Child Health Report

New Jersey Department of Children and Families

Table of Contents	Page

INTRODUCTION

The New Jersey Department of Children and Families (DCF) was created in 2006 and is the state's first comprehensive agency dedicated to serving, protecting and ensuring a better today and an even greater tomorrow for every individual we serve. In partnership with New Jersey's communities, DCF ensures the safety, well-being, and success of New Jersey's children and families.

The State of New Jersey and Children's Rights, Inc. reached agreement on a Modified Settlement of the class-action litigation (Charlie and Nadine H. v. Corzine) in July 2006. The Modified Settlement Agreement (MSA) appointed the Center for the Study of Social Policy (CSSP) to monitor New Jersey's compliance with goals set forth to improve the state's child welfare system. The MSA was implemented in two phases. Phase I (July 2006 through December 2008) focused on building infrastructure and a case practice model within DCF. Phase II (January 2009 through November 2015) focused on reaching and sustaining a variety of process, quality, and outcome measures. In November 2015, DCF entered a new phase of the reform with the Sustainability and Exit Plan, with modifications to the monitoring efforts to create a pathway to transition the state from federal oversight. The Sustainability and Exit Plan acknowledges progress made, particularly in DCF's infrastructure, and puts a sharp focus on outcome measures still in need of improvement.

DCF is comprised of several offices and divisions including Child Protection and Permanency, Adolescent Services, Office of Clinical Services, Advocacy, Children's System of Care, Performance Management and Accountability, Licensing, Educational Services, Family and Community Partnerships, and Women's Services. The offices and divisions that operate under DCF are responsible for managing and integrating the mission, SEP goals and the multiple priorities of the department.

DCF's Division of Child Protection and Permanency (CP&P) is New Jersey's child welfare agency, responsible for investigating allegations of child abuse and neglect and providing supportive services to children and families in need. CP&P contracts with community-based

agencies to provide services to children and families, including but not limited to counseling, parenting skills, and substance use treatment. If a child has been abused or neglected, or is at imminent risk of abuse or neglect, CP&P may ask the local family court to remove the child from the parent's custody and place the child in an out-of-home placement, commonly known as foster care. Whenever possible, the child is placed in a family setting, preferably with a relative caregiver. Both relative and non-relative foster homes in New Jersey are licensed and regulated by DCF's Office of Licensing.

The Office of Child and Family Health (OCFH) and Clinical Services, now the Office of Clinical Services (OCS), was initially created to support the overall safety and well-being of families and children served by the department through developing and administering programs that provide seamless and quality prevention, intervention, primary and other healthcare services. The office was also created to support CP&P in ensuring families and children achieve the physical and behavioral health outcomes to maintain compliance with the state, federal and SEP standards. The primary roles of OCFH and Clinical Services include the Child Health Units (CHUs) and Child and Family Nurse programs, Medicaid and Medicaid Extension for Young Adults (MEYA), required examinations and screenings for children entering out-of-home placement, forensic, medical and psychological evaluations, including Regional Diagnostic and Treatment Centers (RDTCs) and management and oversight of pediatric/psychiatric consultation services. OCS is also responsible for providing Medicaid customer service for DCF staff, families and community partners and serving as the support for Medicaid and Managed Care Organizations (MCO) liaisons to ensure all children in out-of-home placement have health insurance.

In 2014, the OCFH was renamed to the Office of Clinical Services (OCS) to reflect and acknowledge the broadened scope of services managed by the office including developing and overseeing evidence-based substance use and mental health disorder services for adults involved with CP&P. The primary goal of this work is to reduce child welfare risks associated with parental substance use and co-occurring mental health disorders. An additional goal is to support staff in understanding the often chronic nature of these disorders and integrating that knowledge into case practice. OCS is also responsible for the development, oversight and delivery of training and technical assistance to CP&P, the Children's System of Care, and other offices within DCF to

ensure children and families are receiving timely and appropriate health care services. The work of OCS reflects DCF's ongoing efforts to provide comprehensive programs and services that work directly and in alignment with the CP&P case practice model[1] by ensuring quality physical, and behavioral services are provided to the children and families served by CP&P.

As part of DCF's commitment to accountability and transparency, and in line with the Sustainability and Exit Plan (SEP), the department releases a series of annual reports on topics of significance to the improvement and sustainability of our child welfare system. This report will provide an analysis of child health related outcomes data. Additionally, this report will primarily review our child medical and behavioral health services and the integration of the Child Health Units into the CP&P case practice model.

Understanding the Content

This report first discusses the range of children who enter out-of-home placement and how child health measures reflect their abilities to access care and the quality of those services. A primary objective is to evaluate the medical and behavioral health assessments and services that are coordinated through the Child Health Units (CHUs) for children in out-of-home placements. Additionally, the report will provide an analysis of and context for each measure to identify trends, strengths and areas needing improvement.

The report is organized to provide the reader with a historical and current context regarding the development and evolution of child health care case management that ensures the health care needs of children in out-of-home placement are met in the most seamless manner. Additionally, it will provide a framework for the data used to monitor health care service coordination while a child is

[1] The Case Practice Model guides DCFs work with children and families. This is a strength-based, solution-focused, and family-centered approach to help support New Jerseys most vulnerable families and help them achieve the core values of safety, permanency, and well-being for children. Engagement and building family teams are key tenets of the model. DCF works to build trust and mutually beneficial relationships among children, youth, family members, and DCF staff. The four core conditions of the Case Practice Model are genuineness, respect, empathy, and competence. The model was first implemented in four immersion sites in 2007. All 46 local offices were trained by 2012.

in out-of-home placement from the time of initial contact through case closure[2], discharge from placement, or re-entry into an out-of-home placement.

