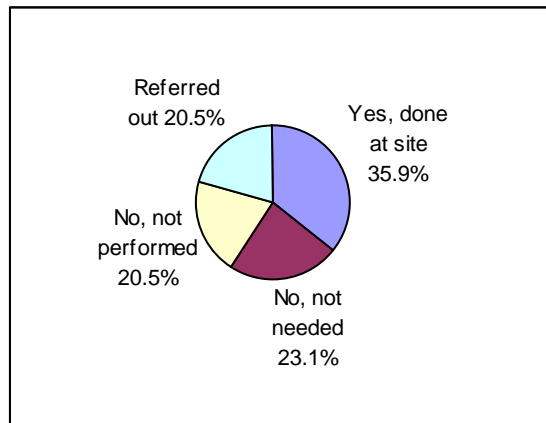
⁵⁴ Canfield, R.L., et al. 2003. "Intellectual Impairment in Children with Blood Lead Concentrations below 10 micrograms per Deciliter." *New England Journal of Medicine*, 348(16): 1517-1526.

⁵⁵ There were 2 children identified as being 6 years old, but over 72 months of age. For the purposes of reporting on this segment of data, these children are not included in this overall total.

⁵⁶ “Did not necessitate a lead screen” refers to situations where the record evidenced previous/recent lead screenings and/or screenings with normal results.

guidelines for lead screening, education to caregivers and case management of children who test with elevated lead levels.

Chart 20:
Lead Screening at CHEC
n = 39*



**This number reflects children who were identified to be between the ages of 6 months to 72 months.*

Prenatal Drug Exposure

The fact that exposure to drugs and alcohol can be significantly harmful on the developing fetus is well-established. The March of Dimes estimates that, “Nearly 4 percent of pregnant women use illicit drugs such as marijuana, cocaine, Ecstasy and other amphetamines, and heroin, according to a 2005 government survey. These and other illicit drugs may pose various risks for pregnant women and their babies. Some of these drugs can cause a baby to be born too small or too soon, or to have withdrawal symptoms, birth defects or learning and behavioral problems.”⁵⁷

For babies whose mothers used drugs such as crack, cocaine, heroin, alcohol and other substances, permanent neurological, developmental, and behavioral consequences can occur that are directly attributable to this prenatal drug exposure. For these children, long-term interventions may likely be needed to improve overall well-being outcomes. Additionally, having this information early on helps child welfare agencies and treatment providers determine needed services and in matching the child with a caregiver who understands these issues and can work with the child in meeting his/her ongoing treatment needs.

Based on a review of DYFS files, it was found that 17 children (21.3%) in the OCA’s sample had evidence in their DYFS record that they were prenatally exposed to drugs. For 25 (31.3%) children, there was documentation to indicate no prenatal drug exposure. However for 38 children (47.5%), the presence of previous exposure to drugs could not be determined by examining the child’s DYFS file. (See Chart 21)

⁵⁷March of Dimes. 2006. “Quick Reference: Fact Sheets, Illicit Drug Use During Pregnancy.” http://www.marchofdimes.com/professionals/14332_1169.asp.

Given the importance of prenatal history in determining the presence of health issues and treatment needs, the OCA also reviewed CHEC files to determine if information relating to prenatal drug exposure was noted by the CHEC site in the evaluation findings. A review of CHEC files by the OCA indicated that CHEC sites identified the prevalence of pre-natal drug exposure for 16 (20%) children. For 63 (78.8%) children, the CHEC evaluation determined that there was no history of pre-natal drug exposure. For 1 child (1.3%), the CHEC evaluation indicated that the presence of prenatal drug exposure was unknown. (See Chart 22)

Chart 21:
Prenatal Drug Exposure Prior to CHEC
n = 80

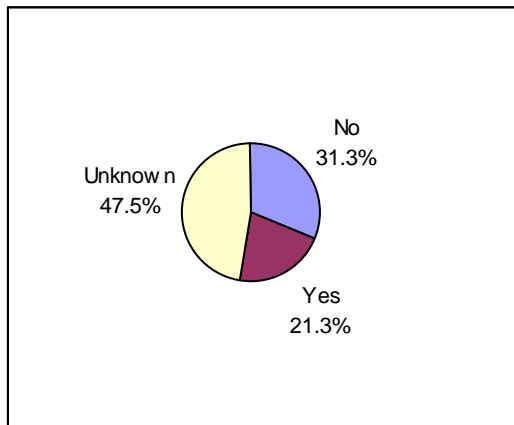
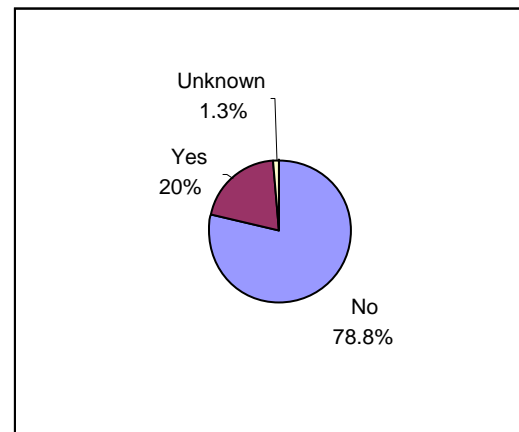


Chart 22:
Prenatal Drug Exposure Reported at CHEC
n = 80



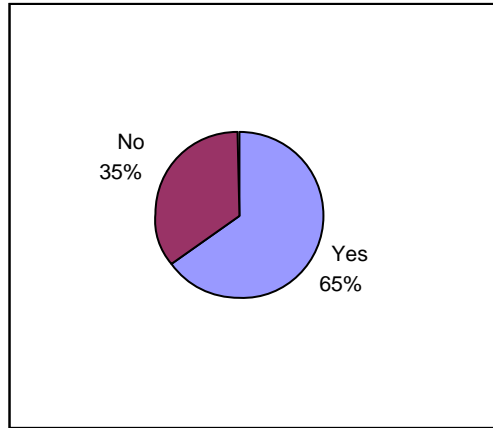
Vision/Hearing Screenings

According to the American Academy of Pediatrics, “Vision disorders are the fourth most common disability among children in the United States and the leading cause of impaired conditions in childhood. Recent studies estimate that only 21% of all preschool children are screened for vision problems and only 14% receive a comprehensive vision exam.”⁵⁸ Moreover, the American Academy of Ophthalmology (AAO) states that factors such as developmental delays, premature births, African-American heritage or use of certain medications, among others, places children at an increased risk for developing an eye disease or vision problem.⁵⁹ Vision screening is a basic component of the EPSDT program and minimally, is expected to be performed at each well-child visit. Vision screens are relatively simple to complete, and are a core provision of the CHEC model in keeping with EPSDT guidelines. However, the OCA review found that only 52 (65%) children received a vision screen at the time of the CHEC evaluation. (See Chart 23)

⁵⁸ American Academy of Pediatrics. “Children’s Health Topics: Vision and Hearing.” <http://www.aap.org/healthtopics/visionhearing.cfm>

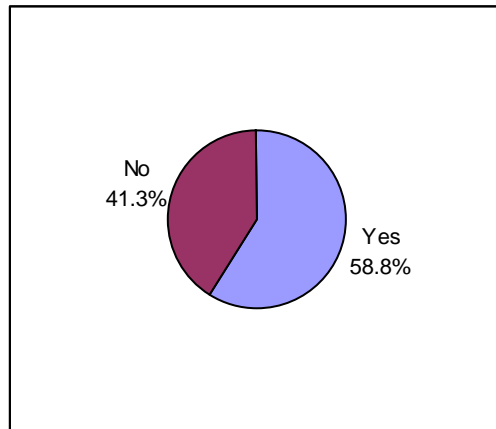
⁵⁹ American Academy of Ophthalmology. 2002. “How Often Should I Have My Children’s Eyes Screened?”

Chart 23:
Vision Screening Performed at CHEC
n = 80



Hearing loss is identified as the most frequently occurring congenital condition in America, as 33 infants are born daily with some type of hearing issue or loss.⁶⁰ Similar to vision screens, early screening and detection are the most effective methods of addressing hearing loss, and are also included within the full complement of EPSDT required services. Despite this fact, the OCA’s review of CHEC files indicated that only 47 children (58.8%) received a hearing examination or screen at their CHEC evaluation. (See Chart 24)

Chart 24:
Hearing Screening Performed at CHEC
n = 80



These variations in the provision of vision and hearing screens once again point to the need for consistency in service delivery among the CHEC sites to ensure compliance with EPSDT standards and RFQ guidelines. Together with the CHEC sites, DCF must develop and implement a standardized system for quality improvement that will identify and correct deficiencies in the program.

⁶⁰ American Academy of Pediatrics. “Children’s Health Topics: Vision and Hearing.”
<http://www.aap.org/healthtopics/visionhearing.cfm>

Dental

Research from the American Academy of Pediatric Dentistry (AAPD) cites that, “Comprehensive health care cannot be achieved unless oral care is included in all health service programs.”⁶¹ Just as children in out-of-home placements should receive regular well-child visits, the AAPD also recommends that preventative and routine oral care begin as early as 6 months of age, and no later than 12 months of age, for every child, and that such care continue every 6 months thereafter.⁶² While the CHEC evaluation cannot provide comprehensive dental exams by a dental specialist, the CHEC sites can examine children for overt dental issues and refer children for needed dental care.

The OCA’s study revealed that 45 children (56.3%) were referred for some type of follow-up dental care by the CHEC sites. Of these children, 29 (64.4%) were referred for a routine, preventative dental exam and 14 children (31.1%) were referred to a dentist for a specific dental problem identified during the CHEC evaluation. For 2 children, the CHEC site made a dental referral, however the reason for the referral was not specified. (*See Chart 25*)

Of significant concern is the fact that based on a review of the child’s DYFS file, the OCA found that for the 45 children for whom a dental referral was recommended, there was clear evidence that only 19 children (42.2%) actually received follow-up care with a dental provider. (*See Chart 26*) For another 19 of the 45 children, (42.2%) the OCA could find no definitive evidence in the DYFS file that a follow-up exam occurred. For the remaining 7 children, (15.6%) OCA reviewers simply could not discern that an appointment did or did not occur, as there was no documented information within the child’s DYFS record.

