American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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May 20, 2011

Mr. Joseph Bock
Acting Associate Commissioner, Children's Bureau
Administration for Children and Families
Department of Health and Human Services
1250 Maryland Ave, S.W.
Eighth Floor
Washington, D.C. 20024

Dear Mr. Bock:

The American Academy of Pediatrics (AAP) appreciates this opportunity to offer comments on the Federal Monitoring of Child and Family Service Programs, as noticed in the *Federal Register* on April 5, 2011.

The AAP strongly supports the Child and Family Service Review (CFSR) process and its goal of producing continuous quality improvement in the delivery of services to abused and neglected children. The medical literature has amply documented the disproportionate rates of physical, mental, and developmental health needs among children in the child welfare system. These children are arguably the most vulnerable in our society – youngsters with special health care needs who often lack strong advocates or a medical home to address those needs.

Through the experience of our state chapters, the AAP has a wealth of knowledge about the challenges in delivering appropriate, timely health care to children in the child welfare system. While many states have developed innovative models that address certain aspects of this care, no state has been able to achieve the goal of consistently providing quality health care to all children. Child and Family Service Plans and the periodic CFSR process serve as important tools for both the federal government and states in examining the challenges and barriers, developing innovative solutions, and continuously improving the quality of health care for children in the child welfare system.

The American Academy of Pediatrics would like to offer our considerable expertise and resources in this field in our mutual quest to improve the health and well-being of children in foster care. If we may be of further assistance, please contact Kristen Mizzi in AAP's Washington, D.C. office at 202/347-8600.

Sincerely,

O. Marion Burton MD

O. Marion Burton, MD FAAP
President

The American Academy of Pediatrics (AAP) appreciates this opportunity to offer comments on the Federal Monitoring of Child and Family Service Programs, as noticed in the *Federal Register* on April 5, 2011. This notice solicited comment on several specific questions and invited general comment on other issues of concern. Following please find the AAP's comments on individual questions, as well as input on the review of Health Oversight and Coordination Plans as part of the CFSR process.

2. ***To what extent should data or measures from national child welfare databases (e.g., the Adoption and Foster Care Analysis and Reporting System, the National Child Abuse and Neglect Data System) be used in a Federal monitoring process and what measures are important for State/Tribal/local accountability?***

The AAP strongly supports the concept of continuous quality improvement in both health care and child welfare settings. In the field of pediatric medicine, the AAP is proud to play a leading role in promoting all aspects of quality improvement and providing our members with the tools to evaluate their practices and improve the care they deliver to children and families.

The medical community has embarked upon the development of a series of health care quality measures, including pediatric-specific measures. Under the Child Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the Agency for Healthcare Quality and Research guided the development of an initial recommended Core Set of children's health care quality measures for voluntary use by Medicaid and CHIP programs.[1] The AAP recommends that the Children's Bureau consider utilizing the measures from this Core Set in the Health and Wellbeing assessments associated with CFSRs. By utilizing the same measures, the Children's Bureau would not only make use of well-researched and validated measures, but could also compare each state's results against larger data sets being collected on the same measures.

4. What roles should State/Tribal/local child welfare agencies play in establishing targets for improvement and monitoring performance towards those targets? What role should other stakeholders, such as courts, clients and other child-serving agencies play?

Through the experience of our state chapters, the AAP has a wealth of knowledge about the challenges in delivering appropriate, timely health care to children in the child welfare system. While many states have developed innovative models that address certain aspects of this care, no state has been able to achieve the goal of consistently providing quality health care to all children.

The AAP urges the Children's Bureau to encourage state child welfare systems to partner with AAP chapters and pediatric health care providers in examining and improving their systems for serving the health care needs of children in the child welfare system. AAP chapters are eager to offer their expertise and could offer valuable state-specific insights regarding improvements.

6. What specific strategies, supports, incentives, or penalties are needed to ensure continued quality improvement and achievement of positive outcomes for children and families that are in substantial conformity with Federal child welfare laws?

The AAP recognizes that most states and locales do not have systems in place to meet all of the requirements of federal laws such as the Fostering Connections to Success and Improving Adoptions Act of 2009 (Fostering Connections.) The Children's Bureau should therefore consider establishing a set of standards for health and well being that evolves over the next several years. Meeting the requirements for Fostering Connections and similar laws will take time, and therefore the expectations should reflect the processes that are needed in order to monitor and improve child health. Ideally, the new requirements should also be accompanied by new resources. States should be expected to provide concrete evidence of progress toward compliance.

7. In light of the ability of Tribes to directly operate title IV–E programs through recent changes in the statute, in what ways, if any, should a Federal review process focus on services delivered to Indian children?

In 2005, the Government Accountability Office (GAO) issued a key study of the Indian Child Welfare Act (ICWA). The GAO made the following recommendations and asked for the HHS Secretary to direct the head of ACF to: 1) review ICWA issues revealed in reviews of state child welfare systems, 2) require states to discuss ICWA issues in their annual reports that were not addressed in performance improvement plans, and 3) use the data identified in these state reports and plans to direct guidance to states on how to improve ICWA compliance. It was the opinion of GAO that these recommendations would require little additional resources and effort on HHS's part and could be undertaken with existing information collected by HHS. The Children's Bureau should consult closely with tribal leadership and the National Indian Child Welfare Association to address the unique issues related to Indian children and their needs.

