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Fostering Healthy Futures for Children in Foster Care

Moira Szilagyi, MD, PhD, FAAP

The nearly 800,000 children and teens who spend time in foster care annually in the United States are identified by the American Academy of Pediatrics as a population of children with special health care needs because of their high prevalence of chronic medical (30-40%), mental health (70%), developmental (60%), educational (45%), dental (35%) and family health (100%) problems. Most pediatricians will encounter children in foster care at some point during the course of their practice and so should be familiar with the scope of their health issues and promising practices for promoting healing.

Except for the youngest of infants, most children enter foster care as a result of complex childhood trauma experiences that include child abuse and neglect and the exposure to domestic and community violence. They have also had a poverty of what developmental experts would call a "normal predictable environment." Their parents have high rates of mental health and substance abuse, unstable housing, unemployment, criminal activity, and impaired parenting skills. Many children have already experienced multiple caregivers even before entering the foster care system. Even so, removal from their family and all that is familiar is emotionally traumatizing for almost all children, and reinforces their view that the world is a dangerous and unpredictable place. Most children are in a state of emotional shock upon entry to foster care. While a few children appear very distressed at entry, most are actually fairly cooperative and compliant. The extent of their internal distress may only become evident after they adjust to their new circumstances over the first six to eight weeks of foster care.

Recent studies on the developing brain have shown that trauma experiences and instability, especially in the first three years of life, have profound, long-term effects on children. Chronic elevation of stress hormones alters the structure and function of those areas of the brain involved in attachment, attention, emotional regulation, cognition, and the association between emotion and thought. Thus, we commonly see children in foster care with insecure attachment behaviors, hyperactivity, impulsivity, poor emotional and behavioral regulation, difficulty with transitions, and difficulty integrating thoughts and emotions.

Early trauma impacts all facets of a child's health and well-being, and foster care, with its instability and uncertainty can exacerbate a child's difficulties. Behavioral, emotional, and developmental problems are usually the direct result of complex childhood trauma or early deprivation on the developing brain. Physical health problems may be genetic or congenital, so immense they simply overwhelmed the family's resources and abilities to care for their child, or they may also be the direct result of early trauma or medical neglect.

Foster care was always intended to be short-term intervention to keep a child safe during a time of family crisis. Its goals are to provide a safe and healing refuge for a child while helping parents address the issues that led to placement. Health, safety and permanency for children are the major goals of foster care. Secondary goals include providing services to families to promote reunification, the support and education of foster parents, and the preparation of teens for independent living when reunification or adoption are not possible. The quality, tenor, and frequency of visitation between children and their birth parents are the best predictors of reunification, although visitation poses great challenges for both parents and children. Children re-live separation at the end of each visit, rejection if a parent fails to show up, and sometimes even re-experience trauma. Parents, dealing with multiple other challenges, may find visitation emotionally overwhelming because of their own feelings of guilt or inadequacy. There are also many critical junctures in foster care than can upend a child's life: changes in foster care placement, other children entering or leaving a foster home, separation from siblings, a birth parent going into drug rehabilitation or being incarcerated, court dates in which decisions about placement will be made, etc.

Foster parents are foster care's major therapeutic intervention, but they are frequently not provided with the support and education necessary to help a child heal. While outside the scope of pediatric practice, there are some promising new foster care models that pediatricians should be familiar with and even advocate for on behalf of their patients. . *Visitation Coaching* is a developmentally-based model in which trained visitation specialists prepare birth parents for each visit, "coach:" them through visits, and debrief with them afterwards. *Shared Parenting* is a model in which foster parents are encouraged and trained to foster the birth parents as well as the children. Evidence based trauma-focused mental health interventions, such as *Parent-Child Interactive Therapy* during visitation and *Trauma-focused Cognitive Behavioral Therapy* are showing great promise.

Pediatricians and child welfare professionals share a common goal of making foster care a healing experience for children and families. Pediatricians can help make healing a reality for children in foster care in many ways. The AAP recommends that children in foster care receive health care services in the context of a pediatric medical home, which includes following AAP practice standards for children in foster care.

