

Report From the AAP Council on Foster Care, Adoption, and Kinship Care's  
Foster Care Chapter Meeting

Prepared by

Joelle Ruben, MSW  
JBS International, Inc.

February 25, 2015

## **Table of Contents**

Introduction	3
I: Improving Communication	5
Spotlight on Ohio	8
II. Fostering Collaboration	9
Spotlight on Pennsylvania	11
III. Identifying Emerging Trends	13
Spotlight on Medicaid Advocacy	15
Conclusion	17

## Introduction

---

For one Ohio foster family, good intentions were not enough when the family unknowingly took in a baby with major congenital heart disease. A misspelling of the infant's name opened a duplicate file without his diagnosis or his scheduled cardiac surgery. Fortunately, child welfare workers found the error in time to reconnect the child to health care providers and to place the boy with a different foster family that could better meet his medical needs.

Stories like this show how easy it is to overlook the health needs of children and teens in foster care, says Colleen Deems, MSN, CPNP, from the Fostering Health Program in Providence, Rhode Island. When children are removed from their biological families, their full medical and behavioral health histories often do not go with them, and new information can get lost easily when those same children are moved from placement to placement.

“Imagine a loved one with a medical issue who suddenly has to go to a new doctor who doesn't know anything about them,” Ms Deems says. “They can't access any of their health records, they can't speak for themselves, and they don't have any family members around them to help.”

Hundreds of thousands of children and teens live in foster care in the United States. For the past 7 years, the American Academy of Pediatrics (AAP) has encouraged pediatricians to improve the health and well-being of children in care by funding chapter grants that focus on state-level reform.

In 2008, the AAP launched the Health Care for Children and Youth in Foster Care Chapter Project to help pediatricians address the unmet needs of children and youth in foster care. AAP chapters submit ideas for change to the Council on Foster Care, Adoption, & Kinship Care (COFCAKC), which awards grants to improve statewide communication, collaboration, and oversight.

“One of our big conundrums was how do we stimulate pediatricians around the country to engage with their child welfare institutions, with mental health, with government leaders to begin the process of change and to improve the health outcomes of children in foster care,” says the council's chair Moira Szilagyi, MD, PhD, FAAP.

Since the project began, the council has awarded 15 chapter grants across its 2008, 2013, and 2014 grant cycles. In recognition of the excellent work that has come from these grants, the council decided to hold a meeting where everyone could come together to discuss their challenges, successes, and lessons learned. Grantees were invited to the AAP headquarters for a day-long meeting on February 13, 2015.

This report presents the information shared during that meeting across 3 major themes: improving communication, fostering collaboration, and identifying emerging trends.

**States Receiving Funding Through the Health Care for Children and Youth in Foster Care Chapter Project**

2008 Grantees

<b>States</b>	<b>Attendees</b>
Maryland	Rachel Dodge, MD, MPH, FAAP Wendy G. Lane, MD, MPH, FAAP
Massachusetts	Linda Sagor MD, MPH, FAAP Heather Forkey, MD, FAAP
Nebraska	Tina Scott-Mordhorst, MD, FAAP
New Jersey	Cathleen Ballance, MD, FAAP E. "Sooze" Hodgson, MD, FAAP
Pennsylvania	Cindy Christian, MD, FAAP

2013 Grantees

<b>States</b>	<b>Attendees</b>
Colorado	William Betts, PhD Kathryn Wells, MD, FAAP
Minnesota	Did not send representative
South Carolina	Greg Barabell, MD, FAAP Ramkumar Jayagopalan, MD, FAAP
Utah	Kristine Campbell, MD, FAAP Julie Steele, DNP, FNP-BC
West Virginia	Jim Lewis, MD, FAAP
Wisconsin	Kelly Hodges, MD, FAAP Lisa Zetley, MD, FAAP

2014 Grantees

<b>States</b>	<b>Attendees</b>
Connecticut	Anton Alerte, MD, FAAP
Georgia	Jennifer Collier-Madon, MD, FAAP Patricia Mason Lantis, MD
Ohio	Mary Greiner, MD, FAAP
Rhode Island	Colleen Deems, MSN, CPNP Carol Lewis, MD, FAAP

## **I: Improving Communication**

---

Since the project's outset, the AAP has emphasized the need for better communication to inform stakeholders about children's medical and behavioral health needs. Grantees touched on several communication-based themes throughout the February meeting, including strategies for getting pediatricians, child welfare workers, foster parents, and others closer to—if not always on—the same page.