Moreover, based on a search for documentation in the child’s DYFS file, and of the 58 children who were subsequently identified as now being over the age of 3 years, only 18 (31.0%) had evidence that any type of dental appointment was either scheduled or kept within the 6-month timeframe after receiving a CHEC evaluation. This means that for nearly half of the children in the sample, there was no evidence in the child’s DYFS file confirming that the child visited a dentist for their required dental exam. (*See Chart 27*)

⁶¹ American Academy of Pediatric Dentistry, Dental Care Programs Committee. Revised 2006. “Policy on Oral Health Care Programs for Infants, Children and Adolescents.” *Oral Health Policies, Reference Manual: 2005-2006*.

⁶² American Academy of Pediatric Dentistry, Council on Clinical Affairs. Revised 2004. “Policy on the Dental Home.” *Oral Health Policies, Reference Manual: 2005-2006*.

Chart 25:
Type of Dental Referral Given at CHEC
n = 80

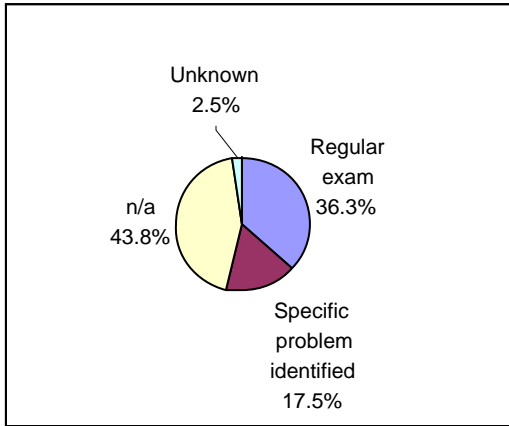
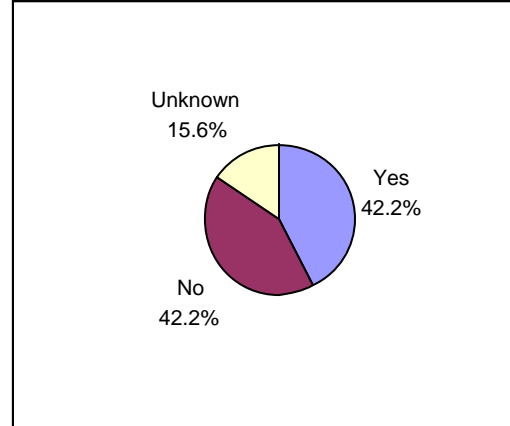
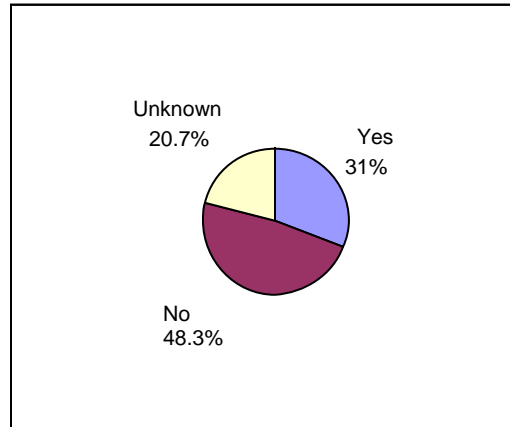


Chart 26:
Follow-up of CHEC Dental Referrals per DYFS File
*n = 45**



**n=45, as 35 children did not receive dental referrals at CHEC.*

Chart 27:
Evidence of Dental Appointment within 6 Months of CHEC per DYFS File
*n = 58***



***n = 58, as 22 children were not age 3 or older within six months after their CHEC evaluation.*

The OCA is aware and DCF has acknowledged that for children served by Medicaid, access to dental services is an exceptionally challenging issue. Additionally, identifying dental health specialists such as orthodontists and periodontists willing to accept traditional or managed care Medicaid is a long-standing problem in New Jersey. There are many variables which likely account for difficulties in accessing these service providers that are not the subject of this review. However, in this project, the OCA was looking for some documentation and evidence in the child’s DYFS file that acknowledged DYFS case work staff understand the need to monitor a child’s routine care with and access to a dental provider. It is particularly concerning that this information was not readily available when reviewing the child’s DYFS file, and illustrates once again that a system is sorely needed to ensure that this and other critical health information is routinely monitored and subsequently captured in DYFS record keeping.

Nutrition

Childhood obesity is becoming an increasingly prevalent and serious health concern for children and adolescents. In 2003-2004, information from the National Health and Nutrition Examination Survey (NHANES) indicated that approximately 17% of children between the ages of 2 and 19 were overweight.⁶³ Not only are overweight children and adolescents more likely to become obese as adults, but they are also at higher-risk for numerous health issues such as high blood pressure, Type 2 diabetes and cardiovascular disease, among others.⁶⁴ Preventative efforts and nutritional education are heralded as some of the most effective ways to combat concerns related to childhood obesity, as well as the associated rise in children's present and future health care costs.⁶⁵ Conversely, some children who enter out-of-home care may also be under-nourished, which poses serious health and medical concerns. Calculating a child's Body Mass Index (BMI)⁶⁶ is a very easy and valuable tool in determining the nutritional well-being of children.

There were 59 children in the OCA study whose age fell within the parameters for a BMI calculation.⁶⁷ Of the 59 children who were 2 years and older at the time of the CHEC evaluation, CHEC sites calculated the BMI for 16 children (27.1%). (*See Chart 28*) Children are considered to be at-risk for obesity if their BMI is at or over the 95th percentile, or higher. Children who have a BMI at or lower than the 5th percentile are considered underweight and may be at increased risk for a condition known as failure to thrive.⁶⁸ For the 16 children for whom the CHEC site calculated a BMI, 11 (69%) had a BMI within the 95th or higher percentile, and were thus considered to be obese. For 3 of these children, CHEC sites made a referral to a nutritionist.⁶⁹ Further, there were 3 children identified as being within the 5th or lower BMI percentile, and were thus underweight. However, the OCA could find no evidence that these children were referred to a nutritionist by the CHEC sites.

Additionally, the original RFQ requires CHEC sites to routinely refer children ages 5 and under to the Women, Infants and Children Program (WIC).⁷⁰ The OCA's study found that of the 44 children who were 5 years old or under at the time of their CHEC evaluation, documentation noting a referral to WIC was present for only 7 children (16%), leaving 36 children for whom no referral was identified. It is unknown if these referrals were in fact made and not documented, or there were other reasons why the referral and service was not provided.

⁶³ National Center for Health Statistics, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 2007. "Prevalence of Overweight among Children and Adolescents: United States, 2003-2004." http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overweight/overwght_child_03.htm.

⁶⁴ National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition and Physical Activity. 2007. "Childhood Overweight." <http://cdc.gov/nccdphp/dpnpa/obesity/childhood/index.htm>

⁶⁵ American Academy of Pediatrics, Committee on Nutrition. 2003. Prevention of Pediatric Overweight and Obesity. *Pediatrics*, 112 (2).

⁶⁶ A Body Mass Index (BMI) calculation is a number, derived by using height and weight measurements, that gives a general indication if weight falls within a healthy range. The BMI is calculated by dividing a person's weight (in kilograms) by his/ her height (in meters, squared).

⁶⁷ Children 2 years of age and older are considered age-appropriate to receive a BMI calculation.

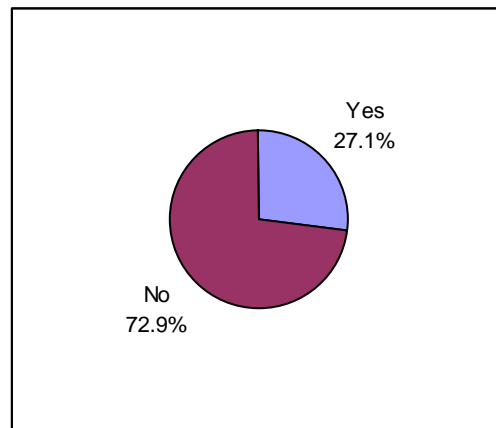
⁶⁸ Failure to thrive is a medical term which denotes poor weight gain and physical growth failure, usually in young children, over an extended period of time.

⁶⁹ It was unknown whether 1 child who fell within the 95th or higher BMI percentile was referred to a nutritionist.

⁷⁰ The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program), serves to safeguard the health of low-income women, infants, & children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.

This low rate among the CHEC sites in calculating BMI's and documenting a referral to WIC is concerning to the OCA, as this important information should be routinely gathered, assessed and documented by all CHEC providers, for all age-appropriate children who receive a CHEC evaluation. Additionally, referrals for nutritional assessments must be provided by CHEC sites as needed, since these services may provide valuable interventions early on in the child's life, assist the child's caregiver in meeting the child's needs and lead to improved overall child health outcomes. Follow-up to ensure the child has seen this health provider must also occur.

Chart 28:
BMI Calculated During CHEC
*n = 59**



**n = 59, as 21 children were under the age of 2 at the time of the CHEC.*

Mental Health

The Child Welfare League of America (CWLA) advises that, “Studies of the health status of children in care identify the pervasive presence of emotional disorders as the most serious unmet health problem.”⁷¹ Further, behavioral and mental health problems among children in foster care have been observed at a rate of two and a half times that observed in the general population.⁷² The American Academy of Child & Adolescent Psychiatry (AACAP), along with the CWLA, estimate that 85% of the over 500,000 children in foster care in the United States have an emotional disorder and/or substance abuse problem. To help address these staggering statistics, the AACAP/CWLA stresses the importance of providing, “The most timely, appropriate, and effective prevention/treatment services and supports to these children and their families to ensure the best outcome.” Strategies noted include responding to the child’s needs with culturally relevant staff and programs, as well as treating mental health issues in a timely manner with well-trained professionals using best practices.⁷³

⁷¹ Child Welfare League of America. 1988. “Standards for Health Care Services for Children in Out-of-Home Care.” Washington, DC: Child Welfare League of America, Inc.

⁷² Clausen, J.M., et al. 1998. “Mental health problems of children in foster care.” *Journal of Child and Family Studies*, 7: 283-296.

⁷³ American Academy of Child & Adolescent Psychiatry. 2007. “AACAP/CWLA Foster Care Mental Health Values Subcommittee.”

