CHCS Center for Health Care Strategies, Inc.

Issue Brief

Health Screening and Assessment for Children and Youth Entering Foster Care: State Requirements and Opportunities

Kamala Allen, Center for Health Care Strategies, Inc.

NOVEMBER 2010

Early assessment and intervention are critical to the well-being of children and youth entering foster care—a population with a high prevalence of physical, behavioral, and oral health needs.[1, 2, 3] An estimated 25 percent of children and youth in foster care have three or more chronic conditions,[4] up to half have significant behavioral health challenges,[5] and roughly 35 percent have considerable oral health problems.[6] Through early identification of unmet and pre-existing conditions, timely services can be initiated to resolve acute health issues and better manage chronic conditions. Accordingly, child welfare advocates and child health policymakers endorse early health screening and assessment for this high-risk population to improve long-term health outcomes and cost savings.[7, 8, 9]

This brief reports on a 50-state survey conducted by the Center for Health Care Strategies (CHCS) to: (1) determine how states have responded to national requirements and recommendations for health screenings and assessments; and (2) identify opportunities for strengthening state requirements to improve physical, behavioral, and oral health outcomes and more efficiently manage health-related costs for children and youth entering foster care.

State child welfare agencies are subject to federal requirements for health screening and assessment of children and youth entering foster care. The Fostering Connections to Success and Increasing Adoptions Act of 2008 places specific requirements on state child welfare agencies to meet the health care needs of children and youth in foster care,[10] including creation of a health care plan. This plan must be developed jointly with state Medicaid agencies and provide for ongoing oversight and coordination of health care services, including a schedule for screenings and assessments. Notably, the law does not specify required timeframes for performance of these services.

As part of the federal Administration for Children and Families, the Children's Bureau[11] conducts a biennial Child and Family Services Review (CFSR) of state child welfare agencies. The CFSR evaluates each state's performance in a number of areas, including child and family well-being, and requires that each state have guidelines for

In Brief

The Center for Health Care Strategies conducted a 50-state survey to understand the extent to which child welfare agencies require physical, behavioral, and oral health screenings and assessments upon a child's removal from the home. The survey found:

- Virtually all states require an initial screening in at least one of the three health domains (i.e., physical, behavioral, and oral health);
- More than half of states require an initial screening in all three domains, and over one-third require assessments in all three domains;
- State-mandated timeframes for initial health screenings vary significantly and do not consistently reflect nationally recognized guidelines; and
- State mandates for in-depth assessments are less rigorous than for initial screenings.

Findings suggest significant opportunities to enhance compliance with nationally recognized guidelines, supporting potential improvements in health outcomes and related costs for the foster care population.

Made possible through support from the Annie E. Casey Foundation and the Centers for Medicare & Medicaid Services.

initial, ongoing, and/or periodic health examinations of children and youth entering foster care.[12] Typically, children and youth in foster care are categorically eligible for Medicaid, which provides coverage for health-related screening and assessment services through its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.[13] As state child welfare agencies work to meet CFSR standards, and state Medicaid programs focus on driving high-quality, cost-effective care, they can best serve this population by working collaboratively – an approach required by the Fostering Connections legislation. Together, child welfare and Medicaid can establish requirements that (1) call for immediate access to services; (2) enable prompt identification of acute and chronic needs; and (3) build upon the EPSDT benefit to better address the needs of these children and youth.

In support of the above requirements, national organizations such as the American Academy of Pediatrics and the Council on Accreditation have established specific recommendations — including timeframes — for screening and assessment of children and youth in foster care (see sidebar). Yet, despite consensus among national organizations that comprehensive screening and assessment are essential and should occur soon after removal from the home, this survey's findings suggest opportunities among the states to strengthen these requirements.

National Screening and Assessment Recommendations for Children and Youth Entering Foster Care

The American Academy of Pediatrics recommends:[14]

- Upon entry into foster care, children and youth should be seen by an appropriate health care professional, and have a health screening within 72 hours of placement.
- Within 30 days of foster care placement, children and youth should have a detailed, comprehensive evaluation of:
  - Mental health;
  - Developmental health (if under age 6 years);
  - Educational needs (if over age 5 years); and
  - Dental health.
- A follow-up health visit should occur within 60-90 days of placement.

The Council on Accreditation (COA) recommends:[15]

- Initial screening from a qualified medical practitioner within 72 hours of a child's entry into foster care to identify the need for immediate medical or mental health care, and to assess for infectious and communicable diseases; and
- Follow-up assessments within 30 days of foster care entry to help child welfare agencies determine the most appropriate placement for a child.