### ***Identifying Children in Foster Care***

For some chapter grantees, the first challenge to helping patients in foster care is receiving notification when children enter, or reenter, the child welfare system.

In Maryland, Making All the Children Healthy (MATCH) provides care coordination and case management for Baltimore children in out-of-home placements. Health coordinators aim to connect children to primary care providers within 5 days of entering care to receive an initial health assessment, says Medical Director Rachel Dodge, MD, MPH, FAAP. After noticing a discrepancy between the program's success rate and that calculated by the child welfare agency, MATCH staff members realized that they were being held accountable for children who had not been registered for the program by caseworkers.

Dr Dodge partnered with child welfare administrators to establish protocols for registering children in the MATCH program, including a new step that tracks the timeliness of registration receipts presented by caseworkers.

“Now, most caseworkers walk across the street and register kids immediately right after court, so we know right away and can get that initial appointment scheduled in the right amount of time,” she says.

As vice president of AAP's Connecticut Chapter, Anton Alerte, MD, FAAP, has spent years trying to establish a medical passport that would follow children and teens throughout their time in foster care. His fellow grantees echoed the importance of a comprehensive document, but Dr Alerte says efforts were thwarted because children receive a new identifier every time they leave and reenter care. How can stakeholders track records for a single child, he asks, when that one child might have 3, 4, or even more ID numbers?

### ***Promoting Better Coordination of Care***

Many grantees shared how they created their own coordination teams to organize patient care activities and communicate information with relevant parties.

Colorado, for example, assembled a team of medically trained coordinators to gather the health history of children entering foster care. That team then adds new information to the state's Statewide Automated Child Welfare Information System, says Child Abuse Pediatrician Kathryn Wells, MD, FAAP.

In Wisconsin, health care coordinators at Milwaukee-based Care for Kids prepare summary letters for pediatricians before they perform comprehensive health exams. The letters include children's medical backgrounds, as well as their relevant family histories and reasons for removal, says Lisa Zetley, MD, FAAP.

Coordinators also communicate with physicians about other needs common to children in the child welfare system, including standardized mental health screenings and metabolic monitoring for those taking psychotropic medications. Care coordination is one of the key elements of the medical home approach, and this allows the program to develop a comprehensive health care plan for each child. This plan is circulated to physicians, biological parents, foster parents, and other relevant stakeholders.

Similarly, the Rhode Island Chapter uses its funds to employ a part-time care coordinator who liaises between medical providers and the state child welfare agency. The coordinator spends 4 hours per week pulling health and immunization records, locating children who do not show up for appointments, and generally "acting like a detective," says Carol Lewis, MD, FAAP.

"I don't think people understand [the] amount of care coordination these patients take," Dr Lewis says. "I definitely think it's one of the reasons that kids in foster care don't get the same baseline health care [as their peers]."

### ***Know Your Audience***

During his presentation on behalf of South Carolina, Greg Barabell, MD, FAAP, reiterated the importance of knowing what may prevent health care providers and social service professionals from accessing key information.

Dr Barabell serves as the medical director at Select Health of South Carolina, a managed care company that recently assumed responsibility for all of the state's children and teens in foster care. In that role, he has learned about other states' challenges getting pediatricians to use a new online health portal that can retrieve information like emergency room visits and medical imaging results. Most doctors do not use the new tool, Dr Barabell says, because it requires extra time to log in and does not uniformly include the same information.

In Pennsylvania, legal concerns about sharing behavioral health information has blocked information about Adderall, psychotropic medications, and other prescriptions commonly given to children in child welfare. "[As a caregiver] there's no information you don't need," Dr Barabell says. "It needs to be like Google, where it's a one-stop shop you can use to get to information."