<http://www.aacap.org/page.www?section=Policy+Statements&name=AACAP%2FCWLA+Foster+Care+Mental+Health+Values+Subcommittee>

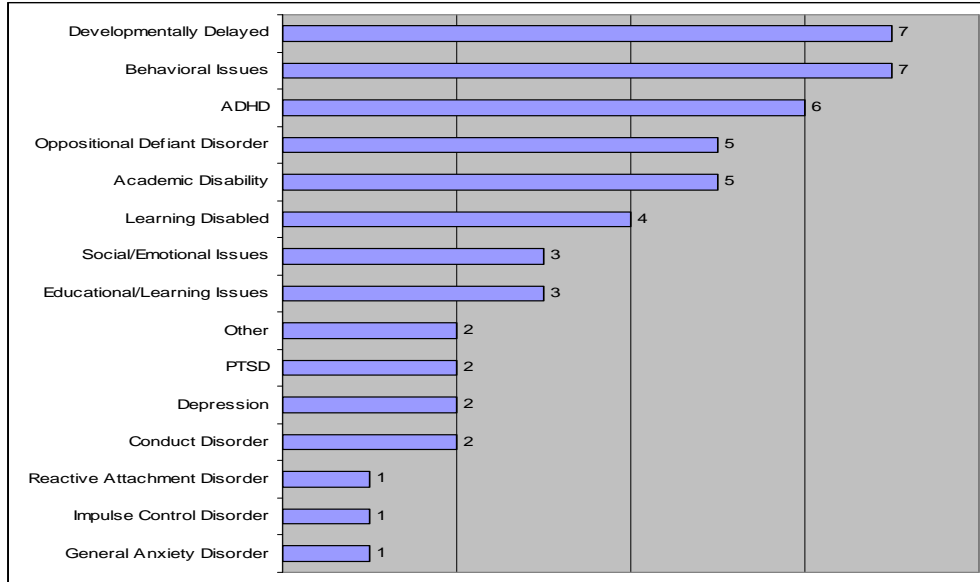
In order to comprehensively assess the well-being of children, the framework of the original CHEC evaluation includes a complete mental health evaluation of the child, and requires the evaluator to provide recommendations for continued mental health care. In the majority of existing CHEC sites, it appears mental health findings are linked with the findings of the child's physical exam to provide a point-in-time and baseline gauge of the child's overall status. This practice assures that all relevant information is connected to form a comprehensive Plan of Care that offers ongoing treatment providers, as well as DYFS staff and caretakers a full understanding of all that is happening or has occurred with the child.

Based on the 80 DYFS files reviewed by the OCA, 27 children (about one third of the sample) were identified as having a behavioral/mental health related issue *prior* to the CHEC evaluation. Of these 27 children, about half (14) were identified as having more than one mental health issue. Within these 27 cases, behavioral issues (7 children or 25.9%) and developmental delays (also 7 children or 25.9%) were the most prevalent, as was Attention Deficit Hyperactivity Disorder (ADHD) (6 children, or 22.2%). (See Graph 6)

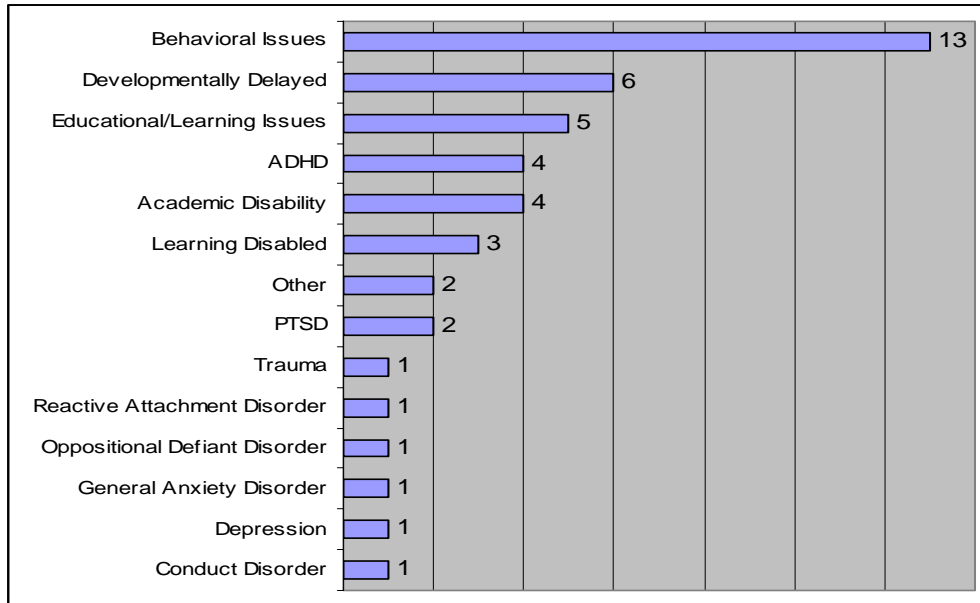
However, the OCA also reviewed the information that CHEC sites were provided by DYFS and the child's caregiver, to determine if this same information had been shared with the site by or during the time the child presented for the CHEC evaluation. Based on this review, the OCA found that CHEC sites identified pre-existing behavioral/mental health issues for 28 children (35%); 11 of those children (39.3%) had more than one identifiable issue. For 6 children (21.4%), developmental delays were identified as a salient issue, while emotional issues were identified as the most prevalent (13 children, or 46.4%).

On the whole, it appeared that the information DYFS provided to CHEC evaluators was similar to the information in the DYFS records, suggesting that DYFS made a good faith effort to share available mental health information with CHEC sites. Both DYFS and CHEC site data indicate that between a third and a half of children for whom behavioral/mental health issues were identified prior to the completion of the evaluation, presented with more than one developmental and/or mental health/behavioral concern. (See Graph 7)

Graph 6:
Frequencies of Previous Mental Health Issues by Type, per DYFS File



Graph 7:
Frequencies of Previous Mental Health Issues by Type – Noted by CHEC Based on CHEC Review of History



Based upon the 79 children who were stated to have received a mental health assessment at their CHEC evaluation,⁷⁴ 41 children (51.9%) were identified in this evaluation as having a mental health/behavioral health issue. (See Chart 29) Within this total, 18 children were identified as having more than one mental health/behavioral health issue. Of the issues identified at the CHEC evaluation, the most frequent diagnoses were developmental delays (14 children, 34.1%), trauma (13 children,

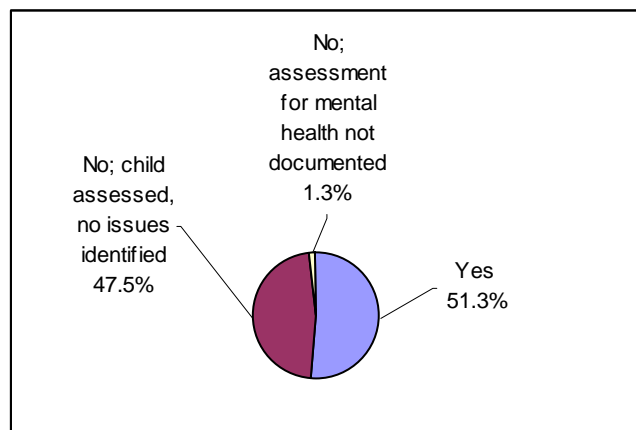
⁷⁴ Based on a review of CHEC files, the OCA determined that one child did not receive a mental health assessment during the CHEC appointment.

31.7%), and behavioral issues (10 children, 24.4%). (See Graph 8) Data regarding the follow-up services children received is discussed later in this report.

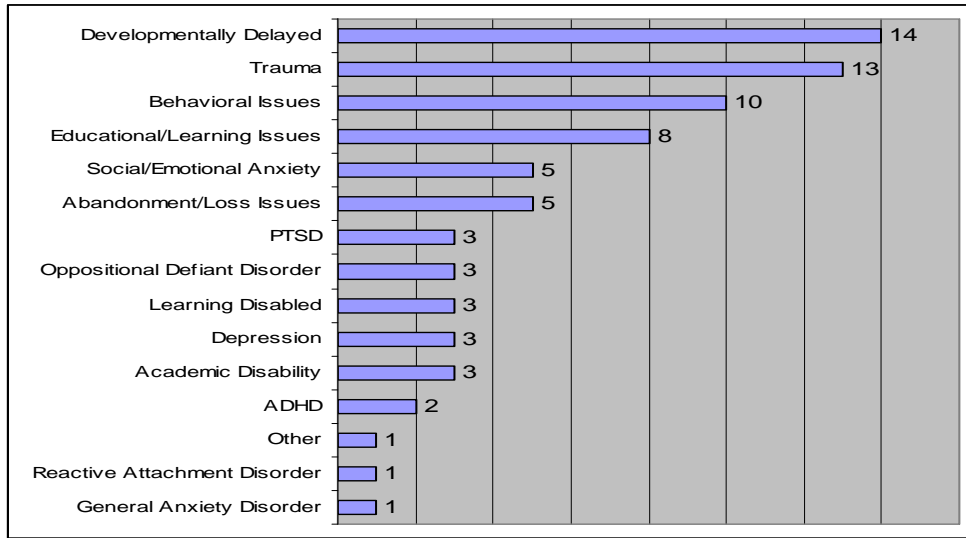
It is noteworthy that while intake data (information DYFS had within the case file and DYFS/caregiver provided to CHEC sites) indicated that about a third of all children entering placement within the OCA sample had at least one behavioral/mental health concern, the actual data after the child was evaluated through the CHEC identified at least twice that number. Thus, while initial charts showed that about 35% of children referred for CHEC evaluations had at least one previously identified behavioral/mental health issue, the data from the CHEC evaluations showed that 51.3%, or slightly over half of all children, were in need of intervention for mental health and behavioral issues. Thus, data in New Jersey seem to bear out the national findings indicating that mental health and behavioral issues are significantly represented among the children in the child protection system, thereby highlighting the critical need for careful examination of the specific problems evidenced by children and informing directions for program development.

To this end, data from this study evidences that particular areas of concern include developmental delays, educational and learning issues, childhood depression, trauma and oppositional defiant disorder. Problems in each of these areas were identified at twice the rate anticipated. For example, information based on what DYFS and/or the child's caregiver knew about the child's mental health status prior to receiving the CHEC showed that the percentage of all 80 children in the sample with developmental delays was estimated at 8.8%, yet CHEC findings yielded rates of 17.5%. Similarly, DYFS data around trauma and Post Traumatic Stress Disorder (PTSD) showed a combined estimated percentage of 3.8% for the 80 children in the sample, yet CHEC findings yielded a combined prevalence rate of 20.1%; over five times higher than the projected rate. This data reflects a need to target and focus treatment and to educate caretakers about specialized care for children with these issues.