Research Methods

CHCS e-mailed surveys to child welfare agencies in all 50 states and the District of Columbia to identify initial screening and assessment requirements, including applicable timelines. Forty-seven states and the District of Columbia responded (Hawaii, Mississippi and Montana did not). CHCS defined a screening as an initial, comprehensive examination to determine the need for further diagnosis or treatment. Assessment was defined as an in-depth, diagnostic examination — often, but not necessarily, in response to a positive screen — to establish the extent of need or presence of a condition that may require treatment and follow-up. While some states require screening or assessment within a certain time period following removal from the home, other states designate timeframes following actual placement in foster care (for simplicity, this analysis did not differentiate between the two).

Findings

Key findings of the survey were:

- *Health screening:* With only one exception, all responding states and the District of Columbia require an initial screening in at least one of the three health domains (i.e., physical, behavioral, and oral health), and 65 percent require screening across all three.
- *In-depth assessment:* All responding states expect assessments to be conducted when necessary in at least one of the three domains, while only 63 percent explicitly require them. Thirty-five percent of respondents require assessments in all three domains.

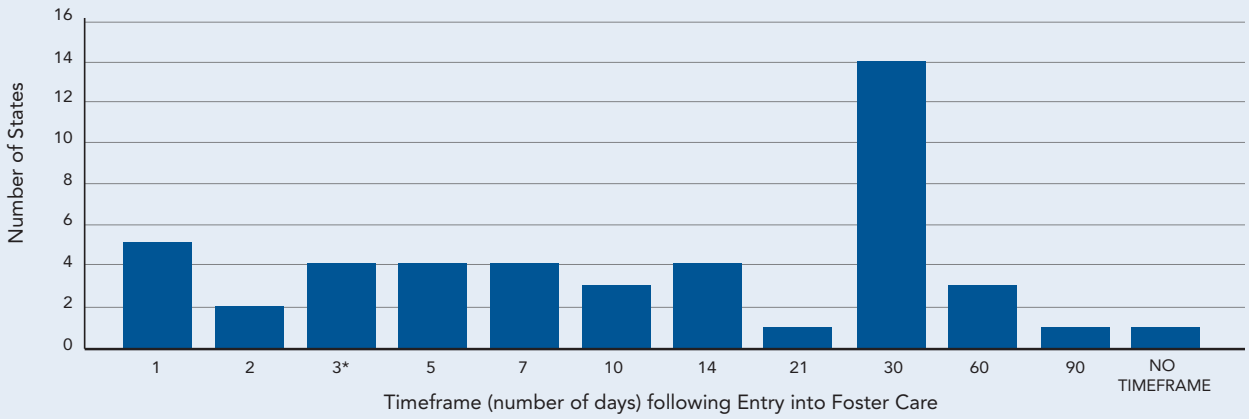
- *Timeframes for screening and assessment:* There is wide variation in the existence and length of required timeframes for completion of the various screenings and assessments — ranging from one day to 90 days for screening, and from three days to 183 days for assessments.

Screening

Physical Health

Virtually all responding states (46) require an initial physical health screening for children and youth removed from their homes (see Fig. 1). Eleven states require the screening to occur within three days or less, consistent with AAP and COA recommendations. Only five states have requirements of greater than 30 days or no timeframe at all.

Figure 1: State Requirements for Initial Physical Health Screening Upon Entry into Foster Care †