In Ohio, an AAP chapter grant helped the Comprehensive Health Evaluations for Cincinnati's Kids (CHECK) Foster Care Center change the way it communicates with child welfare employees. After questioning whether child welfare caseworkers were reading lengthy medical reports, CHECK social workers began replacing those documents with short, bulleted lists that are e-mailed to caseworkers after each appointment.

The switch recognizes the high caseloads and potentially limited medical knowledge of those receiving the information in each e-mail, says Medical Director Mary Greiner, MD, FAAP. It also helps social workers follow up with caseworkers to identify what actions have occurred. “We don’t just want to produce this paper,” she says. “We want something to happen for that kid.”

### ***Keeping the Lines of Communication Open***

Grantees discussed the importance of maintaining communication with their child welfare agency – sometimes difficult for both parties but, as everyone acknowledged, critically important.

Tina Scott-Mordhorst, MD, FAAP, from Nebraska credits initial face-to-face meetings with the state’s Division of Children & Family Services for bringing pediatricians back into the fold after the state decided to privatize child welfare. State employees eventually asked to sit down with AAP chapter members to keep communication alive, she says, despite ongoing transitions at the state leadership level.

“I have to think that somewhere along the line we impacted them, so we’ve been sitting down at the table for the last year now and having conversations about how to best reach out to families and communities throughout the state and in Omaha,” Dr Scott-Mordhorst says.

### ***Recognizing Shared Goals***

Speaking the same language and recognizing shared goals also emerged as a prominent theme.

In Colorado, for example, pediatricians are hoping to implement a Denver-based foster clinic’s integrated health care approach across the state. To facilitate buy-in for that clinic and beyond, chapter members assembled a team of stakeholders to discuss the importance of behavioral health and how it can be integrated into care. The team comprises providers, hospitals, physical health groups, behavioral health agencies, and managed care organizations, Dr Wells says. It also includes William Betts, PhD, associate director for mental health at the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, who can speak to the issue using the language of a behavioral health care provider.

In Wisconsin, Dr Zetley found success laying the groundwork for her foster care medical home by speaking to child welfare workers in terms of their 3 primary goals—safety, permanency, and well-being.

Similarly, Dr Greiner reminds partners in Ohio’s CHECK Center about the outcomes that child welfare agencies and health care providers share, including ensuring that more children and teens in foster care receive initial screenings. “We remind them that that’s an outcome for you, that you need to have your kids be seen, and we want to see them,” she says. The center now sees more than 90% of local children entering foster care, she says, compared with approximately 25% earlier in its history.

## Spotlight on Ohio



### *Securing Community Buy-in*

In 2014, Ohio received a chapter grant to train pediatricians on caring for children and teens in foster care by encouraging collaboration between the medical team and various agencies serving this population. The importance of using communication to secure community buy-in first hit home in 2012, when Cincinnati Children's Hospital set out to establish its CHECK Center. The importance of recognizing the vast amount of work and expertise already present in the community was highlighted.

### *Leaving the "Ivory Tower"*

Using a different AAP grant, Dr Greiner began meeting with stakeholders in Hamilton County and beyond, including local advocacy organizations, foster families, children in medical care, and medical providers working with foster families. The experience exposed her to great work already happening to help children and teens in foster care and to pediatricians who wanted to keep working with their patients.

It also introduced her to the realities of Hamilton County, which did not have enough foster families within the county borders to care for all the children being removed from their biological parents. Approximately one third of children were being placed outside the county, up to 2 hours away, she says, making it difficult for foster families to bring children to the center for a simple earache or head cold.

"After understanding our community, I realized the medical model wasn't right for us," Dr Greiner says. "An evaluation model was right for us."

### *Doing What Works*

The CHECK Center anticipates that it will see over 1,000 children a year using this consultation model. Dr Greiner and her colleagues see children twice on average, once for an initial screening within 5 business days of placement and once approximately 30 days after they enter foster care. Children also come to the center every time they change placements so that center staff can transfer medical records, refill important medications, and make sure new caretakers understand any urgent medical needs.

