Promoting Physical Health

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Initial Health Information Gathering

- Ensure detailed health histories are obtained from the birth parents and other caregivers at placement.
- Ensure medical information is obtained when a newborn enters care from the hospital.
- Ensure the child receives an initial health screen within 24 hours of entering care.
- Ask the child welfare agency to report health screen results at the initial hearing and ensure the child welfare agency is keeping all of a child's medical records on file.
- Request additional health assessments to address missing information.

Comprehensive Physical Assessment

- Require a comprehensive health assessment within 30 days of placement.
- Ensure necessary health care records and consents are available.
- Ensure the comprehensive assessment includes developmental and mental health screens by a qualified provider.
- Request assessment results and ensure services are in place.

Immunizations

- Ensure the child has been properly immunized.
  - Ask about immunization at the first hearing.
  - Ensure immunizations are complete and up-to-date for the child's age.
  - Require catchup immunizations if necessary.

Routine Medical Screening

- Ensure the child has received all appropriate screenings.

Coordinated Medical Care

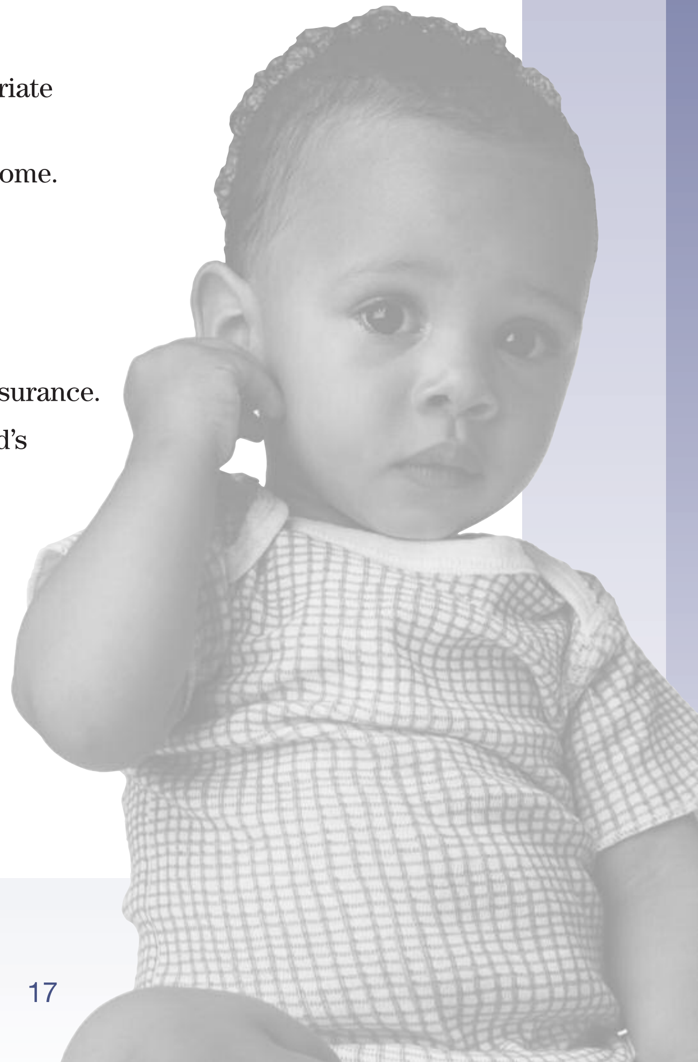
- Require a medical home.
- Address barriers to using a medical home.
  - Make placement decisions with continuity of health care in mind.
  - Ensure the initial placement for a child in care is carefully selected and work to maintain the integrity of this placement.
  - If a change is needed, try to keep the child in the same geographic area and make sure caseworkers and foster parents understand the importance of the medical home.
- Ask if the child has a health passport.

Oral Health

- Ensure the child receives appropriate dental services.
- Help each child access a dental home.
- Remove barriers to dental care.

Barriers to Health Care Access

- Find out if the child has health insurance.
- Identify other barriers to the child's access to medical services.



Many infants and young children enter foster care with complex physical health needs. Acute illnesses, diseases, infections and compromised bodily organs or systems often result from the child's maltreatment and inadequate health care. As the judge, you can affect these young lives when they are most vulnerable and when services and supports can have the greatest impact.

Becoming familiar with the physical health needs and characteristics of each child in your court can help you make the best decisions for these children and their families. You play a key role by:

- ensuring information about the child's physical health is gathered at the start of the case;
- requesting a comprehensive medical assessment to identify gaps in knowledge about the child's physical health;
- asking specific questions about the child's physical health and medical needs (including whether she has a medical home or regular source of routine medical care);
- ensuring birth parents and foster caregivers receive education and training to meet the child's special health needs; and
- securing medical services and supports to treat the child's physical health issues.

Initial Health Information Gathering

When a very young child enters foster care, an opportunity exists to identify and address any unmet physical health needs. Seeking health information as early as possible after placement helps ensure that immediate and long-term health needs of young children are met. To get a complete picture of a young child's physical health upon entering care, take the following steps.

Ensure detailed health histories are obtained from the birth parents and other caregivers at placement.

The child's health history before entering care lays the foundation for services she will receive while in care, so it is essential to obtain this information as soon as possible. As time passes, it may become harder to secure this information. Encourage the agency to follow the American Academy of Pediatrics' (AAP) recommendations by gathering critical information when removing the child, including:

- where the child has been receiving health care;
- immunization record or history;
- any chronic medical conditions (e.g., asthma, sickle cell disease, epilepsy);
- past surgeries or past hospitalizations;

- medications the child takes;
- medical equipment the child uses (e.g., glasses, hearing aids, nebulizers, wheelchairs, epipens);
- any allergies;
- the child's birthplace (so birth records can be obtained);[1] and
- a family health history (particularly hereditable or communicable diseases).

Any additional medical or immunization records in the home, as well as medications and medical equipment, should also be obtained when the child is removed. Agency staff should ensure that the medical records travel with the child. Caseworkers can obtain a more complete health history by using a comprehensive health history form to interview parents. The AAP is developing one and will post it on its Healthy Foster Care America Web site (www.aap.org/advocacy/HFCA/). Daycare providers, grandparents, and others who regularly care for the child can also be rich sources of information.

Ensure medical information is obtained when a newborn enters care from the hospital.

Many infants are placed into care directly from the hospital.[2] When newborns enter care from the hospital, it is important for the agency or caregiver to obtain from the hospital staff:

- instructions for immediate care (e.g., treatment for existing health conditions, signs and symptoms requiring urgent health care);
- information about where the infant will receive follow-up care—primary care and referrals to specialists, if any;
- results of any state-mandated screenings to identify conditions for which the infant will need follow-up care (e.g., genetic defects, metabolic problems);
- a list of immunizations given at the hospital;
- results of the newborn hearing screen;
- any information about risks to later healthy development, such as prematurity, low birth weight, prenatal substance exposures, and lack of prenatal care;[3] and
- birth records and the hospital discharge summary.

Ensure the child receives an initial health screen within 24 hours of entering care.[4]

This initial evaluation:

- screens for acute illnesses;

- identifies chronic diseases;
- documents signs of abuse, neglect, or infectious diseases; and
- assesses any hygiene or nutritional concerns.

These preliminary observations should inform the placement decision and follow-up for health problems. Ask whether the initial health screen identified lower than expected height, weight, or head circumference measurements or obesity. If so, order further evaluation since these findings may suggest growth delays, poor nutrition, or poor general health. (See sidebar, page 46, for an in-depth discussion of failure to thrive.) Having baseline measures of the child's health can help detect disruptions in growth over time. The health screen also allows the clinician to share age-appropriate strategies to help caregivers support children who are experiencing acute grief associated with removal.