Seeing children often at the beginning of foster care placement can help to support foster parents, children and birth parents through this emotionally difficult transition period. Providing advice about routines, predictability, behavior management, and a child's health problems can foster a sense of adequacy for a foster parent who is in the process of getting to know a child. Identifying and managing health problems, conducting appropriate screenings, making timely referrals, and ensuring that a child's emotional and developmental health problems are addressed improves a child's health and well-being. There is ample evidence that significant behavioral problems result in placement disruption and delay permanency, so that prompt referrals for mental health evaluation and services is recommended by the AAP. Discussing behavior management in the context of early childhood trauma and multiple losses can help foster and birth parents to respond to a child's difficult behaviors in ways that promote self-regulation. Pediatricians can provide good counsel to parents about helping children manage the many transitions and critical junctures that occur in foster care. For example, preparing a child for a visit might include packing a transitional object, snack or book to share with their parent. And, children need and should have some "re-entry" time with their foster parent after a visit. Pediatricians can encourage both foster and birth parents to set aside their own agendas and keep their focus on the child's needs for security and safety. Pediatricians can advocate for involving children in normalizing activities as a means of developing a sense self-efficacy, healthy peer relationships, and identifying positive adult role models.

The American Academy of Pediatrics has a number of tools available to help pediatricians, child welfare, mental health professionals and foster parents care for children in foster care. AAP District II was been instrumental in promoting the health agenda for this vulnerable population culminating in the publication of Fostering Health: Health Care Standards for Children and Teens in Foster care by the District in 2001 and by the national AAP in 2005. This book discusses in detail practice parameters for managing the health of children in foster care. In 2009, the AAP launched the *Healthy Foster Care America Website* (www.aap.org/fostercare), an inter-disciplinary website for professionals and parents caring for children in foster care. Pediatricians can encourage foster parents, teens in foster care, and child welfare professionals to use this valuable resource.

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Fostering Connections: Applying the New Federal Law to Ensure the Health of New York's Children in Foster Care

Sheryl Dicker, J.D.

The American Academy of Pediatrics has long recognized that providing health care to children in foster care requires more intensive resources and strategies than for the typical pediatric patient. This recognition emanates from the many studies that document the high prevalence of chronic medical conditions and developmental disabilities among this population and the most recent New York data confirms this need. They have been called the sickest children in America (GAO 1995), yet all too often they have little access to care. The most recent data submitted by New York State to the federal government lists over 3000 children in foster care who have not received required tests or exams. Recognition of these factors has led the AAP to issue stringent recommendations for care for foster children; partner to develop standards for their health care; publish manuals and other materials; and recently develop a website to enhance the health of these most vulnerable children. Yet, despite these bold efforts, implementation of quality health care for these children remains elusive in New York and nationwide. In 2008, the AAP spearheaded the passage of the health oversight provisions in the Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL110-351). This new law provides the strongest weapon in the AAP's arsenal to ensure health care of children in foster care.

Over twenty years ago, Congress passed a mandate requiring medical services for children in foster care. (Title IV Social Security Act). Since virtually all children in foster care were enrolled in Medicaid they would be entitled to EPSDT, a comprehensive medical package that requires medical, visual, hearing, developmental, dental and mental health screenings to be performed at distinct intervals that meet current standards of care. The medical screen under EPSDT must include five components: a comprehensive health and developmental history assessing both physical and mental health, an unclothed physical exam; immunizations; laboratory tests and health education. New York passed even more stringent regulations requiring the comprehensive examination to be performed within 30 days of a child's entry into foster care.

Given these dire needs of children in foster care, in 1988 the AAP and the Child Welfare League of America partnered to develop more stringent standards for health care for children in out- of- home care. And in 2000, after years of effort, the District II published a step-by-step guide that put those standards as well as New York law into practice by delineating every key juncture for children's health from the initial examination through the critical comprehensive exam to discharge examination. Thus, the tools—the law, standards and detailed checklists for practitioners—are in place. Implementation, however, has not occurred and health care for children in foster care in New York and nationwide resembles a checkerboard.