Chart 29:
Presence of Mental Health Issues Identified at CHEC
n = 79



Graph 8:
Frequencies of Mental Health Issues Identified at CHEC



Within the realm of assessing for mental health/behavioral health issues, CHEC sites also have the requirement to evaluate children for age-appropriate neuro-developmental issues as well as special education needs (Early Intervention, Pre-school Disabled and school-based special services). A review of CHEC files reflected that an age-appropriate neuro-developmental assessment was completed for 70 of the 80 charts reviewed (87.5%). Of those reviews, 36 children (45% of the sample) were found to need special educational services. No special education needs were identified for 34 children (42.5% of the sample). However, for 10 children (12.5%), CHEC files did not reflect that an age-appropriate neuro-developmental assessment was performed. In sum, it appears that of the children for whom appropriate evaluations were conducted; about half of them were found to be in need of special services. (See Charts 30 and 31) Information relating to the follow-up of these identified issues is discussed later in this document.

Chart 30:
Use of Age-Appropriate Neuro-developmental Assessment at CHEC
n = 80

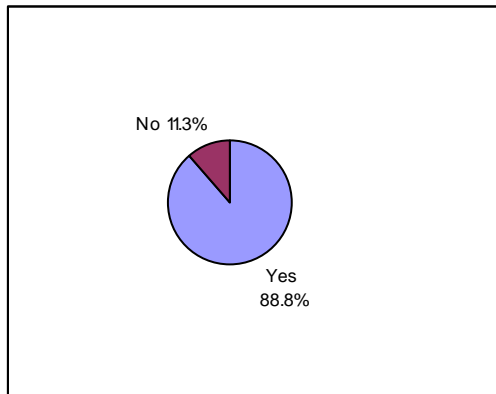
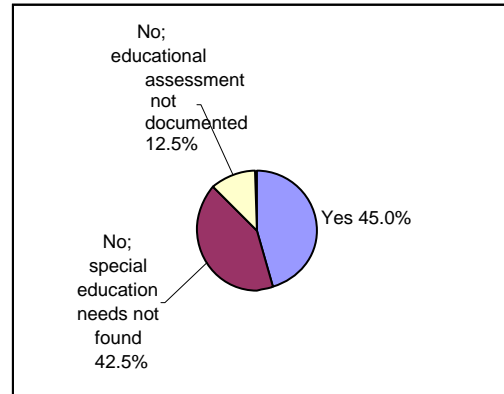


Chart 31:
Special Education Needs Identified at Time of CHEC
n = 80



**The age ranges of children in this category are as follows: 2 children ages 6-12 months, 2 children ages 3-5 years, 3 children ages 6-9 years, 1 child age 10-12 and 2 children ages 13 or older.*

For several CHEC sites, the OCA identified concerns about how mental health and neuro-developmental assessments are provided. As noted, 12.5% of reviewed CHEC reports did not conduct educational/neuro-developmental assessments or did not properly document them. In addition, OCA reviewers noted that for one child, the CHEC site conducting the evaluation did not document that a mental health assessment of any kind was even performed.

Additionally, there was evidence suggesting that mental health assessments conducted for 3 children were severely deficient, as they lacked any reference to the tools utilized to assess the child and did not detail how the information was gathered to arrive at the expressed clinical findings. Lastly, there appears to be variability in tests performed among the CHEC sites, as well as variability within sites, based upon the mental health professional who is evaluating the child. Thus, a lack of uniformity across sites with respect to the selection and utilization of assessment tools is an area that needs to be addressed.

Provision of CHEC Services

Compliance with Appointment

Ensuring that the child receives the CHEC evaluation is a basic responsibility of DYFS, in consultation and partnership with the child's identified caregiver. Information provided to the OCA by each of the CHEC sites revealed an alarming number of appointments made for the CHEC that were subsequently not kept. Specifically, data received from the 7 CHEC sites revealed there were 460 appointments identified by the CHEC as "no-shows" for calendar year 2006. This represents a current overall no-show rate of 18.9%. Of concern is the fact that these 460 appointments were identified as situations where a call to the site to cancel or reschedule the appointment was either not received, or the call came after the 48-hour window allotted to DYFS for cancelling an appointment.⁷⁵

A high percentage of no-shows to the CHEC evaluation is problematic. Children entering out-of-home placement need to receive the CHEC within 30 days of entry into out-of-home placement. The fact that there is a large number of no-shows further demonstrates that CHEC evaluations are not occurring within this specified timeframe as many of the CHEC sites report that they are experiencing up to a 6-month scheduling delay.⁷⁶ No-show appointments exacerbate the existing problem of a lack of sufficient resources for all children to receive the service. In essence, when appointments are not kept (regardless of the reason), and the CHEC site is not advised in advance, the result is an empty slot that cannot be filled by another child. Un-filled appointments cannot be billed for reimbursement, and thus, result in the CHEC site absorbing the costs for professional time, other personnel expenses and office space. The end result is a cycle of appointments made, appointments not kept and an extended delay to reschedule, as well as the CHEC site's inability to adhere to a timely process for filling the open appointment slot.

A review of DCF policies around the CHEC evaluation process revealed that there are no instructions to guide field staff to call CHEC sites 48 hours prior to the appointment. While some individual sites

⁷⁵ DYFS and the CHEC sites maintain an arrangement where appointments are considered "no-shows" when a call to cancel or reschedule the evaluation is not received 48 hours prior to the child's appointment. CHEC sites report this information to DCF monthly.

⁷⁶ Based on the information provided to the OCA by individual sites, several indicate that it is not uncommon for the waiting list for a CHEC evaluation to be approximately 4-6 months. There is individual variation by site.

report that they currently work with DYFS Area and Local Office leadership to address the high no-show rate, the issue remains prevalent.

The OCA recommends that DCF revise its existing policy to reinforce the need to contact CHEC sites prior to the 48 hour window if the appointment cannot be kept.

Timeliness

The CHEC evaluation is intended to provide a point-in-time snapshot of a child’s medical and mental health well-being early on in the child’s initial out-of-home placement. The framework of the CHEC calls for the evaluation to occur within 30 days of an out-of-home placement to ensure that the medical and mental health needs of the most at-risk children are immediately identified and addressed. This timeframe is in keeping with AAP and CWLA best-practice guidelines which stipulate that comprehensive health and mental health assessments occur within the first 30 days of the child’s entry into out-of-home care. Additionally, the need for individuals involved in the decision-making for the child need this information to ensure timely follow-up is received, the caregiver is knowledgeable about the child’s needs and that this information is incorporated into the child’s overall case plan.

Similar to the 2005 OCA CHEC review findings, data in this study identified the fact that children are still not receiving the CHEC evaluation within the required timeframe. The median timeframe for receiving the CHEC was determined to be 126 days from most recent out-of-home placement until the CHEC appointment date. In only one case noted by the OCA upon the review of CHEC and DYFS files, did a CHEC evaluation occur within the intended 30-day timeframe. Further, only 11 children (13.7%) had CHEC evaluations completed within 60 days of an out-of-home placement. This is exceptionally concerning, as 86.3% of children, therefore, waited over two months to receive a comprehensive medical and mental health assessment. (See Charts 32 and 33)

Moreover, the average number of days from the CHEC evaluation until the date of the final CHEC report was 41, with one case taking 206 days, (over 6 months) until final CHEC information was shared with appropriate parties.

Chart 32:
CHEC Completed in 30 Days or Less
n = 80

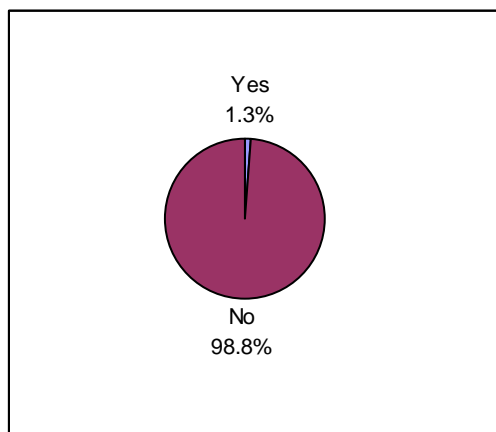
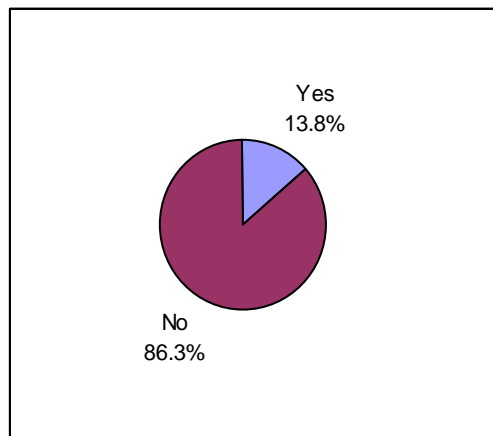


Chart 33:
CHEC Completed in 60 Days or Less
n = 80



Timeliness for children receiving CHEC evaluations and follow-up to ensure Final Reports and Plans of Care are received, must be an area of immediate priority for DCF and the CHEC sites. There is little doubt that timeliness issues can be linked to the current shortage of CHEC resources and significant rates of appointment “no-shows”; however, increased oversight and follow-up to ensure this service is scheduled and received and no-show rates are minimized are key ingredients for overall improvement in this area.

Family Participation and Information Provided to CHEC

This comprehensive OCA study clearly demonstrates that DYFS files contain sporadically documented and incomplete medical records and incomplete medical history on the child under DYFS supervision. While it can be difficult to collect previous health history on a child who enters placement, such information is vital to ensure the child’s health care needs are identified and met. Additionally, case worker knowledge of basic health and mental health information regarding the child must be assured and included in case planning activities that occur on the child’s behalf. DYFS is responsible for the timely collection of relevant medical records and for providing such information to CHEC sites and all treatment providers.

In the absence of complete medical records, an effective method for obtaining a child’s health history is through interviews with birth parents, caregivers, and relevant others who have knowledge about the child. To this end, the person accompanying a child to their CHEC appointment is crucial to ensuring the overall completeness of the CHEC evaluation. The information these individuals may bring to the evaluation can help the CHEC clinician better understand the history of the child, whether any current concerns exist, and can ensure the CHEC sites formally document this information and incorporate it into plans for follow-up care.