The report is comprised of three primary chapters:

1. The Child Health Program
2. Child Health Measures for Children in Out-of-Home Placement
3. Child Mental Health Measures for Children in Out-of-Home Placement

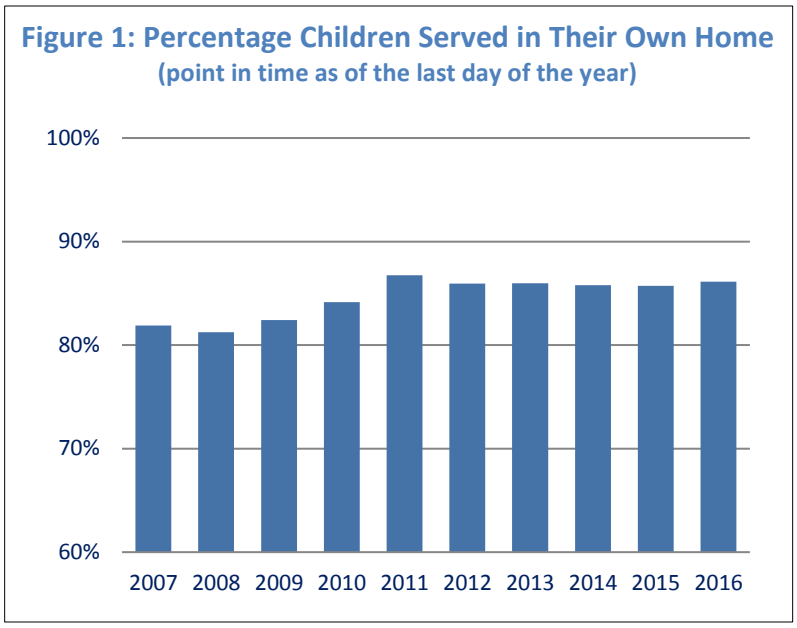
About the Data

Data transparency is an integral component of the department's commitment to achieving and maintaining favorable outcomes for the children served by CP&P. It also has a significant impact on organizational accountability, enhancements and improvements, which will be reflected in the data. This report includes the most recent and reliable annual data available for child health for state fiscal years (SFY) 2016 and 2017.

[2] Once a child is reunified and their case is closed after being discharged from placement, CHU nurses support the transition of the child from out-of-home placement to their biological parent and/or legal guardian ensuring the child's needs are understood, address and continue to be met.

Who We Serve

Research shows maintaining children in their own homes whenever possible, even after a finding of maltreatment, produces better long-term outcomes for children compared to out-of-home placement. It prevents children from experiencing the trauma of being removed from their home and family and placed with a resource family.[3] In New Jersey, the majority of children served by the child welfare system are able to stay home with their families. Over the last 10 years, CP&P has focused its practice and decision-making on maintaining children safely in their own homes whenever possible, resulting in fewer children entering out-of-home placement. Furthermore, as of December 31, 2016, CP&P was serving a total of 48,049 children. As indicated in Figure 1, most of the children were being served in their own homes. Specifically, 86 percent (41,386) were being served in home. Conversely, only 14 percent (6,663 children) were being served out-of-home.



[3] Doyle, J.J. Child Protection and Child Outcomes: Measuring the Effects of Foster Care. American Economic Review. 97(5). December 2007: 1583-1610.

Chapter 1
The Child Health Program

There are nearly 428,000 children in foster care on any given day in the United States. In 2015, more than 670,000 children spent time in out-of-home placement.[4] Nationally, children in out-of-home placement experience unmet health needs.[5] Research has found approximately 80 percent of children in out-of-home placement have chronic health care needs with some also having developmental, emotional, and behavioral concerns.[6] In light of this, DCF recognized the overall safety; physical, mental and social-emotional well-being of children in out-of-home placement requires seamless, consistent and timely access to quality health care services. This led to DCF building these core values into CP&P's case practice model in areas such as health care case management and data collection. The incorporation of case management and data collection related to health care for children in placement allows CP&P, OCS and CHP staff members to use internal data to ensure children in placement do not experience gaps in services. Additionally, these practices help to ensure these children have the ability to achieve favorable outcomes.

DCF understands the importance of transparency and accountability; as such we value self-reflection and critical self-analysis. The mission of CP&P is to ensure the safety, permanency and well-being of children and to support families who are served by the agency. Reviewing and analyzing our data provides opportunities for CP&P to make informed decisions while identifying areas of strength and areas that need improvement. These data allow us to evaluate, learn, implement, provide internal and external feedback and identify possible solutions.

In line with the MSA, DCF restructured the health care delivery system for children in out-of-home placement. This work led to the release of the Coordinated Health Care Plan for children in out-of-home placement in May 2007. The plan identified and focused on challenges related to providing and ensuring children in out-of-home placement received quality health care to meet

[4] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, http://www.acf.hhs.gov/programs/cb
[5] The Children's Partnership, Improving Health Outcomes for Children in Foster Care: The Role of Electronic Systems., http://www.childrenspartnership.org.
[6] ibid

their overall needs. It also identified the need for improved service delivery in order to produce better outcomes for children in out-of-home placement. The following core values were identified for health care reform for children in out-of-home placement: (1) providing health care services in a manner that is sensitive to the child's needs; (2) integrating health care planning into permanency planning; and (3) ensuring success by building relationships and tangible partnerships between state agencies, providers, the children and their family teams.

The child health performance data discussed in this report can be directly linked to and influenced by CP&P's ongoing commitment to providing quality health care case management to children in out-of-home placement. These measures were designed to identify and address the needs of a child at the onset of entering out-of-home placement throughout their placement episode and to monitor each child's progress, needs and developmental milestones. We measure child health outcomes in support of DCF's continuous quality improvement efforts to improve the safety, well-being, and permanency for the children, youth and young adults served by CP&P. Child health measures are also significant, as they represent a combination of ensuring timely identification and attention to health care issues of a child in out-of-home placement. In turn, these measures help to ensure consistent and ongoing quality care, which supports several priorities of DCF's Strategic Plan.[7]

DCF created CHUs in an effort to ensure the measures would be achieved over time. Consequently, the CHUs were developed with the vision of embedding the nursing staff into the culture of the local offices to collaborate with case workers, other local office staff and kin and unrelated resource families. Another objective was to provide local offices with staff members who possessed the expertise and knowledge needed to navigate through the various facets of the health care system. Furthermore, the addition of the CHUs provided CP&P the ability to ensure seamless coordination of services and scheduling, as well as, proper collection of medical records and assessments. Nursing staff ultimately became responsible for completing and tracking the progress for all health related duties previously performed by CP&P caseworkers.