Some jurisdictions provide "Cadillac" care for children and others provide little but a Medicaid card given to a foster parent. New York's situation well-illustrates this dilemma. New York has two of the nation's foremost models for providing high quality health care to children in foster care. The Starlight Health Care Services in Monroe County, New York, founded and directed by Moira Szilagyi, M.D., and the ENHANCE

health clinic in Onondaga County, New York, founded and directed by Steven Blatt, M.D., provide a medical home for most children in foster care in their respective counties. Those programs provide 24 hour 7 day a week medical home for these children including onsite pediatricians, nurses, nurse practitioners, social workers and psychologists, connection to other specialists, and ongoing communication with both the Department of Social Services and Family Court. A similar program is being developed for children in foster care in Buffalo, New York.

Other models have been used as well in New York to provide health care to this vulnerable population. In Westchester County, New York, the Department of Social Services employees two nurses and has a contract with a private pediatric group to provide 24 hour/ 7 day week care for children in foster care. Additionally, the county has a contract with Westchester Institute for Human Development to conduct psychological and developmental assessment on most children and families as well as create and manage an electronic record system that has all the health, mental health and developmental information on each child in foster care.

Yet, in counties just adjacent to these models, foster families are merely given a Medicaid card and told to find health care. And in New York City, the program is even more checkered. 95% of children in foster care in NYC are in the care of voluntary agencies, many with histories of over 150 years of service. These voluntary agencies are given a per-diem rate based on past expenditures to cover all non-hospital health services including the required comprehensive exams. Each of these agencies receives a different per-diem rate and each provides varying services from “Cadillac” services with medical homes to agencies with only part-time health staff. Thus, New York does not have a system for providing health care for children in foster care.

It is imperative that the AAP seize the best opportunity in years to create that system by fully implementing the new Fostering Connections law. The new act requires states to develop a plan in consultation with pediatricians and other experts for oversight and coordination of health care for children in foster care. The plan must describe how health needs will be identified and addressed; how health information will be shared and updated, including the use of electronic records; the steps to ensure continuity of care, including the possible development of medical homes; and a method of oversight for medication. Requiring the state to develop this plan for oversight and coordination with mandated input by pediatricians will compel New York to address this central but ignored problem.

Thus, there now is a vehicle for the AAP to use to press New York to develop a comprehensive statewide system for health care of our most vulnerable children. A plan developed this year can be the blueprint for future statewide development, future statewide monitoring of compliance with federal and state laws and standards, and future data collection to flag problems and aid resolution. Through the hook of the Fostering Connections law, this state, at long last, can provide quality health care services consistent with law and standards to all its children in foster care.

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Message from the District II Chair

Henry Schaeffer, MD, FAAP

In this issue of our District's semi-annual newsletter, we focus on pediatricians and their interactions with children in foster care and the people who work in child welfare systems. Although we understand that the system looks different to pediatricians based on the county in which they practice* and the setting in which they practice, we have tried to present clear, compelling, but generic information on pediatrics and foster care.

As you may know, the national AAP has made the foster care and the child welfare system health services sector one of the important pillars of the work for pediatrics going into the 21st Century. In fact, at the most recent NCE in October, the Plenary Session was devoted to issues relative to foster care and pediatrics. In addition, recent federal legislation, Fostering Connections, outlines new requirements for health care for children in foster care. It also reflects the concerns of the Academy. The Academy was instrumental in helping federal agencies describe the best possible care for these high need children in legislation. And our national staff and members worked with Congress to get the legislation passed.

Here in New York State we have about 27,000 children in foster care at this time. This is lowest census in care for many years. Most children in the system are in community based foster care with foster families and may be seen in your community based practices. Medicaid is their payer. They use all community services and attend school or day care in their neighborhoods. Others are in residential care with foster care agencies, and may receive their health services through the agency responsible for their care. They may also attend school on a residential campus or agency site. You may see these children in residential care either in your practices, clinics or because you work with or for an agency. Or you may see them in emergency rooms or in special clinics or for specialized services. In any case, children in care, whether in community based foster care or residential care, tend to be children with high level health and mental health needs. They are children who very much need a medical home to coordinate multiple health service needs. They are children who desperately need consistent high quality pediatric care.