## **II. Fostering Collaboration**

---

Since adding foster care to its strategic plan in 2006, the AAP has sought to engage communities in supporting children and teens through an integrated, multidisciplinary approach. Similarly, grantees emphasized the importance of cross-system collaboration during the February meeting and shared several approaches to securing allies in good times and bad.

### ***Working Through Staff Turnover and Fatigue***

For many grantees, collaboration is difficult because of personnel changes in state and local child welfare agencies. Partnering with leadership in state agencies is important, says Dr Barabell from South Carolina, but “changes happen so often that you have to continually recruit someone to wear the jersey to be on your team.”

That challenge rings true for Dr Wells, who says she’s worked with 5 different child welfare directors in Colorado over the past 12 years. Dr Wells recommends creating policies and practices that live on at an agency no matter who is working there at a given point in time. She also suggests developing relationships with mid-level staff members who are more likely to stay in their positions in the long term, a recommendation echoed by Dr Lewis from Rhode Island.

Just make sure that long-standing collaborations do not devolve into complacency, cautions Kristine Campbell, MD, FAAP, from Utah. The Utah Chapter is using its grant to reenergize partnerships with local child protective services and to begin discussing new collaborations to help children who have not yet entered care.

### ***Forging New Alliances***

Grantees have established a range of partnerships to help offset staff turnover. For West Virginia, that meant bringing foster parents to local AAP meetings so that parents could present their goals and challenges to the state child welfare agency. Because of these conversations, the state has decided to pilot a discharge summary form provided by the AAP, says Jim Lewis, MD, FAAP.

In Ohio, Dr Greiner used a developmental pediatrician’s interest in the CHECK Center to find other champions within Cincinnati Children’s Hospital. She has recruited help from a mental health provider, a dentist, and a transition medicine researcher who are interested in working with children and teens in foster care.

Motivated by stagnating communication with regional child welfare offices, the Connecticut Chapter began reaching out to regional care nurses similarly invested in children from a health care perspective. Dr Alerte and his colleagues began inviting nurses to AAP workshops and meetings, he says, to give them a forum for sharing their needs, headaches, and desired resources. The chapter also began reaching out to pediatricians who serve as foster parents, he says, to “collaborate with people whose feet are in both places.”

In New Jersey, Cathleen Ballance, MD, FAAP, is one of those collaborators with a dual perspective. Dr Ballance performs comprehensive evaluations of children and teens in foster care

as a pediatric hospitalist, but she credits her time as a foster parent for introducing her to new avenues for advocacy.

“I realized, being a foster parent, that a lot of the problems that indirectly impact the health of children in foster care have to do with permanency, and a lot of those problems stem from the court system and the law,” she says.

### ***Partnering Across County Lines***

Improving the medical care of children and teens in foster care requires forming partnerships that cross county lines. Yet cross-county collaboration can be difficult in states like New Jersey that are primarily rural but densely populated in the metro areas, says pediatrician “Sooze” Hodgson, MD, FAAP.

New Jersey’s recently renamed Child Protection and Permanency agency provides direct services across 21 counties in 47 offices. A 2008 AAP chapter grant helped the state uniformly expand its Child Health Unit model of care to those facilities while building coordination among employees, nurses, pediatricians, and local medical homes. The process was largely successful, Dr Hodgson says, but challenges arose when obtaining buy-in from the local offices.

County variations can be even more significant in state-supervised, county-administered child welfare systems like those found in Colorado, Minnesota, and Pennsylvania. When Dr Wells began providing medical services for Denver-area children entering foster care, she and her colleagues reached out to other health care providers across the largely rural state to explore what was and was not working in their communities.

“Anything that comes out of our community, good idea or bad, is going to be seen as you’re telling us how to do it ‘the Denver way,’” she says. “We didn’t want that, so we used the opportunity to reach out and find out who’s doing awesome work, who we can share information with, in 8 places around the state.”