[7] http://www.nj.gov/dcf/about/NJ%20DCF_Strategic%20Plan_2016_2018%201116%20FINAL.pdf

At a Glance: Child Health Units

New Jersey is one of the few states to have nurse managers in each local office to provide health care case management for all children in out-of-home placement. These nurses are credentialed to work within the department's Statewide Automated Child Welfare Information System (SACWIS)[8], which allows for better communication, documentation, and service provision over time. In the early 1980's the New Jersey child welfare agency contracted with a small number of regionally located nurses to address the health needs of children who were medically fragile or who had unique health care needs. Prior to 2000, New Jersey began to contract with independent health consultants for all 21 counties.

Soon after the creation of DCF as an independent department, DCF established a Memorandum of Understanding (MOU) with the Rutgers University (formerly University of Medicine and Dentistry of New Jersey) Francois Xavier Bagnoud (FXB) School of Nursing to implement the Child Health Program. The Child Health Program (CHP) was envisioned in the Coordinated Health Care Plan for children in out-of-home placement. Teaming with Rutgers and establishing a MOU afforded the opportunity to partner and develop child health case management seamlessly into the CP&P case practice model. The MOU is reviewed, revised and renewed annually to identify and address any gaps in services and case management. This annual review also helps to ensure case management and case practice continues to meet the health care needs of the children served by CP&P in out-of-home placement. The MOU with Rutgers University assists DCF and CP&P with providing seamless medical and mental health needs for children in out-of-home placement.

The Child Health Program is a nursing care management model designed by staff at Rutgers University-FXB to provide health care case management to children in New Jersey's child welfare system. Along with ensuring that the program could function in a manner to successfully meet the identified child health measures, the CHP took into consideration the multiple variables that go into meeting a child's needs, not just the tangible ones. For instance, outside of ensuring that identified health measures are met, the program focuses on providing overall health care case

[8] https://www.acf.hhs.gov/cb/research-data-technology/state-tribal-info-systems/managers

management that addresses a child's daily needs (e.g., asthma related breathing treatments, daily insulin injections, etc.). Other factors addressed through comprehensive health care case management may include complex needs ranging from chronic illnesses to behavioral health conditions for children in out-of-home placement.

DCF has achieved and maintained compliance with the measures since the creation of the CHUs providing health care case management to all children in placement in Phase I of the MSA. In turn, with the DCF's transition from the MSA each of the child health performance measures was identified as a Foundational Element[9] in the newly established SEP[10]. As part of this transition, the department is still required to maintain a sufficiently staffed CHU in each local office. In addition, the SEP requires that each resource home has a designated nurse for health care case management. The Child Health Units were established as part of DCF's reform agenda to support DCF in maintaining compliance with the MSA and SEP in being the cornerstone for providing appropriate physical and mental health care services for children in placement. Moreover, the CHUs were designed and built to coordinate health care services and case management for children in out-of-home placement beginning at the time of removal.

The roles and responsibilities of the Child Health Program staff members are divided into the following three tiers: (1) Leadership Tier-Director and Assistant Directors;[11] (2) Direct Support Tier-Regional Nurse Administrators;[12] and (3) Frontline Staff Tier-Health Care Case Managers[13]

[9] Foundational Elements are identified in the SEP as aspects of the New Jersey child welfare system which are both necessary the foundation for a healthy child welfare system and which were being satisfied at the time of the SEP's creation. These elements must be sustained and are enforceable if the Monitor determines that a foundational element has not been sustained.

[10] See SEP for additional information http://www.nj.gov/dcf/about/welfare/Sustainability-and-Exit-Plan-110415.pdf

[11] The primary role of the Director includes, but is not limited to providing the overall administrative oversight and coordination of nursing services and staff for the Child Health Program and the Child and Family Nurse Program, administrative and fiscal management of the DCF and Rutgers MOU, and ongoing communication and collaboration with DCF, OCS and CP&P.

The Assistant Director provides administrative support and assistance to the Director as needed, including active and direct involvement in in program development, implementation, evaluation and short/long term strategic planning in collaboration with DCF and CP&P leadership, etc.

[12] The Regional Nurse Administrator provides administrative and clinical oversight and supervision of CHP personnel and direct supervision of frontline CHU staff. They are also the key liaisons to DCF/CP&P administrative and local office staff in each regional area etc.

[13] Health Care Case Managers are responsible for providing nursing care case management services in resource home, local office and health care settings to ensure that each child in out-of-home placement receives

and Staff Assistants. As of December 31, 2016, there were 180 Health Care Case Managers and 84 staff assistants. Nurses are required to perform duties outside of the office; as a result, Health Care Case Managers rotate coverage as an in office Resource Nurse. This was done in an effort to strengthen staffing in the office and ensure a designated nurse is always present to answer any questions that may arise about a particular child or case. The ratio has remained under one nurse to every 50 children in majority of the counties and the number of CHU staff has remained steady. Additionally, the local CHUs are supervised by a regional nurse administrator for every two to three counties based on the number of children being served.

appropriate health care services as outlined by Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and American Academy of Pediatric guidelines.