We hope the information provided in this newsletter will help you provide high quality care to more children in the foster care. We also hope that our authors will encourage you to work to take more foster children into your practices. If each of our members who practices primary care pediatrics commits to take two or three more foster children living in their communities into their practices, we will have made a significant positive impact on the health care of these very vulnerable children. Providing a high quality medical home to children in care can make a real difference in health and social/emotional outcomes for these children. We encourage you to reach out to our authors or other colleagues to learn how you can make an even bigger positive impact on children "in the system."

* New York has a state supervised, county administered child welfare program.

*By Henry Schaeffer, MD, FAAP
Chair, AAP District II*

Physician Legal Alert: Child Abuse Reporting Obligations

Michael J. Schoppmann, Esq.

A recent trend involving the investigation of suspected cases of child abuse prompts the recommendation that every physician, especially pediatricians, examine their understanding of the law regarding the reporting of suspected cases of child abuse and the potential ramifications of failing to do so.

Under New York State law, every physician is “required to report or cause a report to be made in accordance with this title when they have reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child, or when they have reasonable cause to suspect that a child is an abused or maltreated child where the parent, guardian, custodian or other person legally responsible for such child comes before them in their professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child.” Each investigation of child abuse, regardless of the source of the allegation, now carries with it a new line of inquiry - what was the level of knowledge held by any child’s treating physicians? What was the child’s medical history? Were there events that should have triggered a reporting? If so, why was there no prior reporting?

For physicians, the exploration, and corollary investigation, of these issues carries the risk of severe penalties ranging from significant civil litigation, loss of license through the Office of Professional Medical Conduct and even criminal charges. Unquestionably, every physician needs to maintain diligent attention to his or her reporting obligations, prepare careful documentation of a child’s relevant history and apply careful consideration toward reporting any cases of potential abuse.

Toward that end, in a joint publication of the New York State Office of Children & Family Services and the NYC Administration for Children’s Services, basic parameters for reporting have been published.

What is child abuse? How do I recognize it?

Child abuse includes physical abuse, physical neglect, sexual abuse, and emotional abuse of a child less than 18 years of age by a parent or other caretaker.

Physical abuse is a non-accidental injury to a child by a parent or caretaker. You may see frequent and unexplained bruises, burns, cuts or injuries; the child may be overly afraid of the parent’s reaction to misbehavior.

Physical neglect is a parent’s failure to give the child food, clothing, hygiene, medical care, or supervision. You may see a very young child routinely left alone at home. You may know that a severe illness or injury is not being medically treated. A neighbor’s child may frequently turn up at your door—inadequately dressed for the weather—saying his or her parent told him or her to stay away. Physical neglect can be hard to determine: Sometimes what you see is simply poor judgment, but not neglect; sometimes what you see is the result of poverty, and not parental neglect.

Sexual abuse ranges from non-touching offenses, such as exhibitionism, to fondling, intercourse, or using the child for pornographic materials. You may see sexual behavior far beyond what is expected for the child's age; a young child might have sudden, unusual difficulty with toilet habits; there may be pain, itching, bruises or bleeding in the genital area. The child might tell you.

Emotional abuse includes severe rejection, humiliation and actions intended to produce fear or extreme guilt in a child. You may see a parent who verbally terrorizes the child, who continually and severely criticizes the child, or who fails to express any affection or nurturing.

How Do I Recognize Child Abuse and Maltreatment?

The list that follows contains some common indicators of abuse or maltreatment. This list is not all-inclusive, and some abused or maltreated children may not show any of these symptoms.

Indicators of Physical Abuse Can Include:

- Injuries to the eyes or both sides of the head or body (accidental injuries typically only affect one side of the body);
- Frequent injuries of any kind (bruises, cuts, and/or burns), especially if the child is unable to provide an adequate explanation of the cause. These may appear in distinctive patterns such as grab marks, human bite marks, cigarette burns, or impressions of other instruments;
- Destructive, aggressive, or disruptive behavior;
- Passive, withdrawn, or emotionless behavior;
- Fear of going home or fear of parent(s).

Indicators of Sexual Abuse Can Include:

- Symptoms of sexually transmitted diseases;
- Injury to genital area;
- Difficulty and/or pain when sitting or walking;
- Sexually suggestive, inappropriate, or promiscuous behavior or verbalization;
- Expressing age-inappropriate knowledge of sexual relations;
- Sexual victimization of other children.