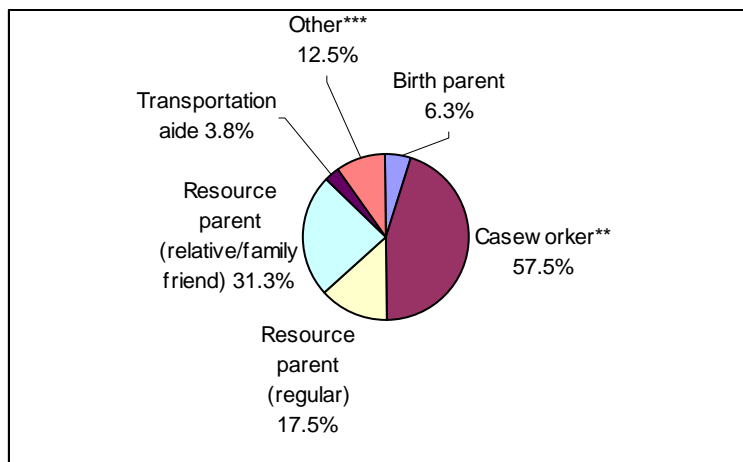
The OCA’s study found that the majority of children are accompanied to their CHEC appointment by their assigned DYFS caseworker (46 children, 57.5%). A total of 39 children (48.8%) were accompanied by their identified resource parent. Of concern is the fact that 3 children were brought to their CHEC evaluation by a DYFS-contracted transportation/case aide, and 10 children were brought by an individual listed as “other”.⁷⁷ There were however, 23 children who were accompanied to their CHEC evaluation by more than one individual. In 5 cases reviewed, the child was also accompanied to the CHEC evaluation by their birth parent, which, depending on individual circumstances, is usually an ideal situation, as this person is often the one with the most historical information on the child. (*See Chart 34*)

As previously stated, a significant component of the CHEC is the ability of the CHEC clinician to provide anticipatory guidance to the child’s caregiver during the CHEC evaluation. Helping the caregiver understand the child’s diagnoses, overall findings and treatment needs are crucial elements to supporting the caregiver and for ensuring that individual has the resources and skills necessary to meet the child’s needs. It is noteworthy that OCA reviewers identified situations where resource parents did not attend the CHEC evaluation, and apparently did not contribute in any way to providing the CHEC with background information or in receiving the results of the evaluation. Also concerning is the fact that CHEC sites have advised the OCA that resource parents are at times dissuaded by the DYFS case worker from attending the child’s CHEC evaluation, and the value of the exam is clearly

⁷⁷ “Other” refers to a covering DYFS case worker, siblings, relative of the resource parent or a staff person from a residential facility.

not presented to the caregiver. Given the critical importance of the CHEC, and the likelihood that a resource parent who is supported, knowledgeable and understanding of the child will be better positioned to meet the child’s needs, ensuring that resource parents understand the value of the CHEC and are encouraged to be present must be a priority for DCF and DYFS field staff.

Chart 34:
Person Accompanying Child to CHEC
*n=80**



**23 children had multiple people accompany them to the CHEC.*

***This indicates child’s assigned caseworker.*

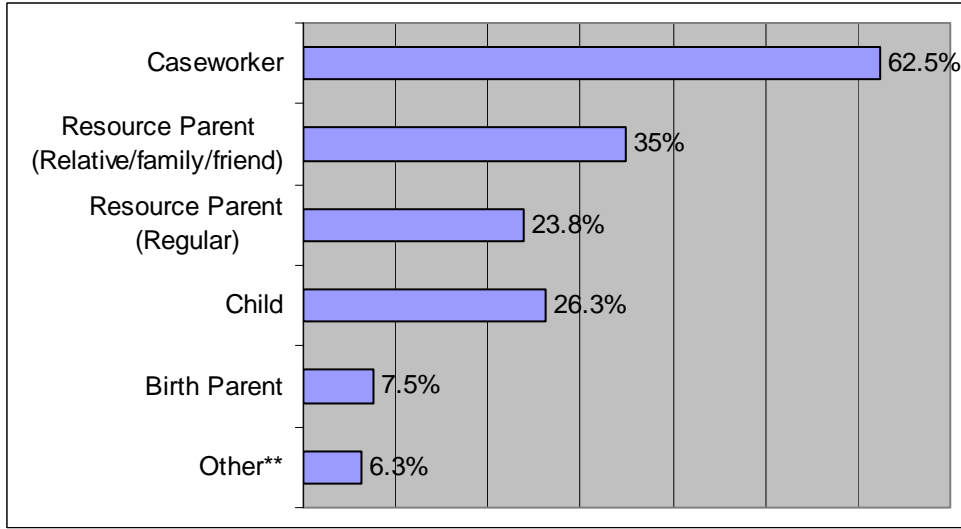
****This category includes caseworkers who were not the child’s assigned worker at the time of the CHEC, siblings, relatives of the resource parent, and caregivers from residential placements.*

Source and Method for Providing Information to CHEC Site

Overall, the child’s DYFS case worker was most frequently identified in the OCA study as the individual providing historical information to the CHEC site. For 50 children (62.5%) in the sample, DYFS was identified as the source for providing the child’s information to the CHEC site. For 47 children (58.8%), resource parents were identified as the source of information. There were 21 children (26.3%) in the sample who were identified as providing their own medical history and background information. For 6 children (7.5%), birth parents were the identified source, and for 5 children (6.3%), the source of information was listed as “other”.⁷⁸ It is noteworthy that for 44 of the 80 children (55%), multiple individuals were identified as having provided historical information regarding the child to the CHEC site. (See Graph 9)

⁷⁸ For the purposes of this report, the term “other” in this category means siblings, caregivers from residential placements, as well as transportation aides.

Graph 9:
Person Providing History to CHEC Site
*n=80**

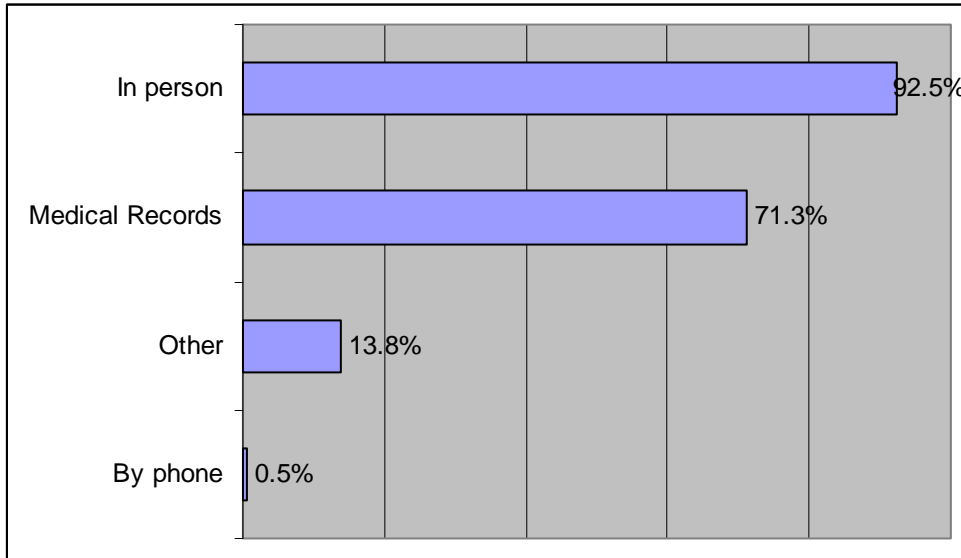


**44 children had multiple people providing history to the CHEC site.*

***This category includes siblings, caregivers from residential placements and transportation aides.*

For the majority of children, (74 or 92.5%) information concerning the child was provided to CHEC site in-person. For 57 children (71.3%), additional information was obtained through the provision of the child’s medical records. In a small number of cases, CHEC sites obtained a child’s history via phone contact (4 children, 5%), as well as through school records and the mail (11 children, 13.8%). (See Graph 10)

Graph 10:
Method of Providing History to CHEC Site*



**For 61 children, there were multiple methods of histories being provided to CHEC sites.*

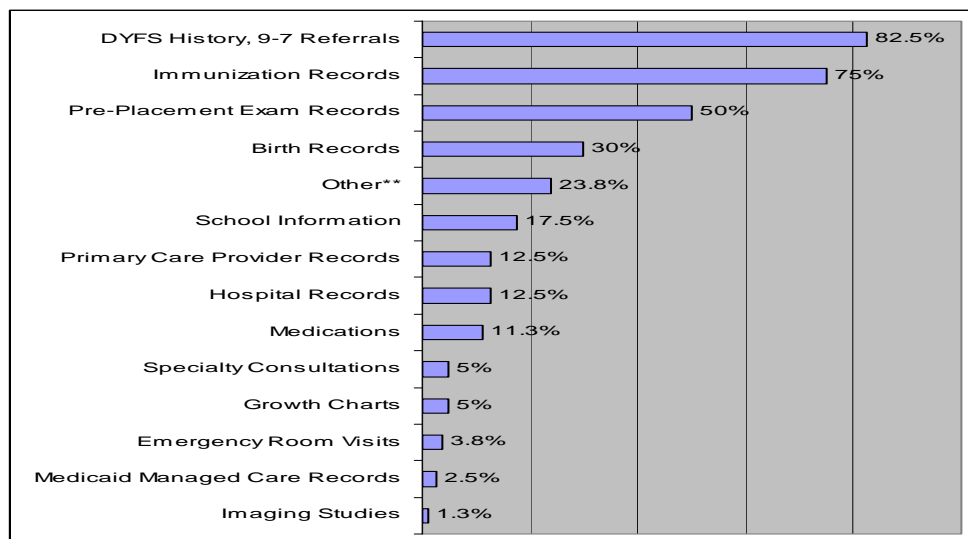
***This category includes history being provided by mail, by a survey sent to the resource parent, and through school records.*

It is encouraging that background information regarding the child appears to have come from multiple sources, as this implies that CHEC sites are seeking this information and DYFS staff and caregivers are perhaps responding to some degree to this request. In 82.5% of the cases reviewed by the OCA, there was evidence that DYFS history, such as the documented referral to DYFS,⁷⁹ was provided to the CHEC sites. Moreover, for three-quarters of the children in the sample, an immunization record was provided to or electronically obtained by the CHEC site.

However, DYFS provided the CHEC with a copy of the child’s pre-placement exam form in only half of the cases (40 children, 50%) reviewed by the OCA, despite the fact that every child is required to receive a pre-placement exam prior to placement, and this exam is required to be documented on a DYFS form. Also concerning is the fact that the child’s birth records were provided to the CHEC site in only 30% of cases, even though obtaining this type of collateral information is a requirement by policy and a stipulation of the original CHEC RFQ. *Graph 11* depicts a complete breakdown of all information provided to CHEC sites in cases reviewed.

Additionally, while *some* significant information was provided to the CHEC sites from a variety of sources, in 70% of CHEC evaluations, OCA reviewers found evidence in the CHEC report that the completeness of the evaluation was compromised by missing records. It is also apparent that in many of the cases, DYFS had information it could have shared with the CHEC site prior to the child’s evaluation, but did not do so for unknown reasons.