Table 1

Child Health Unit Staffing for July 1, 2016 through June 30, 2017

County	Health Care Case Managers	Staff Assistants
Atlantic	11	4
Bergen	8	4
Burlington	10	5
Camden	15	8
Cape May	4	2
Cumberland	7	3
Essex	29	14
Gloucester	11	5
Hudson	13	7
Hunterdon	1	1
Mercer	8	3
Middlesex	9	4
Monmouth	8	4
Morris	5	2
Ocean	9	4
Passaic	8	4
Salem	1	1
Somerset	3	2
Sussex	2	1
Union	8	3
Warren	3	1
TOTALS	***173***	***82***

The nursing staff responsibilities include, but are not limited to the following:

Child Health Unit Responsibilities

- **Perform Pre-Placement Assessments (PPA).**
- **Obtain and review medical records.**
- **Ensure comprehensive medical exams are conducted and immunizations are up to date.**
- **Complete mental health screenings.**
- **Monitor psychotropic medications and treatment.**
- **Manage individual health care case management records.**
- **Work collaboratively with MCO Care Managers.**
- **Perform routine in-person contact, developmental monitoring and follow up.**
- **Team with staff and community partners to support transparency, seamless services and system capacity to identify emerging trends related to child health outcomes.**
- **Provide Child Health Passports to resource parents.**

The CHUs are also supported from a broader perspective from DCF's central office level through the Office of Clinical Services. OCS is responsible for managing the MOU process and interactions between leadership from DCF, CP&P, OCS, and Rutgers University. Additionally, OCS collaborates with the CHUs to identify systems issues and utilize feedback to make necessary changes and improvements. The office also provides oversight and monitors the health care outcomes of all children in out-of-home placement. OCS also monitors the number of staff to ensure compliance; as well as, identify strengths, needs and emerging trends related to child health. Furthermore, they provide direct fiscal oversight of the units to ensure staffing and other applicable resources are available.

Health care case management for children in out-of-home placement in New Jersey has evolved since the inception of the MOU between DCF and Rutgers University in 2006. This collaboration has been instrumental in ensuring the medical and behavioral health care needs are identified and addressed for children in out-of-home placement. The Rutgers CHP is a contracted service that is housed with CP&P staff and works within CP&P infrastructure, policies and procedures. In acknowledging the importance of balancing nursing practices with case practice, the CHP set out to mirror CP&P policies, practice and procedures as much as possible while understanding the significance of being able to track and adjust based on a child's individual health care needs. This philosophy is supported by the American Academy of Pediatrics (AAP) who stated, "Health care management is the responsibility of the child welfare agency, but it is a function that requires medical expertise."[14] Embodying this practice has benefited the children served by CP&P, especially, regarding the coordination of and access to quality health care services.

The CHUs have become a cornerstone of DCF's reform efforts and since June 2011, DCF has maintained or improved performance on all measures related to child health care services. The child health performance measures that are reported to the public and federal monitor have been consolidated into foundational elements under the SEP. Consequently, the work done by OCS, Rutgers University and the nursing staff at the local office level provides comprehensive oversight of children in out-of-home placement to ensure the child health outcome measures continue to be achieved and maintained. The measures that will be presented throughout the remainder of this report are based on best practices and guidelines of the AAP. These measures were established through the collaborative work of DCF, the Federal Monitor, Rutgers University-CHP staff and the New Jersey Office of the Child Advocate.

[14] American Academy of Pediatrics (AAP). *Fostering Health: Health Care for Children and Adolescent in Foster Care.* 2nd Ed. 2005.

Chapter 2
Child Health Measures for Children in Out-of-Home Placement

DCF established standard measures to track health care outcomes for children in out-of-home placement. The child health measures established by DCF, the Federal Monitor, Rutgers University-CHP staff, and the New Jersey Office of the Child Advocate were designed to support DCF in building a cohesive system that could meet and achieve the identified child health performance goals. The move towards standardized measurement was critical to DCF's efforts to ensure the medical and behavioral health care needs of children in out-of-home placement are addressed. Additionally, the measures also reflect the strength of the health care case management model, which includes DCF incorporating best practices of using qualified health professionals, provisions of services inappropriate settings, and developing partnerships to strengthen the system.

As part of its partnership with Rutgers University, DCF built a well-coordinated system comprised of two primary goals to address the overall health care needs of children in out-of-home placement. The first goal was to identify and address the health care needs of children by conducting immediate screening and assessments. The purpose of these screenings and assessments were to identify any needed services prior to children entering placement and mitigate any further trauma. The second goal was to establish a plan for ongoing health care case management. The purpose of ongoing health care case management was to ensure each child's needs; as well as, standards for preventive health care are continuously met.

Building the child health measures and a system that looks beyond the tangible needs is indicative of DCF's commitment to putting a system in place to ensure that the overall medical and behavioral health care needs of children in placement are consistently met by CP&P.

Child Health Measures

Because removing a child from their home is a traumatic experience for them, DCF continuously explores opportunities to use evidenced-based tools, techniques, programs, etc. to help mitigate further trauma. This chapter will discuss the following child health medical performance measures in detail.

Child Health Medical Performance Measures

- **Pre-Placement and Entry Medical Assessments**
- **Appropriate Medical Assessment and Treatment-Comprehensive Medical Examinations (CME)**
- **Follow-Up Care and Treatment**
- **Dental Examinations**
- **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**
- **Immunizations**

Pre-Placement Assessments

Safety and stability are two of the primary concerns when it is determined that child are no longer safe in their own homes. A significant part of ensuring a child is safe and stable is providing thorough health care case management, including timely screening and assessment. All children are required to receive a pre-placement assessment (PPA) either at the time of removal from their home or prior to placement.[15] The purpose of this assessment is to identify, document and develop a plan to address the child's immediate health needs and ensure each child is free from contagion.[16] PPAs are conducted by professionals and in environments that minimize additional trauma surrounding placements, using the following choices: (1) the child's own health care professional; (2) CHU nurse in a CP&P local office; (3) specially designated health care professional, such as