Indicators of Maltreatment Can Include:

- Obvious malnourishment, listlessness, or fatigue;
- Stealing or begging for food;
- Lack of personal care—poor personal hygiene, torn and/or dirty clothes;
- Untreated need for glasses, dental care, or other medical attention;
- Frequent absence from or tardiness to school;
- Child inappropriately left unattended or without supervision.

What if I make a mistake?

You need to have a *reasonable suspicion* of child abuse, not to prove it or be absolutely certain. You might be mistaken, but it is better to err on the side of the child. Not reporting your suspicions may mean that abuse will continue. If you make a report in good faith, you are immune from civil or criminal liability.

The inherent difficulty in defending an action or investigation involving an alleged failure to report child abuse is that each case carries the horrible, foregone reality that a child has been abused. Where a treating physician's responsibility lies in those who may have failed that child will be determined through the pre-judged prism of hindsight. Balancing not only the risk of enabling further harm to a child but also the overwhelming liabilities for failing to report, every physician should inherently and consistently lean toward reporting.

Where Do I Call to Make a Report?

As soon as you suspect abuse or maltreatment, you must report your concerns by telephone to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR). The SCR is open 24 hours a day, seven days a week, to receive your call. The timeliness of your call is vital to the timeliness of intervention by the local department of social services' Child Protective Services (CPS) unit. You are not required to notify the parents or other persons legally responsible either before or after your call to the SCR. In fact, in some cases, alerting the parent may hinder the local CPS investigation and adversely affect its ability to assess the safety of the children. The telephone number to report abuse or maltreatment is: **Mandated Reporter (800) 635-1522**.

Should any physician, or a member of a medical office staff, have any questions regarding child abuse reporting obligations, they can contact Mr. Schoppmann at 1-800-445-0954 or via email at schoppmann@drlaw.com.

By Michael J. Schoppmann, Esq.

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Foster Care & Pediatrics

A Policy & Advocacy Perspective

Elie Ward, MSW

Here in New York we have about 27,000 children in out of home care in the foster care system. Many more children and families are involved with child welfare agencies across the state. The children in these families are at risk of foster care placement and their families are receiving preventive services in an effort to avert the necessity for out of home placement. Parents are learning parenting skills and housekeeping and budgeting skills. They are learning child rearing and discipline approaches. They are getting education and job training services. Agencies are trying to work with families where they are and give them the supports, skills and services they need to appropriately care for their children and avoid out of home care.

Pediatricians can and should have a special role to play. You are often the first professionals to see the results of child abuse. And, as mandated reporters you have a responsibility to report suspected abuse to the hot line. You are sometimes the only professional who has regular contact with a child in care. Social workers and case workers come and go. Placements can be disrupted for various reasons. But, if you provide a medical home for a child, you may be the only consistent adult that child has contact with. This puts the pediatrician in the potential role of the one person who can help a vulnerable child learn how to be resilient. As the health care provider of an at risk child you also have access to parents and other caregivers. You can play a supportive and educational role in assuring that parents and foster parents understand the special of children who are or have been in the foster care system.

It is our hope that each of our members will reach out to those who work with the foster care system and offer to provide the highest quality health and developmental care to these very special and vulnerable children. We have an opportunity, with the new federal legislation, Fostering Connections, to build positive relationships with our state and our local child welfare systems to better provide health care to children in foster care. With the help and support of our own members' expertise at the national and the District levels, many more pediatricians can learn to provide cutting edge health and developmental services to highly needy children. We not only need to advocate for children in the system, we also need to advocate for pediatricians, so that those who care for these very needy and challenging children are paid for the very intensive and important work that they do. The children and families, both biological and foster families, in the foster care system need our help and support. You can become a voice for them, while at the same time voicing your own concerns about how and where they get their health care. Pediatricians can and in many instances already do make a difference for foster children. It is our hope that with this issue of the newsletter, many more pediatricians across the state will reach out and make a special effort to learn how to best care for children in the child welfare system, and to then bring these special children into their practices in every community across the state.

By Elie Ward, MSW

Director of Policy and Advocacy, AAP District II

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