Graph 11:
Information Provided to CHEC Site
n = 80*



**73 children had more than one type of information provided to the CHEC site; each percentage is based on the total sample of 80 children.*

***6 of these include unclear documentation or no documentation as to what information was provided; making it indeterminable what records the CHEC site had access to.*

⁷⁹ Referrals to DYFS alleging abuse/neglect or requesting services are identified in this report as a “9-7”.

Information Sharing

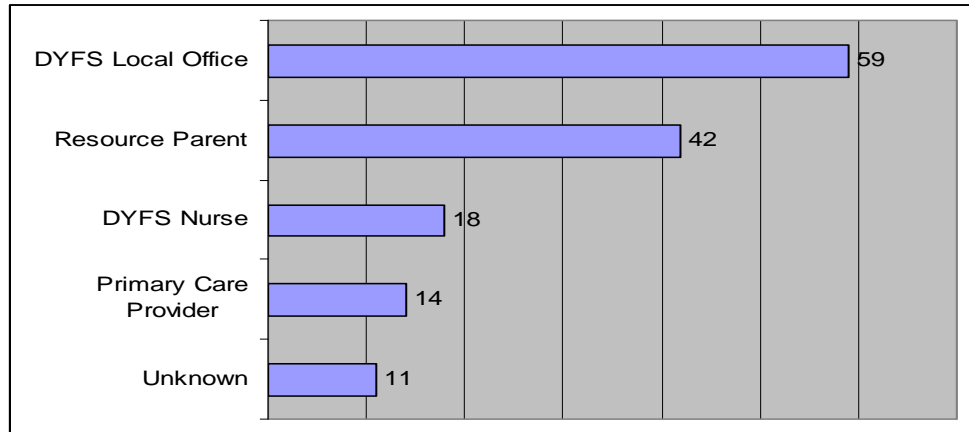
Throughout the study, the OCA team identified differences between specific CHEC sites with regard to their distribution of final CHEC reports and Plan of Care (POC) reports. The CHEC POC is intended to be an overview of any issues identified at the CHEC evaluation, as well as specific recommendations and timeframes necessary to address the child’s needs. The POC provides a tangible document to caregivers, treatment providers and DYFS case workers to assist in meeting treatment needs in a timely manner.

For 59 children (73.8%), the POC was provided by the CHEC site to DYFS local offices. However, the OCA reviewers determined that the POC was shared with resource parents for only 42 children (52.5%). Primary care providers received the POC for 14 children (17.5% of the time), and DYFS nurses received the plan for 18 children (22.5% of the time). (See Graph 12)

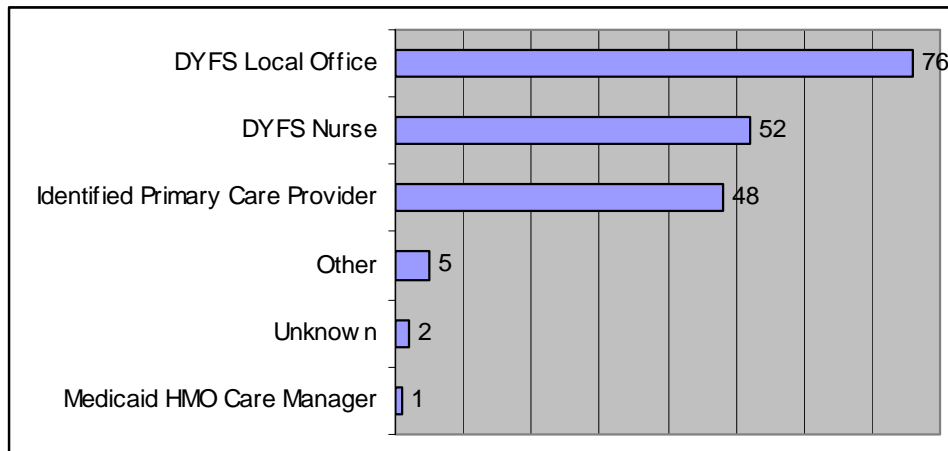
Like the POC, the child’s Final Report provides essential information concerning the full outcome of the CHEC evaluation, including the results of any follow-up testing and diagnostic screening. For confidentiality reasons, the Final Report is not required to be shared with resource parents in keeping with confidentiality laws and restrictions.

The OCA found evidence that the Final Report was provided to DYFS for 76 children (95%). CHEC sites also shared this report with DYFS local office nurses for 52 children (65%). Final reports were provided to an identified primary care physician for 48 children (60%). Of concern is the fact that the CHEC sites distributed the Final Report for only 1 child (1.3%) to a Medicaid HMO care manager. (See Graph 13)

Graph 12:
Plan of Care Distribution



***Graph 13:
Final Report Distribution***



Compliance with CHEC Recommendations

Also similar to the 2005 OCA review, once again, the OCA found significant evidence that children are not receiving timely and full follow-up on treatment recommendations identified during the CHEC evaluation. This is especially concerning and suggests that despite the fact that the CHEC has been operational within DYFS for nearly three years, the basic health and treatment needs of children in out-of-home care remain frequently unmet.

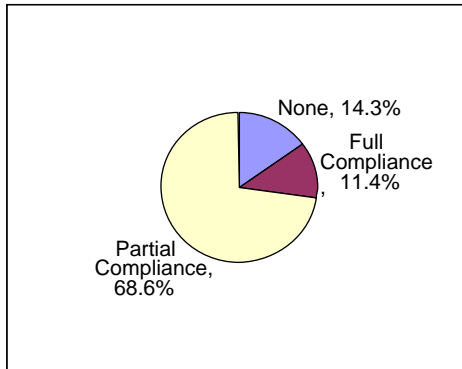
In this study, the OCA established three areas of measurement to determine if recommendations were met regarding the child’s health/treatment needs. Reviewers were asked to rate compliance within the following guidelines:

- Full compliance: there is evidence from a review of DYFS and CHEC files that the child received follow-up on all recommendations made by the CHEC site.
- Partial compliance: there is evidence from a review of DYFS and CHEC files that the child received follow-up on at least one recommendation made by the CHEC site.
- Non-compliance: there is evidence from a review of DYFS and CHEC files that the child received no follow-up on any recommendation made by the CHEC site.

Physical Health

Full compliance with all medical referrals and recommendations provided by the CHEC evaluation occurred for only 8 children (11.4%). There was evidence of partial compliance for treatment needs for 48 children (68.6). However, for 10 children (14.3%) the OCA review team determined that there was no evidence to support that *any* medical referrals or recommendations from the CHEC evaluation were completed. (See Chart 35)

Chart 35:
Compliance with Medical Referrals and Recommendations from CHEC Evaluation
n = 70*

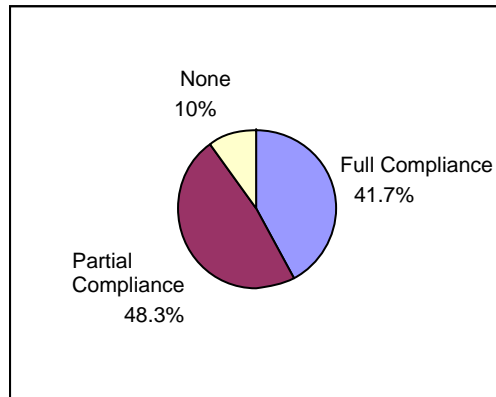


**n=70 as 10 children did not have medical referrals/recommendations from CHEC clinicians.*

Mental Health

For 25 children (41.7%), the OCA study identified evidence of full compliance with all CHEC mental health referrals and recommendations. Partial compliance with treatment and referral recommendations for mental health services occurred for 29 children (48.3%). There were 6 children (10%) that received no follow-up on CHEC referrals and recommendations for meeting their mental health needs. (See Chart 36)

Chart 36:
Compliance with Mental Health Referrals and Recommendations from CHEC Evaluation
n = 60*



**n=60 and is based on the number of children who received mental health referrals/recommendations at CHEC evaluations.*

OCA Key Findings

After careful examination of the information gathered through this study process, the OCA has identified significant findings regarding the CHEC program:

- *The strengths of the CHEC program lie primarily in the expertise and commitment of the dedicated professionals who serve New Jersey's children at the various CHEC sites;*
- *Significant and valuable "snapshots" about the child's health, developmental and mental health status are learned from the provision of the CHEC service;*
- *Critical information concerning identified diagnoses and recommendations for treatment are documented through a CHEC evaluation;*
- *The OCA's study shows that CHEC clinicians uncover and document the prevalence of health issues than were previously identified by others involved with the child;*
- *Children identified in this sample had significant health and mental health diagnoses and treatment needs. These findings are comparable to rates of medical and mental health diagnoses as reported in national data concerning children in out-of-home placement;*
- *It is estimated that less than one-third of children who entered DYFS out-of-home placement in 2006 received a CHEC evaluation;*
- *Children do not receive the CHEC within the recommended 30-day timeframe; the median timeframe for children actually receiving the CHEC is four months from most recent out-of-home placement until the CHEC appointment date;*
- *Children do not receive full and timely follow-up of all recommended treatment and services after the CHEC;*
- *The study reveals that only 11% of children received full follow-up to all medical referrals and recommendations made by the CHEC clinician;*
- *Full caregiver participation, including resource parents and birth parents is infrequently occurring;*
- *There is no evidence of an identified system or policy within DYFS for gathering, organizing and regularly updating information about a child's health history, treatment/services received or health status;*
- *Valuable clinical information is not routinely made available to either CHEC providers or to other persons closely involved with the care and oversight of the child, despite the fact that this information is often present in the child's DYFS record or can be readily accessed by other means;*

- *Integration of the CHEC model into routine DYFS case practice, including the assimilation of clinical findings and treatment recommendations into case planning and follow-up to ensure these recommendations are implemented, requires significant improvement;*
- *There is variation in how CHEC services are provided at each site;*
- *Significant variation exists within the CHEC sites regarding the tools utilized to conduct mental health assessments;*
- *Uniformity is lacking in the formats CHEC sites use for their reports;*
- *Variation exists with how the findings of CHEC are shared with DYFS, the caregiver and other persons closely involved with the care and oversight of the child;*
- *Variation exists among the CHEC sites in the timely provision of final reports and Plans of Care;*
- *Throughout the nearly three years the CHEC program has been operational, State oversight and support of this essential and critical program has been inconsistent; and*
- *DCF and DYFS lack a functional system for quality review and improvement of this service, including the collection, tracking and measurement of relevant data.*

Health Matters:

Making Child Health a Priority in Reform

The issues identified in “Health Matters”, the OCA’s study of the CHEC program, clearly highlight that a system for the provision of health and mental health services for children is an area of reform requiring immediate attention by DCF executive leadership. In areas DCF has established as a priority, there is evidence that the State is working to meet their identified goals. Success has been reported in lowering caseload sizes for front line staff, re-organizing staff responsibilities and establishing new resources to ensure child safety. Other identified areas of achievement include securing timely permanency through adoption for children whose parental rights have been terminated and in the creation of additional resource family homes.