An initial health screen can help detect significant physical, mental health, and developmental problems of children when they enter foster care. Initial placement provides a chance to identify, treat and refer infants and young children with unmet needs. Because children placed in care may return home within 30 days, an initial health screen should be conducted promptly to identify any significant medical needs. Failure to identify these needs places the child at risk for poor health outcomes. It also affects placement adjustment, as potentially serious behavioral, developmental, and physical health problems compromise placement stability and may impact permanency options.

Ask the child welfare agency to report health screen results at the initial hearing and ensure the child welfare agency is keeping all of a child's medical records on file.

Caseworkers should come to court ready to summarize and discuss the results of a child's health assessment. If a child has not yet been assessed, or the results are not yet available, find out why. Ask the caseworker to obtain the information and file a supplemental report. Set clear expectations for agency caseworkers and attorneys for what health information you expect every time they are in your courtroom.

Request additional health assessments to address missing information.

If the health screening report was incomplete, or indicated a need for urgent follow-up, evaluation, or care, require the caseworker to address those gaps and file a supplemental report within a set period.

Comprehensive Physical Assessment

Require a comprehensive health assessment within 30 days of placement.

The AAP recommends that all children undergo a comprehensive health assessment within 30 days of placement in care.[5] Children who lacked routine health care before entering the child welfare system are vulnerable to medical, mental health, and developmental conditions that are normally detected during routine health evaluations.

As part of a comprehensive health assessment, a health care provider gathers information to learn about risks for ongoing health problems. These include:

- chronic conditions
- hospitalizations
- past surgeries
- medications
- allergies
- immunizations
- behaviors and emotional health
- developmental skills
- adjustment to foster care and visitation[6]

The child's prenatal and birth histories are critical as the health provider needs to know about circumstances such as:

- substance exposure during pregnancy
- birth weight
- problems at delivery
- infectious risks for the child
- family health problems that could affect the child
- newborn screening results

This information helps medical providers make care decisions, including recommendations about treatment, referrals, and follow-up, and also helps judges, lawyers, and caseworkers plan for placement and permanency. In addition, the clinician can provide caregivers problem-specific health information, child care recommendations, and strategies to promote the child's emotional and behavioral health.

Ensure necessary health care records and consents are available.

The child welfare agency must provide all relevant records so the health professional can conduct a complete health assessment. These include all past and current records from primary and specialty care providers, hospital records, and agency records containing relevant medical, social, and family health information. Additionally, each state has requirements for obtaining consent to health care of children in the child welfare system. Become familiar with your state's requirements so you can ensure that proper consents for routine and emergency care are secured and a child's care is not delayed. This includes ensuring that birth parents cooperate in signing consents, providing health histories, and attending health visits, when appropriate.

Ensure the comprehensive assessment includes developmental and mental health screens by a qualified provider.

A comprehensive health assessment includes several screenings for problems common to children in the child welfare system, including developmental delays and some mental health concerns. Ensure that these initial screens have occurred for children in your courtroom. (See Chapter 3 for more information, including early intervention services under Part C of the Individuals with Disabilities Education Act.)

Request assessment results and ensure services are in place.

At early hearings, ask the agency if a comprehensive health assessment has occurred (or is planned). Require a summary of the results be given in court or submitted within one week after the assessment occurs. Ask the agency to provide any missing information in a supplemental report to the court before the next scheduled hearing. Any necessary services should begin before the next scheduled hearing if they are not already in place.

As the case continues, ensure that parents have had regular contact with health professionals (medical, mental health, developmental, and dental) and understand their child's care before approving unsupervised visits, and certainly before approving overnight visits or permitting the child to return home.

Children in foster care with communication delays and problems with personal-social and cognitive development should also be screened for autism, as discussed in Chapter 3.

Immunizations

Ensure the child has been properly immunized.

Immunizations protect children against potentially devastating diseases, and are critical for children who have received inadequate health care. Proper immunization decreases a child's susceptibility to many illnesses, some of which have potential long-term effects. Incomplete immunization also generally means a child lacks medical care from a regular provider. An unimmunized child should be considered at risk for many medical problems.

Ask about immunization at the first hearing.

At the initial hearing, ask if a child's immunization records are available and if the child is up-to-date for recommended immunizations. If the child is missing immunizations, require the agency to work with the child's health provider to obtain missing information or provide needed immunizations. Also ask about the immunization status of caregivers. For conditions the child cannot be immunized against because of age or health status, it may be especially important that caregivers are immunized.

Ensure immunizations are complete and up-to-date for the child's age.

All children new to foster care should have a health screen followed by a comprehensive medical evaluation. To achieve this goal, be sure to ask the caseworker to collaborate with health providers to obtain immunization records or begin "immunization catchup" for children at the time of the comprehensive health screen.

Order that the child receive immunizations consistent with the most recent nationally recommended immunization guidelines published jointly by the Centers for Disease Control and Prevention (CDC), the Advisory Committee on Immunization Practices (ACIP), and the AAP, available at www.cdc.gov/vaccines/recs/acip/. Federal law requires that state Medicaid programs use these guidelines, so payment should not be an issue for most children.[7]

Require catchup immunizations if necessary.

Allow about 30 days for caseworkers and health providers to investigate immunization history by exploring avenues such as old health records, immunization registries, and school and child care records. This avoids repeating immunizations the child has already had. Also require that doctors treating children in foster care use the national immunization information system (www.cdc.gov/vaccines/programs/iis/default.htm) to ensure children are not overimmunized. If any necessary

immunizations have not been given, order catchup immunizations according to CDC, ACIP and AAP combined guidelines, beginning at or shortly after the comprehensive health assessment.

Children entering foster care as unaccompanied refugee minors may have inaccurate and incomplete immunization records and may need blood tests before beginning catchup immunizations. Their health screenings should address health risks specific to their countries of origin. Children with immune problems (e.g., due to chemotherapy, treatment with steroids, or HIV infection), should not receive live virus vaccines, so it is essential that health care providers have complete information on the child's health status before administering these vaccines.

Routine Medical Screening

Ensure the child has received all appropriate screenings.

Catching problems and starting services early gives children a better chance of healing or achieving optimal control of health problems. Fortunately, most children in foster care are Medicaid eligible, and therefore eligible for Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The EPSDT program provides essential preventive health services to at-risk children. As part of a comprehensive health assessment, children are eligible for a variety of screening procedures, including evaluation for:

- hearing and vision problems
- lead exposure
- communicable diseases
- nutrition status
- anemia
- growth problems
- mental health issues
- medical problems

For any problems identified by screenings or assessments, order that birth parents and foster caregivers receive assistance to properly care for the child (e.g., training on how to use a nebulizer, education about managing diabetes).

Hearing, speech and language

Ask the agency if the child received a hearing screen at birth and regular speech, language, and hearing screenings thereafter. If not, require that they be done before the next court date. Also ask if any reports from parents or caregivers raise hearing or language concerns. If so, require an assessment and any indicated services.

Normal hearing is essential to a young child's speech and language acquisition, adjustment, and emotional development. Failure to detect hearing loss hampers development in these areas and can impair later learning and academic achievement. Detecting hearing loss and intervening within the first six months of life helps prevent or reduce these outcomes.[8] Annual hearing screening should be conducted for any child with a family history of hearing impairment, and those with syndromes that place the child at risk for hearing impairment (e.g., Down syndrome, Usher syndrome, Treacher Collins syndrome).

Hearing loss can result from congenital diseases, infections such as ear infections and meningitis, head injury, neglect of health problems, or use of medications that damage hearing.[9] In addition, a number of factors put children at risk for developing a hearing problem later in life, including structural abnormalities of the ear or face, certain exposures in the newborn or late gestational period, and speech and language delays.