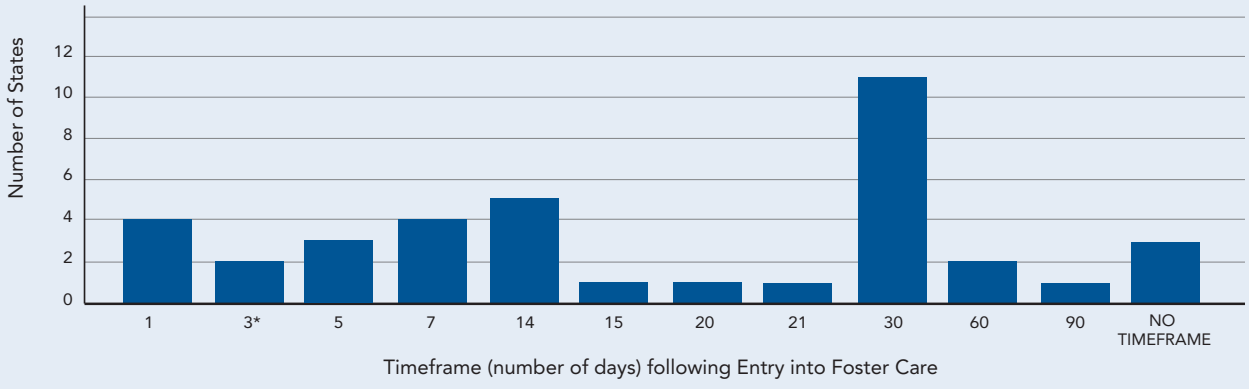


† Includes the 46 states that require an initial physical health screening.
* The American Academy of Pediatrics and the Council on Accreditation recommend an initial health screening be performed within 72 hours (three days).

Behavioral Health

Thirty-eight states require a behavioral health screening for children and youth removed from their homes (see Fig. 2). About one-third (11) of those states have requirements of 30 days; four states require it within 24 hours.

Figure 2: State Requirements for Initial Behavioral Health Screening Upon Entry into Foster Care †

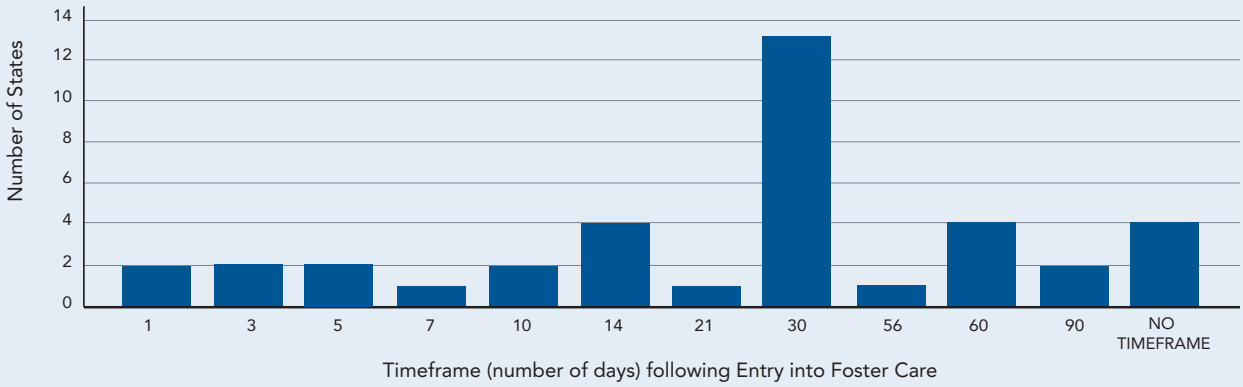


† Includes the 38 states that require an initial behavioral health screening.
* The American Academy of Pediatrics and the Council on Accreditation recommend an initial health screening be performed within 72 hours (three days).

Oral Health

Thirty-eight states require an oral health screening for children and youth removed from their homes (see Fig. 3). The most common timeframe — used by 13 states — is 30 days; two states require oral health screens to take place within 24 hours.

Figure 3: State Requirements for Initial Oral Health Screening Upon Entry into Foster Care †



† Includes the 38 states that require an initial oral health screening.

Assessment

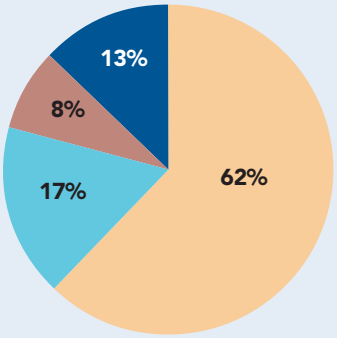
Physical Health

Twenty-four states explicitly require an in-depth physical health assessment (see Fig. 4). Nearly all (21) of those states mandate a timeframe for completion; most within 30 days of removal. An additional 20 states indicated that they expect – but do not require – referral for assessment as needed for children and youth who have a positive screen; however, there are no timeframes associated with those expectations. Nine states tie their expectations to EPSDT or another national or state-specific periodicity schedule, noting that their requirement for care following the initial screening is for subsequent periodic screenings rather than an in-depth assessment. Four states either have no requirement or did not identify policies regarding physical health assessments for children entering foster care.

Behavioral Health

Twenty-seven states require a behavioral health assessment for children and youth removed from their homes (see Fig. 5). The vast majority of these states (23) specify a timeframe for completion: most often, within 30 or 60 days. As with physical health assessments, an additional 20 states expect that a behavioral assessment will be conducted if needed, but do not have an explicit agency policy requiring it.