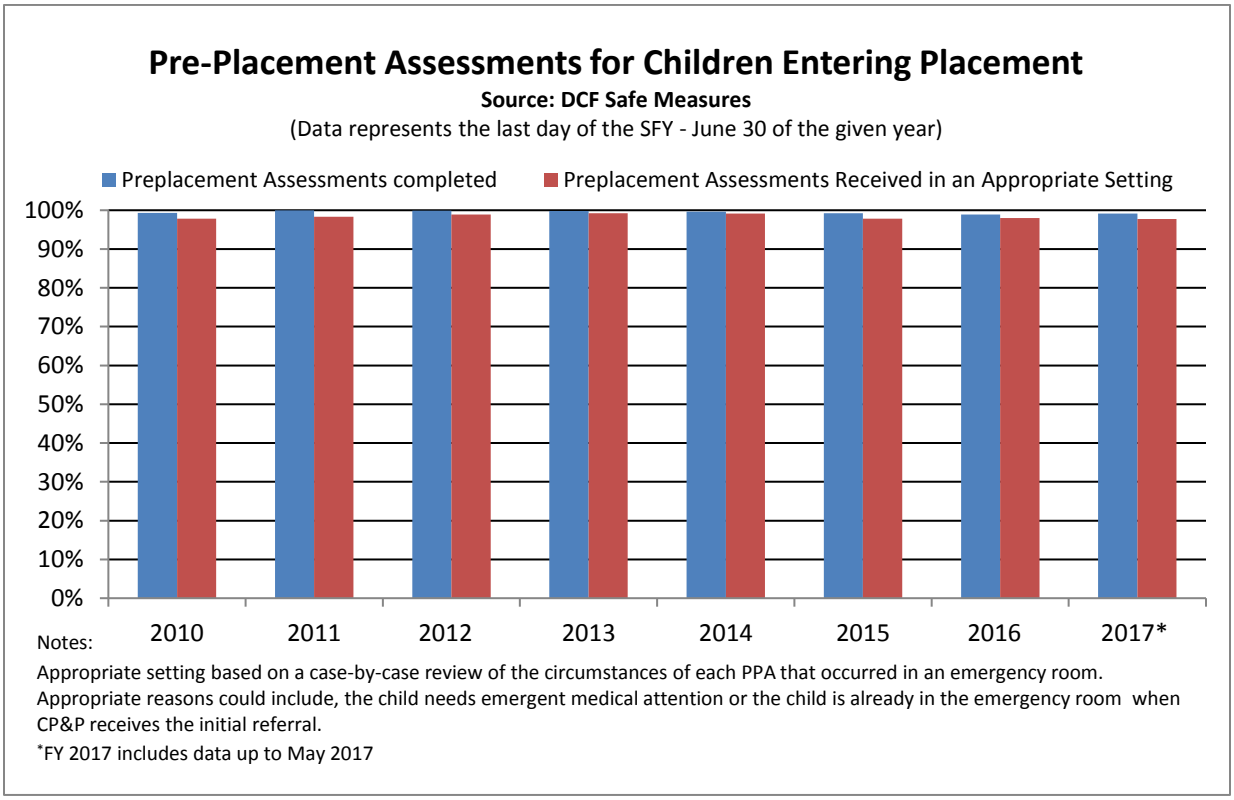
[15] The only exception is when a child enters placement from a medical setting. See DCF Policy Manual CP&P-V-A-1-1300

[16] Ibid

pediatricians or Federally Qualified Health Centers within the local DCP&P community and (4); in very limited circumstances a hospital emergency room.

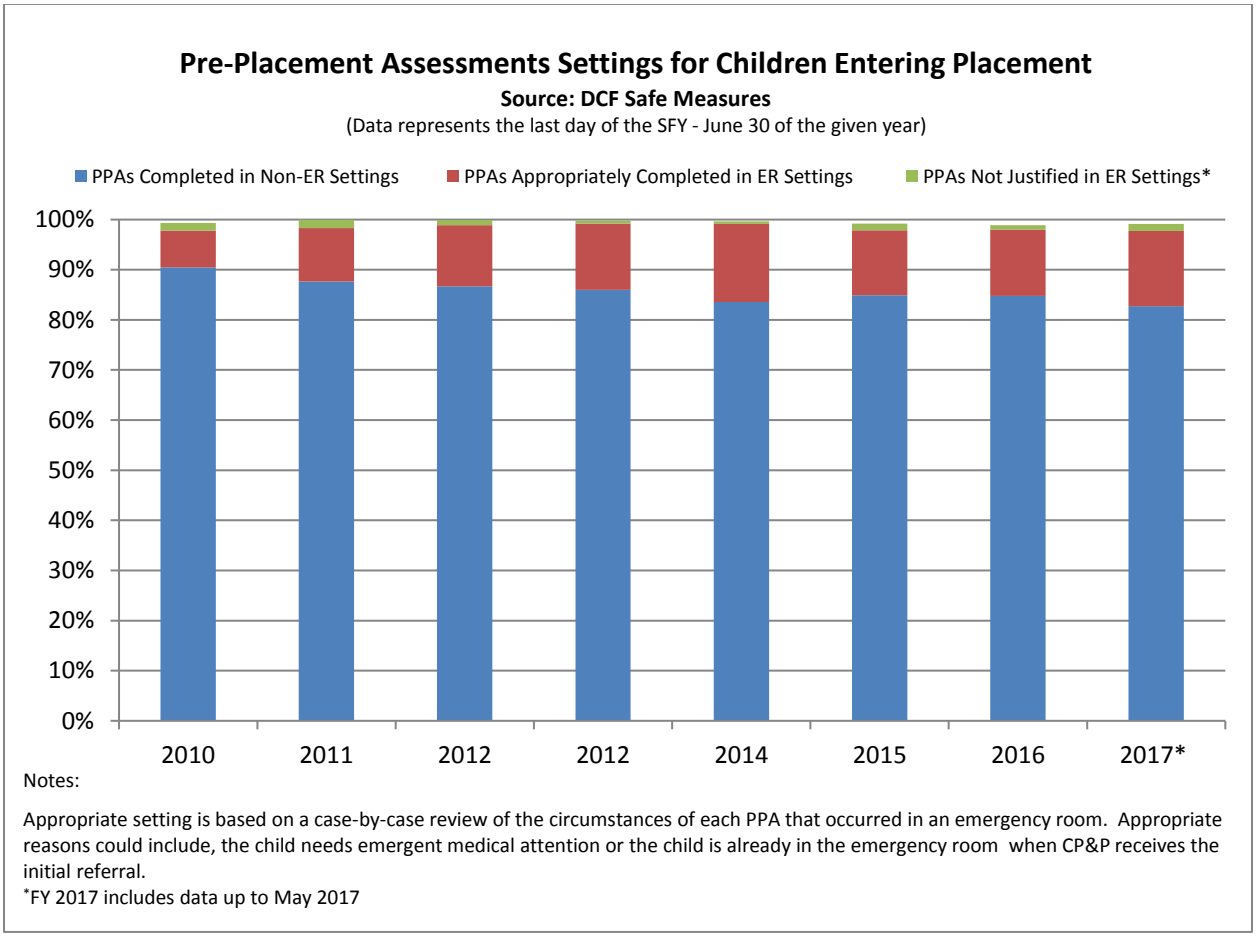
PPAs allow CP&P to obtain information for children entering placement regarding their current physical and behavioral health status. These assessments assist the CHU nurses, CP&P caseworkers and resource caregivers with ensuring the child's immediate physical and behavioral health care needs are recognized and addressed to help minimize the trauma of entering placement. Majority of children entering placement since 2010 received PPAs (see Figure 2). For example, the percentage of children to receive PPAs since 2010 has consistently remained at 99 percent or higher. It is also important to note that DCF has maintained steady performance with the majority (98 to 99 percent) of the children entering placement between 2010 to 2017 receiving a PPA in an appropriate setting (i.e., child's pediatrician, CHU nurse, or non-emergency room or appropriate use of emergency room setting, etc.).