All states but one provide hearing evaluations for newborns.[10] These screens detect most hearing loss due to congenital problems. Many children referred for follow-up hearing exams after the initial screen never go back for those evaluations, however, so it is important to ask if necessary follow-up has occurred.[11] The AAP also recommends a formal objective hearing screen at four years of age in addition to screenings for all newborns.[12]

Speech and language disorders may occur from hearing loss, early neglect and deprivation, or a variety of genetic or medical conditions. Speech disorders may include problems with how speech sounds are pronounced (articulation), the rhythm of speech (fluency or stuttering), the quality of voice or some combination of problems.[13] Language disorders stem from a problem understanding and/or using spoken or written words or sign language.[14] Swallowing disorders, feeding problems, or cognitive impairments may also signal speech-language issues.

A child's speech and language development follows a predictable pattern throughout the first five years of life, beginning at age two months. During the first 18 months, children should be able to imitate sounds, form simple words, point, and use two-word phrases.[15] An important sign of normal social and language development is a child's ability to expand their use of language to convey thoughts and feelings and to show increasing comprehension of the world around them through such actions as pointing, gesturing, or responding to simple commands.[16]

Older children, through age two, should begin to use two-to-three word phrases and understand questions. Children aged two to three years should be able to form short sentences (four to five words or more) and tell brief stories.[17] As children get older and their speech and language develops, their words become more intelligible to adults who do not regularly spend time with them; for three

Speech, Language, and Hearing Milestones for Young Children

	Hearing and Understanding	Talking and Communicating
Birth–6 months	Startle to loud sounds. Respond to changes in tone of your voice.	Cry differently for different needs. Babbling sounds more speech-like with many different sounds, including p, b and m.
7–12 months	Enjoy games like peek-a-boo and pat-a-cake. Recognize words for common items like "cup," "shoe," "book," or "juice."	Imitate different speech sounds. Use gestures to communicate (waving, holding arms to be picked up).
12–24 months	Follow simple directions and understand simple questions ("Roll the ball," "Kiss the baby," "Where's your shoe?"). Point to pictures in a book when named.	Say more words every month. Put two words together ("more cookie," "no juice," "mommy book").
24–36 months (2–3 years)	Understand differences in meaning ("go-stop," "in-on," "big-little," "up-down"). Follow two requests ("Get the book and put it on the table.").	Use two or three words to talk about and ask for things. Speech is understood by familiar listeners most of the time.
36–48 months (3–4 years)	Hear you when you call from another room. Answer simple who, what, where, and why questions.	People outside of the family usually understand child's speech. Use a lot of sentences that have four or more words.
48–60 months (4–5 years)	Pay attention to a short story and answer simple questions about it. Hear and understand most of what is said at home and in school.	Communicate easily with other children and adults. Use sentences that give lots of details (e.g., "The biggest peach is mine.").

Source: Adapted from American Speech-Language-Hearing Association. *How Does Your Child Hear and Talk?* Available at www.asha.org/public/speech/development/chart.htm (last accessed February 18, 2009). View the online chart for a complete list of milestones and ways to help children who are not reaching them.

year olds, 75% to 80% intelligible speech is a good guideline.[18] Children aged three to four should have a vocabulary of over 1,000 words and should ask "why" and "how" questions.[19] The American Speech-Language-Hearing Association lists more hearing, understanding, and talking milestones for different age ranges at www.asha.org/public/speech/development/chart.htm. The absence of certain behaviors (pointing and showing, eye contact with caregiver, limited speech) merits screening for autistic spectrum disorder (see Chapter 3) or other speech-language and developmental problems.

Very young children may also be evaluated for hearing problems when adults observe hearing difficulties, inattention, or erratic responses to sound. Most hearing deficits are uncovered when a parent has concerns and requests an assessment. Parents often identify hearing problems up to a year before a physician would,[20] and can also be essential in catching speech and language delays. Since children in foster care often lack a consistent caregiver who can detect subtle abnormalities or delays, they may be less likely to be identified early. Children in care should undergo regular screenings for deficits in hearing, speech, and language development to ensure their healthy development. Whenever *any* caregiver suspects hearing, speech, or language problems, a formal evaluation should occur.

Vision

Ask if the child's eye exam was abnormal *as a newborn* and at *later checkups*. For children older than three, ask if a vision screen has been completed. (Until age four, children may not cooperate in identifying shapes reliably, so they are not ready for vision screens. They can still receive eye exams that check for expected reflexes, responses to light, and range of eye movements.) If not, require a vision screen before the next hearing. Require the agency to report the results of vision screenings, and to start any recommended services. If a child has impaired vision, ensure he has current prescription glasses.

Vision problems are the fourth most common disability for children in the United States,[21] and are more prevalent among children in foster care. Screening for vision problems detects conditions that can result in serious visual impairment, including blindness. It also detects other diseases that can affect the body.[22] Undetected vision problems can lead to poor school performance and can be life threatening if they lead to a more serious disease.

The AAP recommends all children have a vision exam as newborns and at all routine health visits. A formal vision screen should be attempted at age three (if the child is uncooperative, a repeat screen should be attempted in six months).[23] If screening is unsuccessful despite repeated attempts, the child should be referred (by age four years) to an ophthalmologist trained in examining children.[24]

Screening and Placement Can Decrease Lead Levels

A study[1] of children in foster care, their siblings, and the general population found:

- before entering foster care, children were twice as likely as other children to have elevated blood lead levels; and
- after placement, the children were less than half as likely to have high lead levels.

Practice Tips:

- **Ensure children receiving services in their own home or in kinship care**, as well as children entering care, are screened for lead exposure.
- **Consider environmental and behavioral factors** that may lead to increased lead exposure when making placement decisions. Of particular concern are houses built prior to 1979, especially if they have peeling paint, and children who have the eating disorder pica (which involves regularly ingesting nonfood items).

Source:

1. Chung, E., Webb, D. et al. "A Comparison of Elevated Blood Lead Levels Among Children Living in Foster Care, Their Siblings, and the General Population." *Pediatrics* 107(5), 2001, e81-85.

Lead exposure

Ask if the child had a lead screening at *nine to twelve months* of age and *annually thereafter*. If not, require a screening for lead exposure by a pediatric health professional as soon as possible. If the screening reveals an issue, order an investigation into the source of the lead.

A prior history of abuse and neglect, developmental delay, behavior problems, failure to thrive, and poverty are all associated with an increased risk for lead exposure and poisoning.[25] Children living in poverty are at high risk for lead poisoning, but only 20-30% of this group is screened for exposure. Because most children entering foster care have many of these risk factors, including poverty, they should be considered at high risk for lead exposure.

Lead poisoning harms a child's health and development, and can lead to impaired learning, lower academic achievement and intelligence, abnormal behavioral development, decreased growth and hearing, and damage to the brain, kidney, and blood-forming process. For children in foster care, the AAP recommends blood lead screening at nine to twelve months of age, with yearly screenings through age six.[26] For children with elevated lead levels, the pediatric health

professional should follow the CDC guidelines for more frequent screening and/or treatment.[27]

If the child's current home (or the home the child is expected to move to when case plan goals are reached) has dangerous lead levels, the court should order that lead hazards be reduced to safe levels through abatement or other methods. Some jurisdictions have federal Department of Housing and Urban Development funding to reduce lead hazards, but if your jurisdiction does not (or there are long waiting lists), order the agency to pay for the work (or help the family find new housing) as part of their required reasonable efforts.