The OCA recognizes that DCF is handling a myriad of competing priorities in its attempt to overhaul the child welfare system and we continue to offer our support to DCF in these efforts. However, the OCA also firmly believes that to date, these strategies have focused significantly on systems to improve child safety and permanency. And while these are unquestionably areas in need of reform, issues related to child well-being are not progressing with the same sense of urgency or leadership buy-in. DCF leadership, from executive management to Area Director, Local Office Manager and Case Work Supervisor, must embrace the idea that immediate steps to ensuring child health are necessary before any real progress can be made in this area.

In its publicly released 2007 Coordinated Health Care Plan for Children in Out-of-Home Placement, DCF articulates some definitive plans to achieve an integrated system for delivering health services to children. The plan outlines that building this quality system will take significant time and resources whereby meaningful steps toward full implementation are well over a year down the road. Missing from this plan is the fact that approximately 10,369 children currently in DYFS out-of-home placement simply cannot wait for this system to be implemented. Immediate, interim steps must be taken by the State to ensure the basic provision of health care.

The OCA believes that DCF has unique opportunities to enhance the CHEC program. This report points to the way in which DCF can develop a model system for the delivery of health related services to children under DCF supervision. By fully implementing the following best practice-based recommendations, and through ongoing collaboration with key stakeholders currently providing health services to children, including in-depth internal analysis of its current systems and goals, DCF can ensure that 1) the health needs of children served by DYFS are prioritized with appropriate management and timely follow-up 2) optimal program improvement measures are established and tracked and 3) a solid foundation exists to build capacity to meet the health and mental health needs of children in out-of-home placement.

OCA Recommendations for Enhancing the Delivery of Health Services

A. Improve DYFS Case Handling:

1. Address Overall Policy Development and Case Management

- Decreasing case load sizes in most offices provide a significant opportunity to immediately improve case handling surrounding basic child health issues. The OCA's study highlights the fact that current DYFS case practice and policies are in need of revision to ensure health-related issues are a priority. At a minimum, DYFS policies must be re-established to require that case workers routinely ask caregivers about the child's identified health insurance plan, identified primary care physician, dentist, mental health providers and other specialists, as well as the child's scheduled health appointments, CHEC exam, identified diagnoses and treatment needs. Discussions with caregivers regarding these issues must take place during established visitation schedules and phone contact, and be tracked by frontline supervisors, Local Office Managers and Area Directors to ensure full compliance. Guidelines for documenting this information into worker case notes must be reinforced by DYFS management and supervisory staff.
- Research shows that a number of states have implemented "well-being checklists" for case workers and other professionals involved in child welfare. Generally, these checklists identify key questions and help elicit important information that tracks the child's health and well-being status. This tool allows all participants to work towards achieving measurable progress in well-being-related outcomes and helps establish consistent areas of monitoring for case work staff. Additionally, information obtained through the checklist assists workers in establishing that current or anticipated caregivers can meet identified needs and in recognizing those services and providers necessary to achieve desired goals. The OCA strongly encourages DCF to immediately engage in the process of developing such a tool for its case work staff and begin

the process of requiring that information collected from the tool is inputted into the child's DYFS electronic and paper record.

- In the newly implemented NJ SPIRIT system,⁸⁰ DYFS case worker staff can now document basic health and mental health information, and with the click of a button, supervisors and managers can review the files of each child to ensure compliance.
- The 2007 DCF Coordinated Health Care Plan for Children in Out-of-Home Placement re-introduces the strategy of placing child health units in each DYFS local office. The OCA applauds this goal; it has been a long time in coming! The idea of having medical units, comprised of pediatric nurses and other personnel in each office with the responsibility for coordinating the health and mental health care for all children under DYFS supervision is a concept previously presented to, but not embraced by, former DYFS leadership teams over the course of many years. Moving forward, DCF must prioritize the implementation of this initiative and by June 2008, establish these units in all DYFS local offices.⁸¹ The OCA believes that timely implementation of these units must occur and include collaboration with stakeholders currently providing health-related services to children. Additionally, by starting with those offices which have established collaboration with CHEC sites, timely follow-up on a child's CHEC identified health needs can be assured.
- The OCA has previously provided DCF with suggestions for job duties for nurse health care coordinators and medical records staff for DYFS child health units to ensure that at a minimum, children are, 1) scheduled for and receive CHEC evaluations shortly after initial placement, 2) linked to a medical home, dental providers and with needed specialists, 3) receive timely and full follow-up occurs on all treatment recommendations, and 4) receive ongoing well child visits, dental visits, and care for identified mental health needs. Stakeholders need to work collaboratively with DCF, OCA, and legislators as needed to ensure that adequate funding is earmarked for this essential and missing piece, necessary to meet the health needs of children in DYFS out-of-home placement.

2. Collect Vital Health Information

- The child's health-related information must move through the protective service system with the child. DCF needs to establish a process for gathering, organizing and updating comprehensive and accurate medical records for children, including a medical issues sheet that identifies the child's past and current health and mental health status, treatment received and outstanding health/mental health needs. This sheet should be a synopsis of information identified through regular case monitoring and updated as information is received (as stated above and in utilizing checklist guides). Additionally, including this information electronically

⁸⁰ NJ SPIRIT stands for New Jersey Statewide Protective Investigation, Reporting and Information Tool. "NJ SPIRIT is a comprehensive, automated case management tool that integrates various aspects of case practice in a single statewide system, including intake, investigation, case planning, resource management, service delivery tracking, and financial management."

⁸¹ At the time this study was printed, DCF announced its commitment to build child health units in all local offices by December 2008. The Office of the Child Advocate applauds this initiative.

will facilitate the creation of the child's "health passport", which is a record that is readily accessible and moves through the system with the child.

- In January 2007, DCF publicly released its description of a new Case Practice Model, "intended to define who the agency serves, the expected outcomes of these services, and the guiding principles and expectations of the organization." Within the framework of this Model is a commitment to conduct mandatory Family Team Meetings (FTMs) prior to or within 72 hours after a child's placement into out-of-home care.⁸² In October 2007, DCF articulated its plans for implementing this Case Practice Model. Included in this plan is an extensive outline for training DYFS staff on the concept of family engagement. However, a target date for full implementation of FTM's is not addressed. The FTM is the ideal time to gather needed pre-existing health and mental health information on the child from those sources most likely to have it. Additionally, identified health professionals within local DYFS child health units should participate in these meetings to immediately begin the process of health care planning and data collection. At subsequent family meetings, DYFS staff can use this time as an opportunity to update all interested parties on the child's health status and care/treatment received.
- By utilizing a one-page health background information sheet (such as the one developed years ago by the now defunct RDTC Advisory Council, in collaboration with DYFS), essential information can be gathered by DYFS at family meetings for: 1) collecting the child's medical records 2) identifying previous and current health providers 3) identifying chronic and acute medical issues, birth history etc. 4) reviewing the child's use of medications and 5) identifying any other relevant health related issues/concerns. The OCA encourages DCF to re-visit this idea and implement this process.

3. Eliminate Barriers to Information Sharing

- Contrary to the current practice revealed through this study, all information concerning the child's health history, health status and identified treatment needs must be routinely shared by DYFS field staff with the child's identified caregiver and birth parent. Additionally, individuals such as law guardians, family court judges, Child Placement Review Boards and other decision-makers require this information to appropriately act in their identified roles. This information must also be shared with the child's birth parent when reunification occurs; shared with the adoptive/Kinship Legal Guardian (KLG) caregiver when the child achieves permanency through adoption or KLG; or with the child when of sufficient capacity or when independent living is achieved. DCF should work to update policies on information sharing as needed. Directives to share information can be immediately facilitated through regular DYFS Central Office formal communications to all staff, and through DYFS area and local office staff meetings.
- Based on the findings of this study, CHEC sites and DCF must collaborate to ensure standardization for the process and responsibility for sharing completed CHEC reports with essential stakeholders. For example, a "full CHEC report" should be sent to the DYFS Health Care Coordinator/local office child health unit and the child's assigned worker/supervisor so

⁸² Family Team Meeting means structured planning and decision-making meetings that utilize trained facilitators to engage families, family supports, and professional partners in creating plans for children's safety and well-being and in outlining strategies to achieve permanency for the child.

that they may track the timely and appropriate follow-up to recommendations. At present, some CHEC providers send only Plans of Care to DYFS as the final report. Merely sending DYFS the Plan of Care does not reflect the comprehensiveness (or, in some cases, the lack of provision of services) that OCA found in its review of the full CHEC reports. Some sites send full CHEC reports to DYFS, to identified primary care providers, to Medicaid managed care coordinators, and with releases, to Law Guardians; other sites send a full report to only DYFS and rely on DYFS to send the report or parts thereof to other stakeholders. The OCA's study found that currently, DYFS case workers do not forward CHEC reports to essential stakeholders, nor do they have a clear directive or expectation to do so.

4. Coordinate Children's Health Care

- DCF must develop local and area office systems, as well as a centralized monitoring system to ensure that health care recommendations identified through the CHEC for children in out-of-home placement are actually being followed. In addition to monitoring activities completed by the child's identified case worker with supervisory direction and oversight, full implementation of local office child health units can assure needed follow-up occurs. As an interim, step, and in addition to beginning with DYFS local offices which have an established CHEC site, DCF should consider moving expeditiously to hire professionals who can immediately assume the responsibility for scheduling and tracking CHEC evaluations, and follow-up with CHEC sites to receive the child's Final Report and Plan of Care. Additionally, this individual can ensure that reports are disseminated to those individuals working with the child.
- In forming DYFS child health units and in developing and implementing a system for coordinating children's health care and treatment needs, DCF must ensure that the child's DYFS worker is aware of the plans and treatment needs for the child. An electronic and/or hard copy notification system to alert case work staff of ongoing activity by the health care unit staff on the child's behalf is suggested.