Figure 2



CP&P makes every effort to ensure children entering placement do not receive a PPA in a non-emergency room setting. Figure 3 provides a breakdown for the PPAs completed in non-emergency and emergency room settings. From 2010 to 2017 majority of children entering placement received a PPA in a non-emergency room setting. The percentages of non-emergency room assessments ranged from 83 to 90 percent. The data also revealed a slight increase in assessments being completed in emergency room settings. It is important to note during that this time period, majority of these emergency room PPAs were deemed appropriate based on the circumstances, with no more than two percent of these PPAs being deemed unjustified.

Figure 3



Notes:

Appropriate setting is based on a case-by-case review of the circumstances of each PPA that occurred in an emergency room. Appropriate reasons could include, the child needs emergent medical attention or the child is already in the emergency room when CP&P receives the initial referral.

*FY 2017 includes data up to May 2017

Comprehensive Medical Examinations

Identifying any physical and/or behavioral health needs of children entering placement is essential to providing seamless care and ensuring their overall needs are addressed. To this end, the

comprehensive medical examination (CME) process was developed to ensure all children entering placement receive services and access care to address any identified needs.

All children who enter out-of-home placement in New Jersey are required to receive a CME within 30 days of entering placement. A CME is a full medical assessment that provides an overview of the child's current status, physical and developmental history, medical record review based on what is available, an initial mental health screening[17] and physician recommendations. CMEs are provided by the state's Regional Diagnostic and Treatment Centers (RDTCs), a contracted community based provider or the child's primary care physician. CHU nurses are responsible for scheduling CME appointments and ensuring all necessary parties (i.e., caseworker, resource parent, etc.) are available, and for gathering all required documents and preparing all applicable physical and behavioral health information for individual physicians and therapist when applicable.

Figure 4

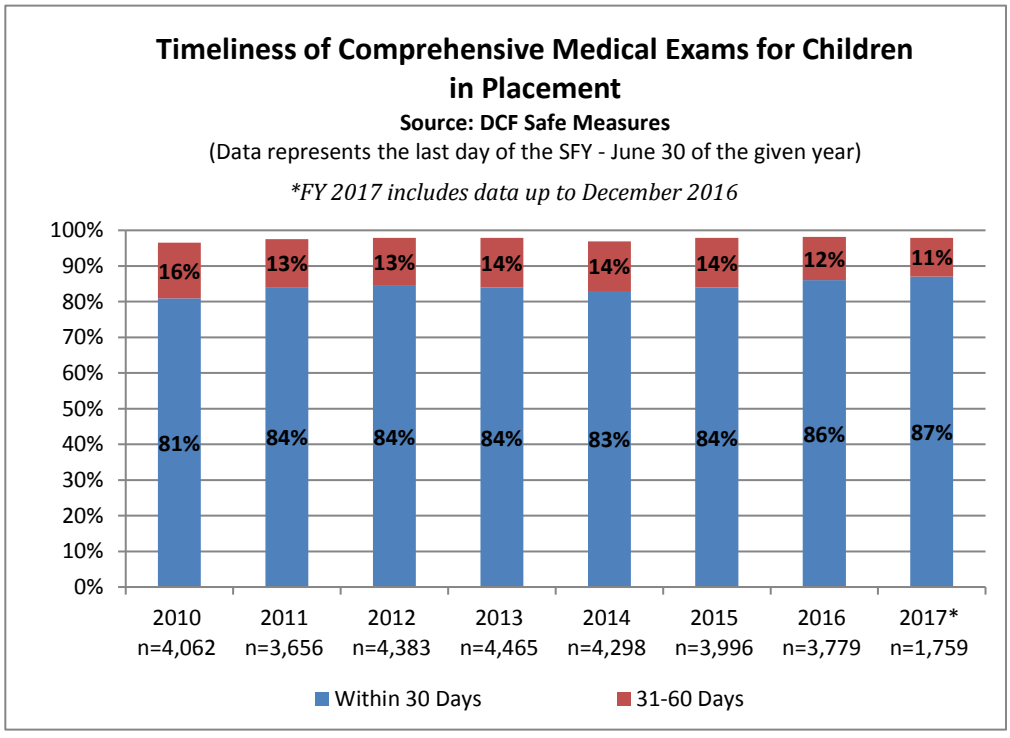


Figure 4 provides an eight year overview of the percentage of CMEs completed within 30 and 60 days for children in out-of-home placement. Historically, CP&P maintained steady performance with an eight year average of 98 percent of CMEs being completed within 60 days. This data also confirms majority of the children in placement are more likely (84 percent average) to receive a CME within 30 days. In addition, CP&P improved

[17] Refer to Chapter 3 for in-depth overview of mental health screening and assessments.

compliance over this time frame, as the data shows slight increases since 2011 in children receiving CMEs within 30 days and subsequent decrease in the numbers completed 60 days of entering placement.