Communicable diseases

- **Sexually transmitted infections:** Many young children in foster care have birth parents whose sexual histories are unknown and who struggle with substance abuse. These exposures place children entering care at high risk for infection with HIV, hepatitis B, hepatitis C, syphilis, and congenital herpes. Children with a history of sexual abuse are also at risk for other sexually transmitted diseases.[28] Ask if the child has been screened for *HSV (herpes), syphilis, hepatitis B, and hepatitis C.*

- **HIV:** A risk assessment for HIV exposure should be conducted,[29] and, if positive, the child should have a blood test to screen for HIV infection once consent is obtained (states vary on who may give consent for testing children in care and the procedures for obtaining consent). Some states' newborn screens also include an HIV test. Order any necessary screenings before the next hearing, and ask the agency to file a supplemental report with the screening results. Early screening and treatment for these conditions promotes the long-term healthy development of children in foster care.

  For young children, detecting HIV is also critical to ensuring an infected child receives modified immunizations to maximize the protective effect of vaccination, while avoiding harm.[30]

- **Tuberculosis:** Tuberculosis (TB) exposure is more common among certain groups, and occurs through exposure to the respiratory droplets of an infected person (e.g., droplets expelled through a cough or sneeze). Those who are or have been incarcerated, live in crowded conditions, or immigrate from certain countries are at high risk. Testing for TB exposure is recommended for all children placed in foster care beginning at 12 months of age. Children should be re-screened every three-to-five years while in foster care or whenever an exposure is suspected. A positive

Data Supports HIV Testing for Infants and Young Children

Children in foster care at all ages are at increased risk for HIV infection. Studies have shown:

- Inner-city newborns placed directly in foster care were eight times more likely to be born to an HIV-positive mother than other newborns.[1]
- Health care providers did not detect infection in 17.7% of HIV-infected children studied until four years of age.[2]
- 36 out of 42 children who acquired HIV during the perinatal period did not display symptoms of infection until after age four.[3]

Practice Tips:

- **Assess HIV status of all children in foster care** since symptoms are not always apparent. Some risk factors include maternal substance abuse, multiple sexual partners, unprotected sex, the presence of other vertically transmitted infections, and sexual abuse. For children who enter foster care secondary to sexual abuse, HIV testing should be done at the time of the incident, and then at six weeks, three months, and six months after the incident.[4]
- **Obtain consent for HIV screening.** If the mother's HIV status was not determined during pregnancy, the HIV exposure status of the newborn or infant should be determined. The AAP recommends discussing testing the newborn with the mother after birth to obtain consent. If the mother refuses consent, or if the authority to consent for medical care has been transferred to the foster care agency, the agency or the court should give consent.[5]
- **Older children, including toddlers and preschoolers, should also be assessed.** The factors that led to foster care placement often correlate with increased risk for HIV infection. Children may display no or only mild symptoms of infection for several years.
- **Know the risk factors.** Understand the risk for HIV infection in infants and other young children in foster care and order necessary evaluations when risk factors are present.

Sources:

1. Nicholas, S., et al. "Maternal Newborn Human Immunodeficiency Virus Infection in Harlem." *Archives of Pediatric and Adolescent Medicine* 148, 1994, 813-819.

2. Persaud D. et al. "Delayed Recognition of Human Immunodeficiency Virus Infection in Preadolescent Children." *Pediatrics* 90, 1992, 688-691 (study not specific to children in foster care).

3. Grubman S. et al. "Older Children and Adolescents with Perinatally Acquired Human Immunodeficiency Virus Infection." *Pediatrics* 95, 1995, 657-663 (study not specific to children in foster care).

4. American Academy of Pediatrics, Task Force on Health Care for Children. *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2005.

5. American Academy of Pediatrics Committee on Pediatric AIDS. *Identification and Care of HIV-Exposed and HIV-Infected Infants, Children and Adolescents in Foster Care*, 2000.

TB screening test requires evaluation by a specialist in TB (local health departments can identify these specialists).

- **Parasitic diseases:** The small population of refugee minors in foster care often come from countries in which parasitic disease is prevalent. Refugees from certain areas of the world, such as Africa and Southeast Asia, should be screened for parasitic disease and treated according to AAP Redbook or CDC guidelines.

Malnutrition

Malnourished children may not meet recommended growth parameters (weight, length, and head circumference) or may have hair, skin, teeth, or mouth abnormalities.[31] Any of these findings on a screening exam should prompt questions about the child's nutritional health.

The special dietary needs of infants and young children (who cannot eat most "adult" foods and instead require formula, baby cereal, and other foods high in vitamins, minerals, and protein) can be costly and difficult for some foster caregivers to maintain. Infants and children up to their fifth birthday may be eligible for nutrition assistance services under the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).[32] WIC benefits include supplemental nutritious foods, nutrition education and counseling at WIC clinics, and screening and referral to other services.

To ensure the nutritional needs of infants and children in care are met, ask whether their nutrition status has been evaluated and whether their growth parameters are normal for their age. Also ask whether a child is being fed an age-appropriate diet as this shows a caregiver's awareness of and attention to a child's needs. For example, children less than one year should not receive regular milk and children less than two should receive a diet with adequate calories and fat for brain development. Consider barriers to food access that may contribute to suboptimal dietary practices. Require the agency to refer caregivers to resources that provide nutritious options for children in their care (e.g., WIC and its "Farmers Market Nutrition Program"). Be sensitive to the fact that dietary choices may be influenced by cultural beliefs and practices.

Many children in foster care have feeding difficulties. Some were premature infants with medical complications that delayed the start of oral feeding. Others have developmental delays, sensory problems or behavioral issues that interfere with feeding. Food insecurity before foster care may lead to behaviors such as hoarding of food, gorging, eating spoiled or discarded food, pica, or strong but unhealthy food preferences.

How the Court Can Support Breastfeeding

Infants who are breastfed have 21% lower mortality rates, and may be less likely to develop diabetes, asthma, leukemia, obesity and other diseases later in life.[1] Breastfeeding also protects against or minimizes the severity of many infectious diseases including bacterial meningitis, respiratory tract infections, and ear infections.[2]

Practice Tips:

- **Order daily visitation** to support breastfeeding when safety is not an issue.
- **Ensure the mother has the equipment she needs** to preserve milk for her child when they are not together (e.g., a breast pump).
- **Order a consultation with a pediatric or obstetric health professional** if a mother's medical condition or other life circumstance raises questions about the appropriateness of breastfeeding. Although breastfeeding may not be in the child's best interest in some situations (e.g., the mother is abusing drugs, has HIV, or is receiving chemotherapy), breastfeeding is the healthiest choice for most infants.[3]
- **Ensure the agency knows about local resources** to support breastfeeding, and has educated the mother on this topic. (La Leche League International maintains a list of resources in each state at www.llli.org/WebUS.html.)

Source:

1. American Academy of Pediatrics, Section on Breastfeeding. "Breastfeeding and the Use of Human Milk." *Pediatrics* 115(2), 2005, 496-506.
2. Ibid.
3. Ibid.

The other form of malnutrition is obesity, which is now more prevalent in children new to foster care than failure to thrive or growth failure. Almost all obesity results from consuming too many calories, lack of activity, and inadequate nutrients in the diet. This problem is compounded when foster parents have difficulty "limiting" access to food in the foster home because it upsets the child or they fear being accused of neglect.

During the first year, regular feeding helps the child trust that his needs will be met. This promotes healthy attachment to caregivers, which is important for healthy emotional and mental development (see Chapter 3). Older children should have a diet rich in vegetables, fruits, whole grains, low fat dairy foods, and protein sources. Desserts, unhealthy snacks, and processed foods should be minimized. Meals should occur at predictable times, at the table, in a pleasant context that engages family members. Portions should be appropriate to the child's age.