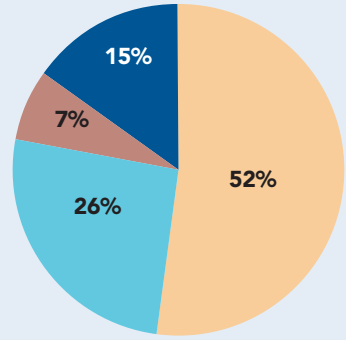
Figure 4: State Requirements for In-Depth Physical Health Assessment Upon Entry into Foster Care †



† Includes the 24 states that require an in-depth physical health assessment.

* The American Academy of Pediatrics and the Council on Accreditation recommend that an in-depth health assessment be performed within 30 days.

Figure 5: State Requirements for In-Depth Behavioral Health Assessment Upon Entry into Foster Care †



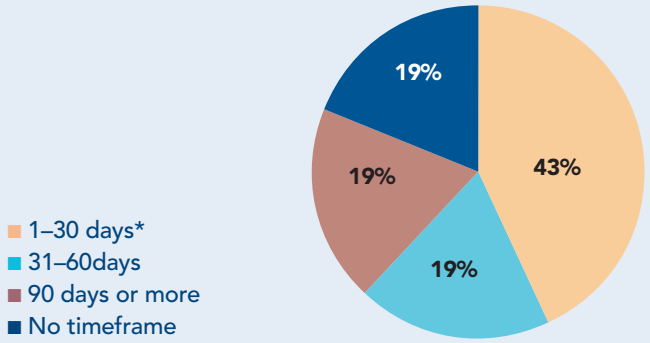
† Includes the 27 states that require an in-depth behavioral health assessment.

* The American Academy of Pediatrics and the Council on Accreditation recommend that an in-depth health assessment be performed within 30 days.

Oral Health

Twenty-one states require an oral health assessment for children and youth removed from their homes. The majority of those states (17) specify a timeframe within which the assessment must occur (see Fig. 6); the most frequent requirement is 30 days. Again, many states (18) without an explicit requirement for an oral health assessment expect one to be provided if necessary.

Figure 6: State Requirements for In-Depth Oral Health Assessment Upon Entry into Foster Care †



† Includes the 21 states that require an in-depth oral health assessment.

* The American Academy of Pediatrics and the Council on Accreditation recommend that an in-depth health assessment be performed within 30 days.

Conclusion

The significant burden of illness among children and youth in foster care makes timely screening and assessment critical. National studies have documented the long-term consequences of unmet health care needs in this high-risk population, including serious and persistent mental illness, substance misuse, and chronic health care conditions that extend into adulthood.[16] Federal and state Medicaid policy can support early identification and treatment of these conditions, improving long-term clinical, functional, and cost outcomes.

Despite this, survey results point to wide variations in the stringency of states' requirements for health-related screening and assessment upon entry into foster care. On a positive note, nearly all states require physical health screenings, and two-thirds of states mandate physical, behavioral, and oral health screenings. In contrast, there are significant opportunities for improvements in health assessment requirements, and in required timeframes for completion of both screenings and assessments.

It is worth noting that some states provided information on the mandatory elements for their required screenings and assessments. These responses revealed wide variations across states, suggesting opportunities to establish guidelines for examination components, including the use of evidence-based practices such as trauma-informed care.

By implementing requirements for immediate screenings and short-timeframe assessments, states are better positioned to meet CFSR standards and Fostering Connections requirements. Critical opportunities for states include:

- Using EPSDT benefits to ensure delivery of required screenings and assessments, as well as subsequent, periodic screenings;
- Avoiding duplicate delivery of services by allowing screenings or assessments that may have been provided shortly before foster care placement to satisfy the requirement;
- Utilizing providers knowledgeable about the unique needs of the foster care population to perform screenings and assessments, including those trained in trauma-informed practices; and
- Facilitating effective care coordination through appropriate data-sharing among providers, as well as across the Medicaid, mental health, and child welfare systems.

State policymakers can further strengthen the impact of mandated screening and assessments for children and youth in foster care by better understanding: (1) which providers are performing them and in what settings; (2) processes for making, acting upon, and tracking referrals; (3) current best practices for ensuring coordination of care across service systems; and (4) how health information technology, particularly electronic health records or "passports," can be used to reduce unnecessary, and potentially harmful, duplication of services. Greater understanding of these factors can support states in identifying and addressing the health needs of this at-risk population, thereby promoting long-term health outcomes and quality of life, while more effectively managing costs.