Follow-Up Care and Treatment

The CME is also used as a means to identify if children entering placement need immediate follow-up care or treatment related to their health care needs. The CME provides necessary recommendations for CHU nurses and CP&P staff members to ensure children in placement receive ongoing follow-up care with appropriate primary and specialty services. Follow-up care and services are essential components of helping to ensure the identified medical needs of children in placement are addressed and met on a continuous basis. Table 2 shows DCF's adherence to recommended medical follow-up care needs identified by the CME. These data are typically gathered through a Health Care Case Record Review.[18] From July 2010 through June 2015[19] the percentage of children entering out-of-home placement referred for follow-up medical care ranged from 84 to 93 percent. In fact, children entering placement during this time period were more likely (90 percent on average) to be referred or recommended to receive some form of follow-up care than not. In July of 2015, DCF changed its methodology for reviewing health care case records, shifting the focus to conducting a more comprehensive review regarding the types of follow-up care recommendations being made. The results of this analysis found that a large percentage of recommendations were standard and linked to routine care, rather than referrals addressing a specific health care need. The Federal Monitor assigned to DCF conducted multiple assessments of the department's Health Care Case Record Review and found the medical follow-up care and treatment of children in placement was accurately measured and reported.[20]

[18] The Health Care Case Record Review is conducted by DCF to report on indicators not typically captured from DCF's other data sources, and involves reviewing records of a random sample of CHU health care records. The sample is statistically representative of children in CP&P out-of-home placement who were removed between the October 1 and April 30 period preceding the fiscal year and were in care for a minimum of 60 days. The results have a ± 5 percent margin of error.

[19] State Fiscal Years 2013 and 2014 are combined due to the change in the federal monitor reporting schedule that was altered to accommodate delays related to Hurricane Sandy.

[20] As cited in previous Federal Reports, the methodology and analysis remain comparable to the Health Care Case Record Review conducted by the Monitor. https://www.cssp.org/publications/child-welfare/class-action-

Because CHU nurses ensure routine care as part of providing health care case management, DCF began conducting a case review process for reporting medical follow-up findings based on specialty care regarding the specific needs of children entering placement. Subsequent to the implementation of this change in case record review, there was an evident decrease in the number of CMEs with referrals for follow-up care. One of the most notable findings occurred from 2015 to 2016, as the data revealed a decrease from 90 percent to 48 percent of children referred for follow-up care. While, there was an increase in 2017 (65 percent) the percentage remains considerably lower than years prior to the change in case review. During this time, DCF also began to closely discuss and analyze best practices around effectively addressing follow-up care, and identifying any potential gaps in provision of follow-up care services that could be rectified. DCF is now able to distinguish those cases where only some of the follow-up care needs are able to be addressed and determine if barriers are due to community or internal challenges. As Table 2 shows, there is a small percentage of cases (approximately 17.5 percent) where only some of the follow-up care was being addressed and an even smaller percentage (4 to 11 percent) where the follow-up care was pending some type of specialty appointment.

reform/2013/Charlie-and-Nadine-H.-v.-Christie-Monitoring-Report-XIII_October-1-2013.pdf (accessed October 5, 2017).

Table 2

Health Care Case record Review - Medical Follow-Up Care						
SFY	**2011**	**2012**	**2013-2014**	**2015**	**2016**	**2017**
Sample Size	659	669	1078	675	634	664
CME Records Within the Sample	650 (99%)	666 (100%)	1075 (100%)	674 (100%)	632 (100%)	659 (99%)
CME Records Indicating a Need for Follow-Up Care	544 (84%)	613 (92%)	1003 (93%)	607 (90%)	301 (48%)	431 (65%)
Records with Evidence of Follow-Up Care Being Addressed	94%	94%	95%	94%	90%	95%
Follow-Up Care Received	n/a	n/a	n/a	n/a	68%	67%
Some Follow-Up Care Received	n/a	n/a	n/a	n/a	18%	17%
Follow-Up Care Scheduled by the Time of Review	n/a	n/a	n/a	n/a	4%	11%
Records without Evidence of Follow-Up Care	6%	6%	5%	6%	10%	5%

Early and Periodic Screening, Diagnostic and Treatment Exams

In general, routine health screenings for all children and youth play a significant role in ensuring that health care needs are identified and addressed. They are an important means of prevention and early identification of physical, mental and behavioral health concerns. Physicians use screening and assessment to identify potential health problems and address physical and behavioral health concerns as early as possible. Children and youth can be linked to appropriate supports and services to address any needs or concerns identified through screening. Periodic routine health screenings are endorsed by the AAP, which recommends regular and ongoing screenings and developmental

and behavioral assessments for children from the time of birth through adolescent years as a means to provide preventive pediatric health care.[21,22]

All children under the age of 21 who are in a CP&P out-of-home placement are enrolled in and receive Medicaid for the duration in placement. The Medicaid plan provided to children and youth in CP&P placement is identical to New Jersey's Children's Health Insurance Program (CHIP)[23] plan. As a result, children in placement are eligible to receive the same[24] Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as children birth through age 21 received through Medicaid/CHIP. The goal of EPSDT is to provide comprehensive and quality health care services to low-income children from infancy up to age 21 to ensure they are provided appropriate health care services and treatment.[25] EPSDT is also a preventive strategy designed to minimize the possibility of a child/youth developing an advanced or chronic illness that require costly treatment.[26] EPSDT includes well child checkup visits as well as additional screenings that were designed to serve the following goals: 1) to assess a child's healthcare needs through initial and periodic examinations/screenings; 2) provide health education and guidance; 3) prevent and/or diagnose health problems as early as possible; and 4) provide treatment and referral services as necessary.