Children with Chronic Health Care Needs Benefit from Specialized Nutrition Services

Compared to other children from the same socioeconomic background, children in foster care have much higher rates of chronic physical disabilities.[1] Children with such special health care needs experience greater rates of nutrition-related health problems because their chronic condition may alter their appetite or food intake.[2] Environmental factors may also affect access to or acceptance of food. [3]

Nutrition-related special health needs may include:

- delayed growth
- difficulty feeding and eliminating
- interactions between foods and medications
- altered appetites
- unusual eating habits
- early childhood dental problems
- difficulty maintaining a healthy weight (either overweight or underweight)

Practice Tips:

When chronic illness and nutrition concerns arise:

- **Ask whether the child's nutrition status has been assessed.** If not, order an assessment.
- **Order an assessment for early intervention services.** Early intervention services provide access to dietitians, occupational therapists, physical therapists, and speech and language pathologists who are trained to address nutrition and feeding issues.

Sources:

1. American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care. "Health Care of Young Children in Foster Care." *Pediatrics* 109(3), March 2002, 536-541.

2. Hagan J.F., J.S. Shaw and P.M. Duncan, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3d ed. Elk Grove Village, IL: American Academy of Pediatrics, 2008.

3. Ibid.

Coordinated Medical Care

The average stay in foster care is roughly 28 months,[33] and approximately two-thirds of children in care for 24 months or longer have three or more different placements while in care.[34] For this reason, children in foster care are less likely to receive ongoing care by the same provider than other children. Having contact with a single health care provider is crucial for children who are slowly adjusting to separating from a primary caregiver and adapting to a new placement.

Preventive Health Care Schedule

Age	Recommended Frequency of Visits
Birth to six months	Monthly
Six months to one year	Every two months
One to two years	Every three months
Two years through adolescence	Every six months

In addition to age-based visits, AAP also recommends supplemental visits at critical child welfare junctures, including:

- system entry;
- placement transitions;
- significant changes within the home environment (health issues or death of a caregiver, disruption of sibling from a home, etc.);
- when significant issues arise around visitation;
- when any concern is raised regarding potential child abuse or neglect;
- deterioration in child behavior or developmental skills;
- deterioration in health; and
- system exit—either based on discharge, termination of parental rights, or adoption.

Source: American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care. "Health Care of Young Children in Foster Care." *Pediatrics* 109(3), March 2002, 539 (supplemental examples provided by Moira Szilagyi, MD, PhD, FAAP, Vice-chair of the AAPs Task Force on Foster Care).

Ideally that health provider is familiar with the impact of complex trauma, separation, and loss on the emotional and developmental health of children in foster care. Since the harmful experiences of children in care can negatively impact their health and well-being, the AAP recommends an enhanced preventive health care schedule for these children. Regular contact with a knowledgeable medical home provider (discussed below) helps detect subtle changes in the child over time, and supports and educates foster parents, who are the primary therapeutic intervention for the child in care. The AAP recommends an increased preventive health care schedule for children in foster care (see above).

To help ensure adequate health care:

- Ask at each hearing when the child's last medical appointment was, and when the next one is scheduled.
- Require that additional appointments be scheduled at critical points in the child's case or according to the AAP age-based recommendations above.

- Ask the caseworker to obtain a health update after each well-child visit and to incorporate that information into the permanency plan in a meaningful way (e.g., for the child with asthma, all current and potential caregivers should have asthma education and understand the signs and symptoms, which medications the child needs, how and when to administer them, and when to seek help).
- Ensure all current and potential caregivers know the child's doctor's name and number.

Require a medical home.

Ask if the child has a medical home, a single source of coordinated health care and if the caseworker receives health updates from that resource. A medical home ensures a child is being seen frequently (because records will accurately show the last visit) and allows health care providers to develop a relationship with the child.

A "medical home" offers coordinated, comprehensive, compassionate health care that is continuous over time. Continuity of care in the medical home promotes better outcomes for children, including increased immunization rates, fewer emergency department visits, decreased hospitalization, and improved perceptions of quality of care. This continuity can be especially important to children in care, who have greater health and social needs. The medical home may be essential to timely identify health care needs and deliver appropriate health services for children in foster care.

Other advantages of the foster care medical home are it maintains a detailed health record for the child in foster care, develops care plans for children with special health care needs, assumes responsibility for care coordination, and exchanges health information with child welfare at regular intervals. Recognizing this, the AAP stresses that children in foster care should receive continuity of care through a medical home.[35]

A medical home is centrally located, accessible, and accepts a variety of insurance. It is family-centered and offers culturally effective care. One practitioner acts as a single point of contact for a child and knows the needs of children in the foster care system. The practitioner oversees primary care and periodic reassessments of the physical, developmental, and emotional health of the children under her care.[36] The primary care practitioner for the child in foster care can facilitate access to all other mental health, developmental, and dental health care services, and maintain uninterrupted treatment and health information for the child.

Another benefit of a medical home is its cost-effectiveness. Children who use emergency departments, walk-in clinics, or urgent care facilities for regular

medical care receive services that cost more and are less effective, particularly for children with special health care needs.[37]

A medical home can also reduce the duration of inpatient hospitalization and medical errors, because the child's provider knows her health history. Care by a skilled pediatric health professional in the context of a medical home helps the courts and child welfare agencies' efforts to support caregivers, improve health outcomes, create stable placements, and promote permanency for children.

Address barriers to using a medical home.

For the system's most medically needy children, meeting the medical home recommendation will be difficult. Finding health providers familiar with the impact of complex trauma on children and families, willing to accept Medicaid and to spend the extra time for the poor reimbursement Medicaid offers, is a challenge. Maintaining continuity of care with a single provider for children experiencing multiple placements or moving into and out of foster care is difficult. To address these concerns and support medical home use, take the following steps:

- **Make placement decisions with continuity of health care in mind.** Reducing multiple placements for children in foster care promotes medical home use, which reduces placement instability.
- **Ensure the initial placement for a child in care is carefully selected** and work to maintain the integrity of this placement. For children with complex health care needs, a medical home provider who knows the foster care agency and foster parents in the area can help select placements for children.
- **If a change is needed, try to keep the child in the same geographic area** and make sure caseworkers and foster parents understand the importance of the medical home. This also promotes educational stability and maintains the child's other connections within the community.

Ask if the child has a health passport.

Continuity of health care services is particularly challenging for children in foster care whose placements change frequently. Besides establishing medical homes, health data-sharing efforts can help ensure continuity of services. Several states have developed a health passport for children in foster care. Health passports are snapshots of a child's health history that provide useful information to the child's health providers, caseworkers, and caregivers and help ensure appropriate health care is received while minimizing medical errors and duplicated services. The health passport may be in electronic or paper format, or a combination, and

Health Disparities and Culturally Effective Health Care

Black infants have more than twice the infant mortality rate of White infants, and are almost twice as likely to have low birth weights.[1] Black children are also more likely than White children to have asthma, to be hospitalized for asthma, and to die from asthma.[2] They are also more likely to be uninsured, have elevated lead levels in their blood, be overweight, and be diagnosed with type-2 diabetes.[3]

In response to these disparities and other factors, the AAP believes all children should receive culturally effective pediatric care.[4] It encourages increased training for health professionals on cultural diversity, and increased institutional efforts and government funding to support culturally effective care.[5]

Practice Tips:

- **Be aware of cultural and racial differences in your communities** that may be affecting health service delivery and use.
- **Learn about health disparities or cultural attitudes towards health** common among people in your jurisdiction.
- **Partner with local medical organizations to address health disparities** (e.g., by serving on a task force addressing the issue, or testifying on the issue, along with medical professionals, to local or state government).

Sources:

1. Disparities in Children's Health and Health Coverage, Children's Defense Fund Healthy Child Campaign. Available at www.childrensdefense.org/child-research-data-publications/data/childrens-health-disparities-factsheet.pdf.