Chapter members traveled to each community, where they presented a list of 14 guidelines built around 3 main areas: how the community organized its treatment team, provided care, and made changes to the system of care. Participants measured where their community fell in each of the 14 guidelines and determined what they needed to move ahead.

“From a collaboration perspective, it was really helpful to come to them and say what ‘works well for you,’” Dr Wells says. “Our plan now is to figure out how [to] build on that feedback.”

### ***Coming Together in Challenging Times***

Two grantees shared how tragic events capturing national attention led to notable increases in political will. In Pennsylvania, for example, new collaborations arose from the case of Jerry Sandusky, a former assistant football coach at Penn State University charged with dozens of counts of sexual abuse against young boys.

In Connecticut, the fatal shooting of 20 children and 6 adult staff members at Sandy Hook Elementary School motivated the legislature to pass nearly a dozen laws related to the state's psychiatric offerings, Dr Alerte says. One of those laws allowed primary care providers to conduct timely psychiatric consultations about child patients using teleconference.

Legal action provides another common incentive for collaboration.

In Baltimore City, a decades-old consent decree has provided a supportive backdrop for those trying to figure out how to keep Maryland kids healthy, Dr Dodge says. In Wisconsin, Care for Kids has adopted protocols for foster care health screens established by local child advocacy centers as the result of a lawsuit.

Conversely, lawsuits can sap the resources and attention of a child welfare organization trying to manage crises with limited energy, says Dr Lewis from Rhode Island. With legal challenges rising, she asks, "How do I get them to hear that these kids need really basic care?"

## **Spotlight on Pennsylvania**



### ***Leveraging Political Will***

When a Pennsylvania jury found Jerry Sandusky guilty of child sexual abuse in 2012, the verdict set the stage for legislative upheaval to the state's child protection laws, says Cindy Christian, MD, FAAP.

As a child abuse pediatrician at Children's Hospital of Philadelphia and part-time medical director for Philadelphia's Department of Human Services, Dr Christian was already aware of state laws that made it difficult to report cases of child abuse and neglect.

According to Dr Christian, state advocates spent years knocking on the doors of legislators to remove those roadblocks to little avail. Following the guilty conviction and subsequent media attention, she says, legislators became more interested in passing new laws.

### ***Adopting a Systemic Approach to Change***

State leaders responded to the sudden rise in political will by creating a Pennsylvania Task Force on Child Protection to examine current state law and potential changes. Dr Christian credits the AAP for ensuring that the task force included the voice of 2 pediatricians, herself and Rachel Berger, MD, MPH, from Children's Hospital of Pittsburgh.

Approximately 1 year after its creation, the task force handed the governor and legislature a nearly 450-page report with recommendations. This systemic review, Dr Christian says, spurred the legislature to pass more than 20 new bills.

### ***Mandating Information Sharing***

One of these new laws, PA Act 176 of 2014, mandates information sharing between physicians and child welfare agencies during a child welfare investigation. Primary care and other health care practitioners must now share certain information with the child welfare agency regardless of parental consent, Dr Christian says, including health information, treatment being offered, medical needs, and medical information about siblings or other children in the household. On the flip side, pediatricians can now call child welfare agencies and request information about a child's situation. This development, she says, is just one of many positive changes that emerged from Sandusky's terrible actions. "You have to take bad situations, like lemons, and make lemonade out of [them]. For us in child welfare, we got that opportunity, and we seized it."

### III: Identifying Emerging Trends

---

Throughout the day, grantees shared key areas they are targeting to bolster children’s health and well-being. Additionally, several trends emerged in 3 AAP-led presentations selected by the COFCAKC Executive Committee to help grantees further effect change.

#### *Moving Forward With Trauma-Informed Care*

As a 2013 grantee, South Carolina set out to provide regional trainings on the impact of trauma on children in foster care. The state chapter organized a day-long collaborative to help pediatric practices become trauma-informed and plans to collaborate with other initiatives to continue spreading the word, says Ramkumar Jayagopalan, MD, FAAP.