Appendix: Screening and Assessment Requirements and Timeframes (in days) for Children Entering Foster Care by State*

STATE	INITIAL SCREENING			IN-DEPTH ASSESSMENT		
	Physical Health	Behavioral Health	Oral Health	Physical Health	Behavioral Health	Oral Health
Alabama	10	Not required	Not required	30	30	30
Alaska	30	30	30	As needed†	As needed	As needed
Arizona	30‡	30	30§	Not required	7	Not required
Arkansas	3	3	3	3	5	Not required
California	30	Not required	30	As needed	As needed	As needed
Colorado	14	Not required	56	As needed	As needed	As needed
Connecticut	30	30	30	Not required	30	30
Delaware	5	5	5	14	14	14
Dist. of Columbia	1	1	Not required	30	60	30
Florida	3	7	Not required	3	7	As needed
Georgia	10	30	10	As needed	As needed	40
Hawaii	DATA UNAVAILABLE			DATA UNAVAILABLE		
Idaho	30	30	90	As needed	As needed	As needed
Illinois	1	1	1	21	45	21
Indiana	10	5	10§	As needed	10	Not required
Iowa	14	14	14	As needed	As needed	As needed
Kansas	30	20	30	As needed	As needed	As needed
Kentucky	2	30	14	No timeframe	No timeframe	No timeframe
Louisiana	7	15	60	As needed	As needed	As needed
Maine	3	30	Not required	As needed	As needed	As needed
Maryland	5	Not required	Not required	60	60	60
Massachusetts	7	7	Not required	30	30	30
Michigan	Not required	30	90	30	As needed	As needed
Minnesota	30**	No timeframe	30	Not required	As needed	Not required
Mississippi	DATA UNAVAILABLE			DATA UNAVAILABLE		
Missouri	1	30‡	30‡	30	Not required	Not required
Montana	DATA UNAVAILABLE			DATA UNAVAILABLE		
Nebraska	14	14	14	As needed	As needed	As needed
Nevada	No timeframe	No timeframe	No timeframe	No timeframe	No timeframe	No timeframe
New Hampshire	30	Not required	No timeframe	As needed	As needed	As needed
New Jersey	1	14	30§	30	As needed	Not required
New Mexico	30	Not required	30§	Not required	As needed	Not required
North Carolina	7	7	7	14	14	14
New York	14	14	14	14	14	14
North Dakota	1	1	1	60	60	60

* Among 47 states and the District of Columbia (DC).
† "As needed" indicates that an assessment is expected if recommended by a positive screen or provider referral, but not explicitly required in policy.
‡ State requires subsequent periodic screenings.
** "No timeframe" indicates that there is a requirement, but it is not time-bound.
§ State also requires semi-annual periodic screenings.

State	INITIAL SCREENING			IN-DEPTH ASSESSMENT		
	Physical Health	Behavioral Health	Oral Health	Physical Health	Behavioral Health	Oral Health
Ohio	30	Not required	Not required	60	60	60
Oklahoma	90	90	Not required	60	60	Not required
Oregon	Not required	Not required	Not required	30	60	30
Pennsylvania	60‡	Not required	60‡	15	15	183
Rhode Island	60	60	60	183	183	183
South Carolina	5	1	5	No timeframe	No timeframe	No timeframe
South Dakota	30	No timeframe	No timeframe	As needed	As needed	As needed
Tennessee	30	5	30	As needed	As needed	As needed
Texas	21	21	21	As needed	As needed	As needed
Utah	30	30	30	120	120	120
Vermont	7	7	Not required	30	30	183
Virginia	60	60	60	As needed	As needed	As needed
Washington	5	30	30	As needed	No timeframe	No timeframe
West Virginia	3	3	3	As needed	30	As needed
Wisconsin	2	Not required	No timeframe§	As needed	As needed	Not required
Wyoming	30	14	30	As needed	30	As needed

* Among 47 states and the District of Columbia (DC).
‡ State requires subsequent periodic screenings.
§ State also requires semi-annual periodic screenings.

Acknowledgements

The author is grateful to CHCS Program Associate Roopa Mahadevan, and interns John Pourciau, Beth LaPiene, and Lauren Marino, for their assistance with data collection, and to Jan McCarthy, MSW, for her review of the study findings.