2. Ibid.

3. Ibid.

4. American Academy of Pediatrics Committee on Pediatric Workforce. "Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy." *Pediatrics* 114(6), 2004, 1677-1685.

5. Ibid.

summarizes essential health information including medical problems, allergies, chronic medications, and immunization data, as well as social service and family history. The passport can also be used to record behavioral health, dental, hearing, and vision services.

The passport is available to all of the child's health providers, regardless of placement changes. Paper passports alone are less successful because they get lost or forgotten or are not filled out. Some states have better success with Web-based secure health passports which maintain data on a specific child from multiple data systems and can include immunization, EPSDT, lead, WIC, and other

data. However, there are often no requirements or incentives for providers to fill them out and passports are only useful if updated regularly. Health passports are more useful where medical homes dedicated to the care of the child in foster care do not exist.

Encourage agencies to use health passports and ensure the foster parent has access to a health passport when the child is first placed. Instruct the foster parent to bring the record to all health evaluations, and make sure the record goes with the child if placement changes. When electronic records are available, ensure confidentiality protections are applied.

Oral Health

Ensure the child receives appropriate dental services.

Early childhood caries (previously known as baby bottle tooth decay) is a common infectious disease among children, according to a U.S. Surgeon General's report, more common even than asthma or hay fever. Although this disease is chronic, transmissible and *progressive*, it can also be prevented, and is manageable once acquired. It affects infants from all racial and socioeconomic backgrounds, but low-income children are especially at risk.[38] More than 40 percent of children show signs of tooth decay before reaching kindergarten.[39] Tooth decay and cavities cause pain and potentially life-threatening swelling. They also affect learning, communication, behavior, mental health, and nutrition and are linked to lower body weight and lost time in school. Often, tooth decay and other dental problems are overlooked.

Children may also experience dental neglect, defined by the American Academy of Pediatric Dentistry (AAPD) as the "willful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection."

Promoting children's oral health from birth can prevent the onset and delay the progression of dental caries. Doing this takes ensuring children have the proper exposure to fluoride, adequate nutrition and limited exposure to sugar, and regular access to oral health professionals. Proper dental care helps children gain nutrition from their food, develop language skills, and improve their overall health. To ensure the healthy development of infants and young children, access to routine dental services should be included in an overall health plan for every child in care.

Ask about children's brushing and flossing habits. Children should brush three times a day and floss at least once, especially at the end of the day. They should be using nonfluoride toothpaste until the child can spit toothpaste out,

since swallowing large doses of fluoride can be unhealthy. Ask if children age six months or older have been seen by a dentist and are having regular visits. The AAPD recommends that a primary care physician or health provider refer a child to a dental home as early as six months and by no later than 12 months of age.[40] A referral should also be provided as soon as the baby's first tooth erupts. Ask the agency to report on the initial visit and any recommended follow-up care, as routine follow-up decreases the risk of preventable dental disease. When physical or sexual abuse involving the mouth or dental neglect is suspected, ask whether the child was referred to an appropriate specialist.

The National Council of Juvenile and Family Court Judges encourages judges to ask specific dental health questions during hearings and to coordinate agency efforts to ensure each child's access to a dental home.[41] Relevant questions include:

- Does the child have a dental home and/or access to preventive and treatment services?
- Has the child had a dental exam? When?
- What dental health needs does the child have?
- How are the child's dental health needs being met?
- How often does the child brush? Floss?
- How does the child receive fluoride?
- When is the child's next dental exam scheduled?[42]
- Has the child received sealants?

In addition to health benefits, early preventive care is a sound financial investment. Low-income children who receive their first dental visit by age one are not only less likely to have subsequent restorative or emergency room visits, but their average dental costs are almost 40% lower over a five-year period than those for children who receive their first preventive visit after age one.[43] Communities that fluoridate their water save $38 in dental treatment costs for every $1 spent and giving children sealants reduces treatment costs by preventing cavities.[44] Children who lack periodic preventive dental care are more likely to wait until symptoms (i.e., toothache) become so severe that a visit to the emergency room is warranted. Managing symptoms in an emergency room costs approximately 10 times more than preventive care in a dental office.[45]

Help each child access a dental home.

A "dental home" refers to the ongoing relationship between a patient and a licensed dentist. All aspects of oral health care are delivered in a comprehensive, coordinated, and family-centered way. Like a medical home, the dental home brings together patients, parents, and dental professionals to deliver continuous,

Low-income Children and Dental Health

Low-income children and children of color are at greater risk for tooth decay and untreated cavities:[1]

- Poor children are almost twice as likely to have untreated cavities.
- Poor children have more severe tooth decay than higher-income youth.
- 54.9% of Mexican-American, 43.3% of Black non-Hispanic, and 37.9% of White non-Hispanic children aged 2-11 had untreated tooth decay in their primary teeth.

Source:
1. Beltrán-Aguilar, Eugenio D. et al. *Surveillance for Dental Caries, Dental Sealants, Tooth Retention, Edentulism, and Enamel Fluorosis—United States, 1988–1994 and 1999–2002, 2005*. Available at www.cdc.gov/MMWR/preview/mmwrhtml/ss5403a1.htm.

cost-effective and high-quality oral care. Tooth decay, cavities, and other oral health issues are easily prevented when routine services are provided by a dental home.

A dental home will:

- provide comprehensive oral health care services, including acute and preventive treatment that follow accepted practices and timelines for pediatric dental health;[46]
- conduct an oral disease risk assessment and provide an individualized program for preventive care;
- offer caregivers guidance about growth or development issues (teething and bite development), behavior modification techniques, dietary counseling, and plans in case of emergency dental trauma;[47]
- provide referrals to adult oral care providers when needed, and to other dental specialists, such as endodontists, oral surgeons, orthodontists, and periodontists, when care cannot be provided directly within the dental home.[48]

A referral to a pediatric dentist or a family dentist is the first step in accessing a dental home. It helps to give families a list of providers who participate in the Medicaid program. In addition, local Head Start programs, dental associations, and Internet resources (such as www.aapd.org) are all useful for locating a dental home.[49] Many communities have low-cost dental clinics for low-income children and families.

Innovative Oral Health Programs

- **Prevent Abuse and Neglect through Dental Awareness (PANDA) Program**
  This program, which started in Missouri but is now running in most states, trains dentists to identify child maltreatment.

- **I Smiles**
  www.idph.state.ia.us/hpcdp/oral_health_ismile.asp
  This statewide program links children to a dental home and is a good example of a coordinated system of care.

- **BEST Oral Health Program**
  http://baystatehealth.com
  (type "Oral Health" in the search box, then click on "BEST Oral Health")
  This Massachusetts program addresses oral health issues among vulnerable infants, toddlers, and preschoolers through Early Care & Education Centers.

- **Klamath County (Oregon) Early Childhood Cavity Prevention Program**
  www.oregon.gov/DHS/ph/oralhealth/programs/klamath.shtml
  This initiative links mothers and children to dental care through referrals to local WIC programs.

- **Cincy Smiles**
  www.cincysmiles.org/
  CincySmiles Foundation runs a well-coordinated mobile dental care program in Cincinnati, Ohio, along with several other school- and community-based programs.

- **AAP Oral Health Initiative**
  www.aap.org/commpeds/dochs/oralhealth/index.cfm
  Prepares pediatricians to provide oral health screenings and referrals for young children.

Remove barriers to dental care.

Oral health awareness

Caregivers often lack awareness of the importance of oral health for young children and may be unaware of the need for early and regular oral health care. The priority of oral health can vary due to social, cultural, and economic factors. Dietary practices specific to certain cultures may promote the onset or development of dental caries, while other factors may discourage some groups from pursuing care. Without proper dental care referrals, caregivers may miss the importance of dental care for offsetting and managing dental caries.