In addition to responding to the specific questions posed above, the AAP would like to revisit issues related to the Health Oversight and Coordination Plans (HOCPs) that states are required to have in place under the Fostering Connections law. The AAP was proud to work closely with Congress in crafting this provision, which is designed to bring new attention to the health needs of children in foster care. Despite the overwhelming evidence of need, studies consistently demonstrate that many health care needs for children in the foster care system go unmet. Stark evidence that children are not receiving timely services has come from a range of studies, from the 1995 General Accounting Office (GAO) report demonstrating that 1/3 of children had health care needs that remained unaddressed while in out-of-home care, to the 2004 analysis of the National Survey of Child & Adolescent Well-Being documenting that only a quarter of the children with behavioral problems in out-of-home care received mental health services within a one-year follow-up period.[2]

Fostering Connections requires state child welfare and Medicaid agencies to examine the delivery of health care services to children in foster care in order to identify opportunities for improvement. On June 3, 2010, the Administration for Children and Families issued a Program Instruction (ACYF-CB-PI-09-06) that directed each state to include a health oversight and coordination plan as part of its Child and Family Services Plans for Fiscal Years 2010-2014.

The Program Instruction provided little guidance to states beyond what was set out explicitly in the Fostering Connections statute. Since that time, an AAP review of state Child and Family Service Plans has revealed tremendous disparities in the attention and resources being devoted by individual states to HOCPs. States have interpreted the direction of the HOCPs in very different ways; for example, in addressing the requirement to improve sharing of medical records, one state might be developing an electronic medical record while another is focusing on communication between providers. The AAP would therefore recommend that the Children's Bureau take into account each state's HOCP and its work when evaluating service outcomes and program systems during CFSRs. States should be able to demonstrate that each of the six key components of their HOCP, as required by Fostering Connections, is in place, is operational in terms of actual care provision to children in foster care, and is actively helping to guide progress in improving overall child health outcomes.

Following is a brief review of AAP's recommendations for a high-quality HOCP.

Consultation. The law directs state child welfare and Medicaid agencies to develop the HOCP in consultation with "pediatricians, other experts in health care, and experts in and recipients of child welfare services…" Given the complexity of the health needs of children in foster care, a model consultation process should involve an interdisciplinary Foster Care Health Coordination Team. In order to make the consultation process more manageable, the AAP suggests that states consider strategies that streamline the process. For example, plan development could be led by a Foster Care Health Leadership Team comprised of child welfare administrator with the authority to make decisions regarding financing and care, a pediatrician, and a mental health care provider.

Plan Adequacy. Fostering Connections directs that the HOCP should consist of "a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs." At present, none of the states has a seamlessly coordinated health strategy for the children under its care. While a number of states may address some of the plan components required by Fostering Connections, no state has been able to achieve the goal of providing all the components to all children. States should be able to point to examples of meaningful progress toward this goal.

Plan Components. Fostering Connections requires that state plans address six discrete issues:

Schedule of Screenings. The HOCP must contain a "schedule for initial and follow-up health screenings that meet reasonable standards of medical practice."
Monitoring and Treatment. The law requires the HOCP to address "how health needs identified through screenings will be monitored and treated." Given the complex, long-term health needs of many children in foster care, concerted efforts must be made toward coordination.
Medical records. Virtually every pediatrician has encountered a child in foster care who arrives in their practice with no medical records or history. Fostering Connections requires that the states develop a plan to address how "medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record."
Continuity of Care. The law directs state plans to include "steps to ensure continuity of health care services, which may include the establishment of a medical home for every child in care."
Oversight of Prescription Medication. ACF's Program Instruction "encourage[d] States to pay particular attention to oversight of the use of psychotropic medicines in treating the mental health care needs of children."
Consultation Regarding Care. Fostering Connections directs states to indicate in the HOCP "how the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children."

Some of the plan components lend themselves to review in the context of CFSRs. For example, during case record reviews, Children's Bureau reviewers could determine whether the child has a medical home and whether the use of any prescription medication is being monitored appropriately.

In closing, the American Academy of Pediatrics stands ready to assist you in improving the health and wellbeing of children in the child welfare system. The Academy has substantial expertise and specific resources regarding health care for children who have suffered abuse or neglect, including books, checklists and guidelines. We hope you will call upon the AAP as a resource both on the federal level and in assisting individual states to improve the health of the children in their care.

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[1] Core set available online at http://www.ahrq.gov/chipra/corebackground/corebacktab.htm.
[2] Burns BJ, Phillips SD, Wagner RH, et al. Mental health need and access to mental health services by youths involved with child welfare: a national survey. *Journal of the American Academy of Child and Adolescent Psychiatry.* 2004;43(8):960-970.