Following the release of the AAP’s anticipatory guidance on “Helping Foster and Adoptive Families Cope with Trauma,” the West Virginia Chapter polled pediatricians about their trauma screening experiences and what information they need going forward. Similarly, pediatricians used Utah’s chapter grant to learn how the state can better train residents on using standardized trauma screenings.

Meeting attendees revisited trauma-informed care through the lens of toxic stress, thanks to a presentation led by Heather Forkey, MD, FAAP, a member of COFCAKC. Dr Forkey encouraged grantees to look past the question of what constitutes a traumatic event. Instead, she asked them to question what makes people respond differently to childhood adversity and how early events become embedded in children’s brains and bodies.

To illustrate the latter, Dr Forkey compared children in foster care to 2 different types of flowers—orchids that easily flourish or wither based on the nature of their surroundings and dandelions that manage to survive, if not thrive, in multiple environments.

Dr Forkey advised attendees to think about the biological impacts of toxic stress, such as overwhelming stress to the hypothalamic-pituitary-adrenal axis designed to cope with short-term stressors. She reiterated the impact of continued stress on children’s brains—namely, its ability to trigger young people’s emotional memory systems while shutting down their impulse controls and ability to access and share information.

Dr Forkey’s top recommendations for providing advanced trauma-informed care to children and youth in unstable family situations include focusing on the following:

- The epigenetic impact of trauma and a lack of caregiver predictability
- Ideas for how to promote positive parenting within the context of a medical home
- Strategies for appropriately handling tantrums and other forms of acting out
- Ways to talk to parents about their own life experiences and common household stressors
- Keeping an open mind about what may act as traumatic triggers

## ***Testing Out Triage***

Several chapters shared their initial efforts with triaging young patients to help practitioners cope with competing caseloads and resources. At MATCH, case coordinators recently began using a population-based team model that groups children by age and assigned risk level. A coordinator on the high-risk behavioral team is likely to work with children and teens who need frequent psychiatric hospitalizations, whereas a colleague working with low-risk infants and toddlers will rarely work with clients requiring these types of services.

Dr Dodge says she hopes the new model will encourage staff members to increase their expertise in a specific area while helping her better focus the energies of the program's consultant psychiatrist.

In Wisconsin, Care for Kids uses a 3-tier triage system where level 1 refers to a crisis and level 3 reflects more routine needs. The system provides a guiding framework for health care coordination teams working to develop and communicate an appropriate care plan. Outreach coordinators will review level 1 patients and address their acute health needs quickly through follow up and coordination with child welfare partners. This is a fairly simple task because Care for Kids falls within the hospital-run insurance plan.

In Pennsylvania, Dr Christian says the Philadelphia child welfare system is considering its own triage system to reduce the number of steps required when children enter foster care. Stakeholders may decide that some children need an initial health assessment based on their individual circumstances, whereas others do not.

## ***Streamlining Systems Through Managed Health Care***

Pediatricians feel the impact of states transitioning their Medicaid systems to managed health care models.

In Georgia, children in foster care were transitioned to one managed health system through the state insurance program, says Patricia Mason Lantis, MD. They are also collaborating with colleagues across the state to ensure they are willing to work with that managed care operation, whether they routinely see patients on that plan or not.

Dr Barabell from the South Carolina Chapter serves as the medical director at Select Health of South Carolina, a Medicaid managed care organization that assumed responsibility for all of the state's children in foster care in 2011. Having everyone within one system, he says, enables the agency to improve on overarching operational and process issues. The move also allows children and teens to stay in the same system once they exit foster care, which limits interruptions to their service array if they reunify with their family or get adopted.

As with any large system, Dr Barabell says there are both benefits and challenges. Behavioral health is "carved into" managed care organizations in South Carolina—meaning that social workers and counselors receive payments from Select Health instead of fee-for-service

payments. Other services are still “carved out,” however, fragmenting the overall delivery of care and the ability to take a comprehensive data snapshot.

“There are a lot of plates that are spinning in the air, but overall, I think having the kids under one system has been an amazing blessing for us and an amazing blessing to get the system in order,” he says.