There is often a misconception that primary teeth are unimportant since they

Safety Net Providers of Dental Care

Where can low-income children in your community turn for dental care when few dentists will take Medicaid? Safety net providers and services, such as mobile dental programs, community health centers approved by the state or federal government, or dental schools, may fill this need.

Safety net facilities and programs include:

- **State-Recognized Safety Net:** These providers include hospitals, diagnostic and treatment centers, community health centers, school-based health centers, and county health departments approved to operate by the state department of health. They receive public funding for oral health services. Dental schools and dental hygiene training programs may also be state-recognized safety net providers if they have explicit policies regarding care for vulnerable populations.
- **Federally Recognized Safety Net:** These facilities have been approved as safety net providers by federal agencies such as the Health Resources and Services Administration or Center for Medicare and Medicaid Service. Each agency sets its own administrative and/or service requirements, and recognition provides access to federal funding.
- **Community Hospitals:** Although local hospitals and their emergency departments provide medical treatment regardless of ability to pay, these hospitals rarely have the capacity to address routine dental complaints. Young children who come to the emergency room with severe acute dental pain and infection are usually given antibiotics and pain medications to ease their symptoms but may not receive treatment for the underlying disease. Their parents must then take them to a dentist suggested by the hospital, or locate dental care on their own.
- **Community & School-Based Centers:** Facilities supported by public and private funders, including school-based (onsite) or school-linked (offsite) health centers, freestanding voluntary health centers, and city and county health centers.
- **Head Start and WIC:** Head Start and Early Head Start are required by federal regulation to give clients oral health education, screening, and referrals for treatment. Head Start and the American Academy of Pediatric Dentistry are also working to establish "dental homes" for all children in Head Start.

  WIC nutrition programs also provide counseling on oral health and childhood caries prevention and are often co-located in health centers. Local programs that target young at-risk children with health education and social services may also provide oral health services or education.
- **Mobile Dental Programs:** Like school-based health centers, mobile programs bring care to children where they are during the day rather than bringing children to care.

Mobile programs include both self-contained vans, and satellite-site programs that bring mobile dental equipment onsite to gyms, auditoriums, and function rooms. Mobile programs may also be used to screen children and identify those who require additional care in a traditional dental setting.

- **Medicaid-Focused Private Practices:** Some private practices focus on children on Medicaid. They are easily accessed by public transportation and schedule flexible appointments that accommodate clients' constraints and adjust for high rates of missed appointments. They may engage in more flexible appointment management (e.g., filling in missed appointments by providing more care for children who are present). These practices may provide comprehensive care or limited services.
- **Training Programs:** Dental schools, postdoctoral dental residencies, and dental hygiene programs also support the dental safety net.

Source:
Adapted from Edelstein, B.L. *Maximizing Public Dollars in the Provision of Dental Care in New York State*. The Community Health Foundation of Western and Central New York, January 2009.

will eventually fall out, yet they are essential for: biting and chewing food, assisting in speech development, developing jaw bones and facial muscles, reserving space for permanent teeth, and developing self esteem. Additionally, tooth decay in primary teeth is the most reliable predictor of dental caries in permanent teeth.[50]

Access to dental care

Medicaid covers a quarter of all children in this country, but only one-third of enrolled children see a dentist annually. Children enrolled in Medicaid must receive comprehensive dental coverage under EPSDT. Comprehensive dental care is also provided to low-income children through the state Child Health Insurance Program (CHIP). However, dentists' participation in these programs is limited, and access is severely inadequate in many areas.[51]

Fewer than 5% of all U.S. dentists are pediatric dentistry specialists, dentists uniquely trained to manage the behavioral and treatment complexities of children who experience the most severe dental disease. These specialists are commonly located in suburban areas. While more pediatric dentists participate in Medicaid than general dentists, their suburban location is often a barrier for inner-city and rural children. A national survey suggests that fewer than one-in-five dentists participate in Medicaid and far fewer participate significantly.[52]

Due to these barriers, low-income children may need to access dental care through "safety net"[53] providers and services, such as mobile dental programs,

community health centers approved by the state or federal government, or dental schools. (See "Safety Net Providers of Dental Care" box.)

Judges can work on several levels to expand access to dental care for children:

- Order that each child in your courtroom have a dental home.
- Advocate for increased Medicaid reimbursement rates for providers.
- Engage state and local dental associations to develop referral and care programs for children in the child welfare system.
- Strengthen relationships with, and state support for, the various safety net providers.

Barriers to Health Care Access

Find out if the child has health insurance.

Many young children in foster care will not receive the medical, dental, developmental, or mental health services they require because of insufficient health insurance coverage. Most children in care are eligible for Medicaid based on their eligibility for Title IV-E foster care funds. Some states also cover non-Title-IV-E eligible children in foster care as an optional category. Children in foster care who are not eligible for Medicaid may be eligible for coverage under the state Children's Health Insurance Program (CHIP). Ensuring all children in care are covered by health insurance will help to maintain continuous health care.

Ask whether the child has health insurance (e.g., Medicaid, private coverage). If the child is uninsured, ask if she is eligible for any programs (e.g., Children's Health Insurance Program) and require that she be enrolled as appropriate. If the child is insured, ask if the coverage is adequate (e.g., does it cover mental health and dental care in addition to routine pediatric care)? If necessary, ask the agency to look into switching to better health insurance, or paying for medical costs that aren't covered by insurance (e.g., broken or lost glasses which Medicaid won't replace, or a wheelchair or ventilator that could take months to procure through Medicaid). Require a supplemental report be filed with the court discussing eligibility, enrollment, and payment of burdensome medical costs before the next court hearing.

Under Medicaid, children are eligible for EPSDT services, which include recommended assessments, screens, and treatment services. Because only Medicaid requires EPSDT services, children without Medicaid coverage may or may not receive such services.

Guidelines for Health Care for Children in Foster Care

This chapter summarizes research and best practices for meeting the health needs of children in care. Two national publications provide additional guidelines:

- **Fostering Health: Health Care for Children in Foster Care**
  American Academy of Pediatrics (AAP)
  Describes practice guidelines for primary care, developmental and mental health care, management of health care, and approaches to child abuse and neglect.
- **Standards for Health Care Services for Children in Out-of-Home Care**
  Child Welfare League of America (CWLA)
  Provides a comprehensive framework to organize physical, developmental, and mental health services for child welfare organizations.
- **Additional resource:**
  Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates, and Child Welfare Professionals
  New York State Permanent Commission on Justice for Children
  Asks questions related to the above standards developed by the AAP and the CWLA and gives recommendations for how to meet them. Available at: www.courts.state.ny.us/ip/justiceforchildren/PDF/ensuringhealthydevelopment.pdf.

Identify other barriers to the child's access to medical services.

The lack of qualified providers who accept Medicaid, or who have experience and knowledge about the health care needs of children in foster care, and the fact that many jurisdictions do not require comprehensive exams, are additional barriers to health care. The high mobility of children in foster care can cause interruptions in insurance when a child moves out of a plan's coverage area. Agencies must make reasonable efforts to meet children's medical and dental health needs. As a judge overseeing the agency's efforts, you can ensure children receive necessary care by ordering the agency to pay the full cost of a visit to a provider outside the child's health insurance plan if there are no qualified providers, or to insure the child under a different health plan with more providers.

Reduced Medicaid spending also prevents many children from accessing services despite insurance coverage. Many states have shifted from a fee-for-service-based Medicaid reimbursement system to a managed care plan, which raises

Red Flags for Health Concerns

The following health conditions are common in young children in foster care. Be familiar with them to quickly identify when a child requires more attention.