Resources from the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and youth and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS is working with states, health plans, and federal policymakers to develop and support programs that improve the quality of care for children with complex physical and behavioral health needs, including children involved in child welfare. Related resources are available at www.chcs.org:

- **Improving Medicaid Managed Care for Youth with Serious Behavioral Health Needs: A Quality Improvement Toolkit:** This toolkit shares promising practices tested by plans participating in CHCS' Collaborative on Improving Managed Care Quality for Youth with Serious Behavioral Health Needs, and the resulting impact on access, care, and avoidance of unnecessary services and costs.
- **Medicaid Managed Care for Children in Child Welfare Issue Brief:** This issue brief examines the complex physical and behavioral health care needs and associated costs for children in child welfare and outlines critical opportunities and challenges within Medicaid to better manage care for this high-risk, high-cost population.
- **The Use of Psychotropic Medications for Children Involved in Child Welfare Webinar Resources:** This CHCS webinar presented evidence-based and promising practices related to the use of psychotropic medication among children involved in child welfare and the critical role of families as partners in care.
- **Improving Managed Care for Children in Child Welfare:** This series of fact sheets was created for those seeking to improve the care provided by managed care organizations to meet the physical and behavioral health care needs of children and youth involved in the child welfare system.

Endnotes

1 R.L. Hansen, F.L. Mawjee, K. Barton, M.B. Metcalf, and N.R. Joye. "Comparing the Health Status of Low-Income Children In and Out of Foster Care." *Child Welfare Journal*, July/August 2004.

2 Chernoff et al. "Assessing the Health Status of Children Entering Foster Care." *Pediatrics*, 93 (1994): 594-601.

3 L.K. Leslie, J.N. Gordon, L. Meneken, K. Premji, K.L. Michelmore, and W. Ganger. "The Physical, Developmental, and Mental Health Needs of Young Children in Child Welfare by Initial Placement Type." *J Dev Behav Pediatr*, 2005 Jun; 26(3):177-85.

4 L. K. Leslie, M. S. Hurlburt, J. Landsverk, K. Kelleher et al. "Comprehensive Assessments for Children Entering Foster Care: A National Perspective." *Pediatrics*, July 2003.

5 B. J. Burns, S. D. Phillips, R. Wagner, R. P. Barth, D. J. Kolko, Y. Campbell, et al. "Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey." *Journal of American Academy of Child and Adolescent Psychiatry*, v43 n8, August 2004.

6 Healthy Foster Care America (2010). "Dental and Oral Health." Available at http://www.aap.org/ fostercare/dental_health.html.

7 S. Grosse and K. Biernath. "Vision evidence-statement: screening." In: K.P. Campbell, A. Lanza, R. Dixon, S. Chattopadhyay, N. Molinari, and R.A. Finch, editors. *A Purchaser's Guide to Clinical Preventive Services: Moving Science into Coverage*. Washington, DC: National Business Group on Health; 2006.

8 S.B. Williams, E. O'Connor, M. Eder, and E. Whitlock. "Evidence Synthesis No. 69: Screening for Child and Adolescent Depression In Primary Care Settings, A Systematic Evidence Review for the U.S. Preventive Services Task Force." Agency for Healthcare Research and Quality, April 2009.

9 S. Rosenbaum, K. Allen, and S. Wilensky. *EPSDT at 40: Modernizing a Pediatric Health Policy to Reflect a Changing Health Care System*. Center for Health Care Strategies, Hamilton, NJ, July 2008. Available at www.chcs.org.

10 For more information about the Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351), visit: http://www.govtrack.us/ congress/billtext.xpd?bill=h110-6893.

11 Note: The Children's Bureau seeks to provide for the safety, permanency and well being of children and youth through leadership, support for necessary services, and productive partnerships with States, Tribes, and communities.

12 For more information about the CFSR, visit: http://www.acf.hhs.gov/programs/cb/cwmonitoring/ tools_guide/statewidethree.htm #Toc140565129.

13 Note: Children in foster care can be categorically eligible for Medicaid based on based on family income, disability, or links to federal Title IV-E payments for out-of-home care.

14 For more information about the AAP guidelines, visit: http://www.aap.org/fostercare/health_care_ standard.html.

15 Note: COA is an international, independent, not-for-profit, child- and family-service and behavioral healthcare accrediting organization. For more information about COA accreditation standards, visit: http://www.coastandards.org/standards.php? navView=public&core_ id=253

16 P.J. Pecora, R.C. Kessler, J. Williams, K. O'Brien, A.C. Downs, D. English, et al. Improving Family Foster Care: *Findings from the Northwest Foster Care Alumni Study*. Casey Family Programs, 2005. Available at http://www.casey.org/resources/publications/pdf/improvingfamily fostercare_es.pdf.