## **Spotlight on Medicaid Advocacy**



Meeting attendees heard from Jim Pawelski, MS, who spoke about potential avenues for state advocacy related to Medicaid. As the director of AAP’s Division of State Government Affairs, Mr Pawelski says Medicaid is beginning to surpass education as the single largest item in many state budgets.

Statement Plan Amendment (SPAs) offer one avenue for change. These plans spell out whom and what Medicaid will cover in each state, Mr Pawelski says, and can include such relevant services as the following:

- Rehabilitative services option
- Targeted case management
- Health homes

In addition to SPAs, Mr Pawelski offered information about a variety of Medicaid Waiver Options state can seek to address the needs of children in foster care.

Interested pediatricians can contact their AAP state chapters to leverage existing relationships with state Medicaid agencies, child welfare partners, and other stakeholders. The AAP Division of State Government Affairs can provide assistance with navigating through Medicaid options.

“I think the most important thing you can do is to tell your story. That’s the key to all advocacy,” he says.

## ***Monitoring Psychotropic Medications***

Several chapter attendees talked about nascent efforts to review psychotropic medications prescribed to children and teens in foster care.

In South Carolina, pediatricians are looking to Texas’ model for monitoring psychotropic medications and attempting to overcome a limited number of pediatric psychiatrists in the state who accept Medicaid.

In Wisconsin, Dr Zetley and her colleagues are crafting a Poly-Pharmacy Interdisciplinary Case Review that interviews stakeholders, gathers information and identifies unmet needs about children on 4 or more psychotropic medications across 3 or more months in care. The goal is not

to micromanage prescribing psychiatrists, Zetley says, but to equip them with information they might not know about children's placements, permanency plans, and past reactions to medication.

Executive Committee Member David Harmon, MD, FAAP, provided a short background on the inclusion in President Obama's budget of a program to address the "overprescription" of psychotropic medications. Some funding would support capacity development for states, and some funding would incentivize the achievement of certain benchmark measures. The AAP created a list of possible measures/benchmarks that could be used by states and would help to ensure that children and teens in foster care receive appropriate mental health care and appropriate monitoring of any psychotropic medications.

The group's final recommendations include measures that aim to:

- Determine whether mental health assessments have been provided or used to prescribe psychotropic medications
- Assess whether children have face-to-face visits with the professionals prescribing their medication at least every 90 days
- Gauge whether children are receiving psychosocial interventions in addition to psychotropic medication therapy
- Verify that youth have the opportunity for thorough mental health assessments before receiving a prescription for psychotropic medication

## Conclusion

---

Since 2008, the AAP Health Care for Children and Youth in Foster Care Chapter Project has helped 15 states strengthen their medical responses to children and teens in foster care through advances in communication, collaboration, and other emerging practices. This progress has occurred because of the tenacity, ingenuity, and passion of the pediatricians who set out to improve young people's care by addressing pressing state-level issues. Yet even the strongest champions can benefit from opportunities to provide support and validation in the face of ongoing, complex challenges.

Linda Sagor, MD, MPH, FAAP, closed the February 13 meeting by asking the group to suggest ways to stay connected. Suggestions included the following:

- Continue engaging national child welfare partners like the Child Welfare League of America, National Council of Juvenile and Family Court Judges, FosterClub, and others to better understand their perspective and shared goals.
- Share resources created by grantees to overcome roadblocks, including Colorado's 14 child welfare guidelines and Pennsylvania's new information-sharing law
- Poll chapter colleagues to determine whether they have effectively addressed other states' continued challenges with the aim of planning a national Webinar series
- Use the upcoming 2015 National Conference & Exhibition in Washington, DC, as an opportunity to continue sharing new information and lessons learned

The AAP closed the meeting by pledging its continued support to keep the conversation going, both among grantees and across the field at-large.

"Nothing ever happens because of one person," Dr Sagor says. "It always happens because like-minded people gather together and really put a lot of effort into doing tremendous work on behalf of children and families."