5. Integrate Health Information into Child Welfare Case Planning

- Repeatedly throughout this study, the OCA found evidence to indicate that vital health information was not routinely included in DYFS documentation and case plans. The OCA recommends that DCF immediately establish the practice of integrating information regarding the child's physical, developmental and mental health into case planning and into all key decisions made on the child's behalf. Children regularly move in, out and around the child welfare system and many experience multiple caregivers in addition to regular case worker turnover. Formally documenting health information, and subsequently using this information when making key decisions on behalf of the child and family, are essential ingredients to ensuring that sound and substantive case plans are established.
- While DYFS has responsibility for ensuring that the needs of children in out-of-home placement are met, there is also a larger community of individuals and agencies involved in the child welfare system. Best practice emphasizes that judges, attorneys, social workers, service providers, caregivers, and others who work with children and families, focus on and diligently track efforts to ensure well-being. Collaboration among these system entities must occur. This includes representatives from other systems serving the child as well as caregivers and birth families. These individuals need to be brought into the oversight process, and encouraged to

ask about and monitor information about the child's health and mental health to allow for coordinated and consistent oversight.

6. Clarify and Support the Medicaid Managed Care Enrollment Process

- The findings of the OCA's study demonstrate the need for DCF to re-establish supportive efforts for the managed care enrollment process for children as they enter and change out-of-home placement. Resource parents must understand the need to enroll the child. They need DYFS assistance and support throughout this process to establish a medical home for the child early on in their placement. Establishing this linkage will enable the child to receive all ongoing treatment and care and will assist in the communication of information to the identified health provider.

The OCA study confirms that there is a pressing and current need to improve the Medicaid HMO enrollment process. As an interim measure while child health units are being formed, DYFS field staff have the ability to work with support staff in their local office and others to identify any existing Medicaid coverage at the time of placement.⁸³ This information must be shared with the child's new caregiver, who may then opt to continue this child with the same health provider and/or stay within the same plan. Policy and practice must be updated to reflect that within 5 working days of the child's placement, the child's DYFS case worker identifies the resource parent's choice of plan for Medicaid managed care, documents that the child is in the process of enrolling, verifies completion and assists resource families as needed in this process. DYFS supervisory oversight to ensure the child is linked to a managed care plan or has an established medical home through fee-for-service must also exist. Efforts must also be undertaken to identify a dental provider for the child.

7. Re-Assess the Child's Health Status

- Children move through a varied amount of experiences and developmental stages while in out-of-home care. The OCA recommends that DCF develop and implement a system for the periodic re-assessment of the child's health, developmental and emotional status to assess progress and changes in the child and need for additional services and interventions. In keeping with American Academy of Pediatrics (AAP) and American Academy of Child and Adolescent Psychiatry (AACAP) best practices, these assessments should occur every 6 months in first year of placement and yearly thereafter. Additional points where re-assessments may be beneficial for children in out-of-home care occur particularly around times of transition, such as transition to a new out-of-home placement and especially before reunification with birth family and/or other permanency placement. The OCA recommends that DCF work with its provider community to establish parameters for when and how re-assessments will be completed.

⁸³ Additional assistance may also be obtained through the State's Health Benefits Coordinator via a toll-free number, as well as through the DCF Child Health Unit, local office Resource Family Support staff and local Medicaid Offices.

B. Standardize Health Practices

1. Establish Basic Areas of Standardization within the CHEC Framework

- This study documents a need for DCF and CHEC site collaboration to standardize CHEC reporting templates statewide. Additionally, DCF must share these templates with all newly established providers. Such templates must include domains of information important to DYFS in its case handling and tracking, as well as the domains of care indicated by the RFQ, in accordance with EPSDT and best-practice guidelines. Standardized templates must have the capability of being transferred electronically, whether through the Internet and/or via disc. For example, new providers should be able to obtain CDs or software from DYFS with standardized templates for CHEC evaluations as part of “toolkits for CHEC providers” that DYFS and CHEC sites develop collaboratively.
- Similar to reporting templates, DYFS and CHEC sites must standardize the process for completion and sharing of the CHEC report and Plans of Care. Failure to do so to date has significantly undermined the utility of the CHEC reports.

2. Increase Family Participation

- All families; including birth, relative, foster, and adoptive families, must be viewed as partners in providing healthcare. These individuals are vital sources of information on the child’s health care history and needs, and for the child’s ongoing health care. Their involvement is necessary to ensure continuity of care in the transition from out-of-home care to permanent placements. DCF and CHEC sites must strive to engage families in the provision of the CHEC on behalf of the child, encourage and support their participation in the CHEC evaluation process and ensure families understand the need for follow-up on all recommendations and treatment needs.
- The OCA study revealed that children continue to be brought to the CHEC appointment by case aides and individuals removed from direct responsibility for the child. The OCA recommends that DCF cease this practice, and establish this service as a priority. The CHEC process requires joint worker-caregiver, and birth parent (as appropriate) participation.

3. Provide Training and Education

- In collaboration with current CHEC providers and resource parents, DCF must endeavor to include additional information about the CHEC program and the overall provision of health/mental health in all DYFS-related training curriculums. DYFS field staff, resource families and other caregivers need updated information about the CHEC program, as well as information pertaining to expectations around meeting the child’s health needs, Medicaid managed care enrollment and all other key aspects of health care management.

4. Monitor and Evaluate the CHEC Program

- A coordinated system for monitoring and evaluating the CHEC program is a necessary and critical aspect currently missing from the State’s oversight of this service. While Medicaid assists DCF in providing individual chart reviews of services provided, it is not the only area where tracking is needed. Regular DCF oversight, with established measures for this

monitoring must be implemented, and include information obtained from Medicaid for this process. Currently, providers of CHEC services receive infrequent feedback from DCF regarding the program. Establishing and monitoring how the CHEC program is working in all areas, what core services it provides to children and areas where inconsistencies are identified, will assist DCF in communicating clear expectations to CHEC providers and DYFS staff. Benchmark measures for performance around CHEC-related responsibilities at the local DYFS offices must also be developed and implemented. Additionally, there is a need to include satisfaction assessments from caregivers, children, and providers as well as a system to ensure that this resource is cost effective. Improvements or adjustments can then be made based on the results of this monitoring system.

- There is an urgent need for DCF to develop a system for tracking health outcomes for children, and for this data to be made available to the public. Establishing core areas of measurement that include identifying what needs children have as they enter and remain in placement, and tracking that these identified needs have been met will provide some baseline as to their overall outcomes. Aggregating this health-related information on individual children can be utilized to determine system-wide, area and localized needs, gaps in services, outcomes, and policies. Additionally, understanding the presenting issues children face can assist in recruiting, training and supporting families who can effectively meet these identified needs.

C. Create a Solid Health Care Infrastructure

1. Increase Provider Resources

- The OCA's study highlights that less than a third of children placed by DYFS in out-of-home care received a CHEC evaluation in 2006. This number is unacceptable by any measure. The established data documenting the fact that children entering out-of-home placement have significant physical and mental needs and the fact that DCF is falling short of meeting these needs must be the impetus for change in creating and supporting additional CHEC resources. Specifically, DCF should consider implementing an immediate plan and timeline for increasing CHEC resources to ensure all children receive the benefits of a comprehensive assessment. Baseline information regarding a child's health history, current health status and treatment plan is critically needed for all children entering out-of-home placement.
- Despite commitments in previous years from prior DHS leadership to develop additional provider resources to serve children in the remaining counties in the provision of CHEC services, no additional sites were added. DCF, under the leadership of Commissioner Kevin M. Ryan, recently announced the availability of fiscal resources to increase provider sites and expand CHEC services. This proposed CHEC model deviates from the original in several significant and concerning ways. The OCA recommends that DCF fully articulate their plan for 1.) implementing this new model, including when these resources will be functional; 2.) integrating all domains of the current CHEC model in keeping with best practices; and 3.) establishing a system for tracking their viability. Progress on these goals must be publicly reported. A plan for ensuring coverage in all twenty one counties must be developed and publicly articulated.
- Given that the CHEC has existed for several years, a cost-analysis by DCF is now necessary to determine if the level of reimbursement is meeting, exceeding or falling short of actual costs

experienced by provider sites. Reimbursement for CHEC medical, mental health and neuro-developmental assessments must reflect the actual cost of providing these services.

2. Establish Support for Provider Resources

- A formal collaborative process to improve health care for children in DCF out-of-home placement, previously established at the program's inception and attended by DYFS, CHEC providers and other stakeholders is no longer in existence. Consequently, in recognition of this exceptionally pressing and important need, the OCA urges DCF to immediately re-convene the CHEC Advisory Board and extend invitations to the aforementioned representatives to address quality improvement initiatives that must be integrated into the CHEC program.

Within its charge, the CHEC Advisory Board must establish and implement regular reviews of key CHEC data, examine currently utilized reporting templates and Medicaid audit tools, with the goal of developing a process for improving these tools, establishing quality measurement indicators including services required and provided, and for the purpose of improving the communication among stakeholders in the overall delivery of CHEC services.

- Given the pressing need for expanded CHEC resources, CHEC appointments should not go unfilled. No-show rates reported to OCA by CHEC provider sites are unacceptably high, and are largely due to lapses in communication between DYFS staff, CHEC provider sites and resource parents. Medicaid is the payer for actual CHEC evaluations and services, although Medicaid cannot be billed for no-shows. This creates financial challenges for CHEC sites, which DCF needs to address at a statewide and local level.

Significantly decreasing no-show rates would improve the likelihood that current sites are able to see children needing CHEC evaluations within 30-60 days of initial out-of-home placement. Additional policy changes that guide caseworkers and mini health unit staff around parameters for scheduling and cancelling appointments is also necessary. Consistent follow-up by DYFS staff and other stakeholders (such as judges, CASA volunteers, Child Placement Review Board representatives) to ensure appointments are made and kept is also recommended. Lastly, opportunities exist to train caregivers around the value of the CHEC and the importance of meeting the health needs of children.

Conclusion

The CHEC program is valuable in the overall continuum of health-related services to children whose situation requires out-of-home placement. Overall, children receiving CHEC evaluations benefit from a comprehensive panel of physical, developmental, dental and mental health assessments that identify issues and treatment needs, to potentially improve the child's overall health-related outcomes. Three years after its implementation, however, there continue to be significant areas in need of improvement. Any newly established system requires support, guidance, measurable benchmarks and oversight in order to continuously improve – CHEC is no exception.

DCF must use the information from this study to strengthen this resource and address areas in need of improvement. The OCA shares DCF's health and mental health-related focus for children and as DCF continues its efforts to improve case practice and case handling, the OCA remains committed to identifying and implementing well-being indicators in these areas to track progress. Greater collaboration and support for CHEC resources from DCF will also ensure that NJ builds on the existing best practices of the current program and creates an overall system for health and mental health that serves all children who enter out-of-home placement.

New Jersey's children are counting on it, because health matters.

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