Failure to Thrive/Malnutrition:

Failure to thrive (FTT), or growth failure, occurs when a child does not receive sufficient nutrition for proper physical growth and development. FTT is often associated with poverty and may have multiple causes, such as difficulty feeding or underlying medical conditions, including three of the health problems described below (Fetal Alcohol Spectrum Disorders, vertically transmitted infections, and lead poisoning). FTT can also result when a caregiver does not have the means to provide adequate nourishment or does not use available resources. Sometimes, maternal or paternal neglect of a child's nutritional needs stems from mental health and cognitive issues that result in a failure to supply adequate nutrients (nonorganic FTT). Malnutrition in children with FTT not only results in poor growth, but also in long-term deficits in intellectual, social, and psychological functioning. Although not directly linked to FTT, attachment disturbances often accompany the condition, especially nonorganic FTT. Therefore, infants with FTT should be referred for an early childhood developmental and mental health evaluation. Their parents should also be referred for mental health evaluation.

Practice Tips:

- Ensure caregivers meet medical recommendations and adhere to treatment plans for children with FTT.
- Mandate education for birth and foster parents on the importance of feeding and close social interaction to promote healthy growth and strong attachments.[1]
- Mandate a mental health evaluation for the birth parents.

Fetal Alcohol Spectrum Disorders (FASD):

FASD is an umbrella term for three outcomes that can result from a mother drinking during pregnancy (fetal alcohol syndrome, fetal alcohol effects, and alcohol-related neurological disorder).[2] Fetal alcohol syndrome is most known and may be characterized by specific facial features. The other symptoms are common in all the disorders in the FASD spectrum: growth deficits, mental retardation, heart, lung, and kidney problems, chronic ear infections, hyperactivity and behavior problems, attention and memory problems, poor coordination or motor skills delay, difficulty with judgment and reasoning, and learning difficulties.

Practice Tips:

- Screen for FASD in all children in foster care.
- Require birth parents and foster caregivers to be trained to recognize signs of these disorders.

- Ensure an assessment is completed in suspected cases, preferably one conducted by a developmental or behavioral pediatrician or a geneticist. If the assessment reveals a problem, ensure the child's caregiver has the knowledge and support to meet his needs, and the child is receiving early intervention services.
- Visit the federal FASD Center for Excellence Web site to learn more about FASD: www.fascenter.samhsa.gov/index.cfm

Because FASD affects learning, especially for young children, assessment is critical to identify services to help a child get ready for school. Obtaining information about a mother's drinking history while pregnant is also vital, since an accurate history of maternal alcohol use is the key to the most conclusive FASD diagnosis.[3]

Vertically Transmitted Infections:

Vertically transmitted infections are infections that a mother passes to her baby, either through the placenta or when the baby passes through the birth canal. Infants can contract viruses, including HIV, hepatitis B, hepatitis C, herpes, HPV (genital warts) and syphilis, among others. A mother may not experience symptoms related to the infection and may unknowingly pass the infection to her child during pregnancy or child birth.

Vertically transmitted infections can be difficult to diagnose because the effects of the infection may not be seen at birth. Complications associated with these infections include damage to the developing brain and other body systems.

- Hearing loss may be associated with vertically transmitted infections and may be present at birth or progressively develop and present later in childhood.
- Visual problems are also common.
- Brain damage can be mild or severe and may cause mental retardation, learning and behavioral disorders, and autism. Special education is frequently required, and early intervention services should also be accessed.

Practice Tip:

- Because of the varied effects of vertically transmitted infections, early and periodic hearing, vision, and developmental screens are essential. Make sure screens occur and are repeated at recommended intervals. If necessary, ensure special education or other services are in place.[4] Poor growth is also an early sign of vertically transmitted infections, and calls for screening.

Shaken Baby Syndrome (SBS):

SBS, also called shaken impact syndrome, describes the effects of violently shaking an infant or young child. Children, especially infants, have weak neck muscles, which cannot fully support their heads. When a baby is shaken his brain moves back and forth inside his skull. This movement can cause severe injuries including blindness or eye damage,

Red Flags for Health Concerns (continued)

developmental delay, seizures, paralysis, brain damage, and sometimes death. SBS often occurs in children under two years old, but has been reported in children up to age five.

Although severe cases of SBS may present with signs of head injury, less serious cases may result in symptoms mimicking colic or a viral infection—poor feeding, vomiting, lethargy and irritability—and may delay early attention. Outcomes for children who do not receive medical attention are unknown but they may have learning, motor, or behavior problems later in life with no known cause. When severely injured children survive, they may experience blindness, seizure disorders, severe cognitive impairments, and other serious brain defects.[5]

Practice Tips:

- If SBS is suspected, ask if a head injury evaluation has been performed. If not, order one. An adequate assessment of a child with a suspected shaking injury includes a head MRI or CT, an ophthalmology examination to look for retinal hemorrhages, and a skeletal survey to look for subtle fractures of the ribs and long bones that occur with shaking and chest compression. A "babygram" (which gives a single image of the entire infant) is not sufficient; ordering a full range of tests helps establish whether or not the child was the victim of abuse and confirm a diagnosis of SBS.
- At the initial hearing, order a thorough investigation of who cared for the child during the seven days before the onset of symptoms.

Lead Poisoning:

Usually caused by environmental lead exposure, lead poisoning can have many long-term effects including decreased intelligence, impaired behavioral development, short stature, hearing problems, and learning difficulties. Children living in poverty, and those in foster care, are at risk for elevated lead levels. Blood screening for elevated lead is the most common way to detect lead poisoning.

Practice Tips:

- Ask about lead screening results for all children under age six years or a developmentally delayed child of any age who has a history of pica. Require a lead evaluation if these results are not available.[6]
- If the home the child currently lives in (or will live in if case plan goals are met) contains lead-based paint hazards, order lead remediation services.

Respiratory Illness:

Respiratory illnesses are the most common medical problem among children in care. One study reported 19% of children in care as having a respiratory illness. Ear infections make

up a large percentage of these infections and can result in long-term problems in hearing, speech, and language development. Asthma and chronic respiratory diseases, such as cystic fibrosis may be less common, but more dangerous for children in care. Respiratory illnesses can also cause breathing difficulties.

Practice Tip:

- Make sure any young child with a respiratory illness is evaluated by a medical provider.[7]

Hearing and Vision Problems:

Hearing impairments can hamper a child's speech and language development, personal-social adjustment, and emotional development. As a result, later learning and academic achievement may be limited. Similarly, vision problems may impair school performance, and can signal more significant disease.

Practice Tips:

- Hearing, language, and vision should be periodically evaluated in children in foster care because caregivers may be less likely to report subtle abnormalities in these areas. Ask if such screens have been completed regularly coinciding with well-child care visits.
- Ask if there is information about the child's newborn hearing screen.
- Ask if there is a family history of hearing impairment and ensure this information is relayed to the child's medical home.
- Eye exams occur at each well-child visit beginning at birth, but formal visual acuity screening begins successfully around age four.

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Closely watching the needs of this population and whether necessary medical care is provided can help counter difficulties that funding restrictions create for public health programs that serve children.

Conclusion

Infants and toddlers in foster care are more likely to have physical health problems than other children. Identifying these problems and intervening early to treat and prevent them is key. Ensuring access to high-quality, consistent health care promotes their optimal physical health and development. You can help ensure that each child in your courtroom achieves optimal physical health by following the guidelines set out in this chapter including each child having a medical and dental home that has all of her relevant medical history and records and provides assessments, indicated follow-up, and preventative and routine care on the schedules advised by the AAP or AAPD. You can also help reduce barriers to good health by ensuring that all children in your courtroom are enrolled in Medicaid or another health insurance program. With effective oversight, court-involved infants and toddlers can grow into healthy children, adolescents, and adults.

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