[21] David Satcher, M.D., Ph.D, Surgeon General, U.S. Surgeon General's Conference on Children's Mental Health: A National Action Agenda, 2000. http://www.childrensdefense.org/library/data/mental-health-screening-assessments-children-importance.pdf (accessed September 15, 2017).

[22] https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. (accessed October 3, 2017).

[23] CHIP provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ *(accessed September 15, 2017).*

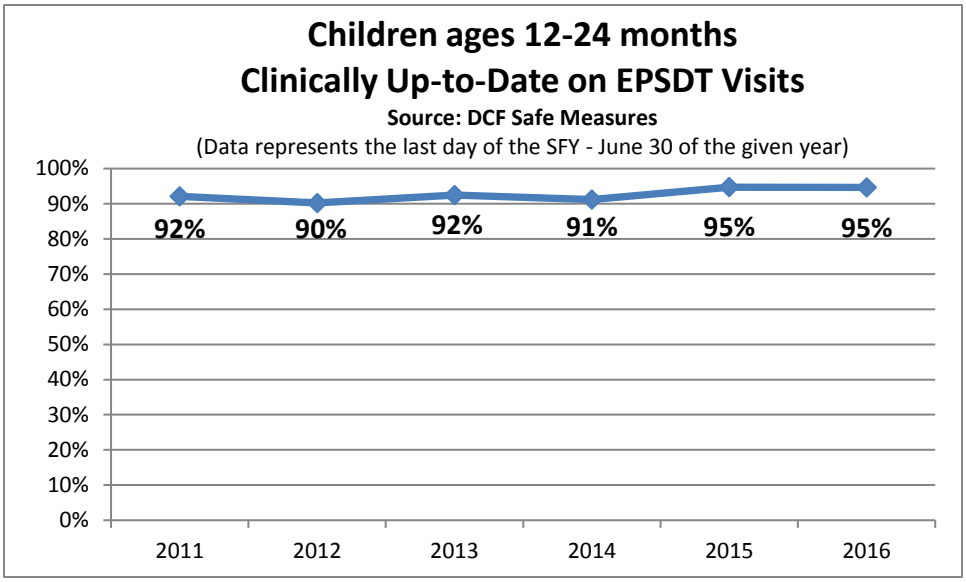
[24] https://mchb.hrsa.gov/maternal-child-health-initiatives/mchb-programs/early-periodic-screening-diagnosis-and-treatment. (accessed October 3, 2017).

[25] https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf. (accessed October 3, 2017).

[26] ibid

DCF makes every effort to adhere to the federal EPSDT examination schedule and guidelines for all children in placement.[27] Figure 5 provides a six-year[28] overview for the percentage of children in placement ages 12 to 24 months. The data shows these children were clinically on schedule with their EPSDT exams. CP&P maintained steady performance of at least 90 percent or higher, with an average of 93 percent of the children in placement ages 12 to 24 months being clinically on schedule with EPSDT exams. There was also a finding of a slight increase in the number of children ages 12 to 24 months being clinically on schedule with their EPSDT exams during this six year timeframe.

Figure 5

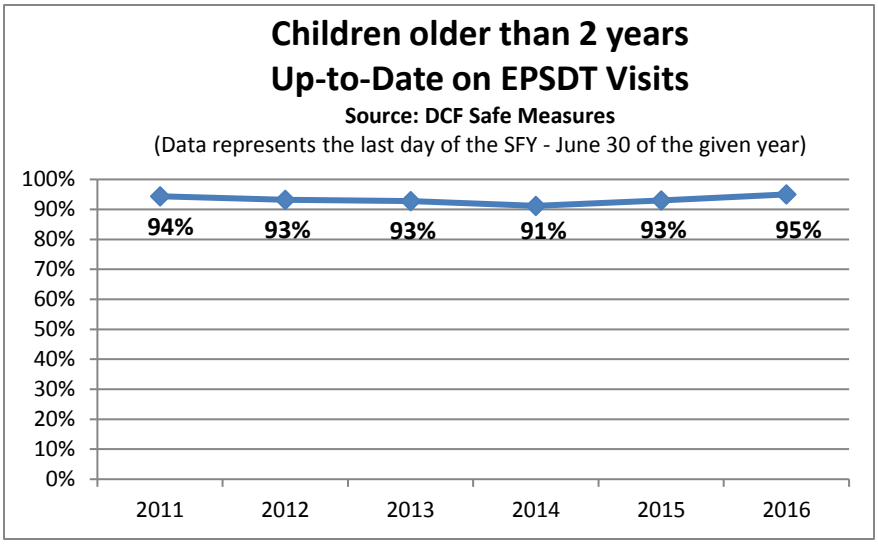


[27] DCF's SACWIS and Safe Measures (http://www.nccdglobal.org/sites/default/files/pdf/safemeasures-jj-overview.pdf) systems report EPSDT exam data for children in CP&P placement. Neither system has the ability to determine whether a child is clinically on schedule with their EPSDT exams. For instance, exams are only done during well child visits and a child who is sick at the time of their EPSDT visit will be reported as late. With the oversight of DCF, CHU staff conducted a supplemental record review for children who were recorded as not being clinically up-to-date with their EPSDT exams. In turn, staff was then able to reconcile EPSDT data from Safe Measures to accurately reflect a child being clinically up-to-date.
The Federal Monitor reviewed the data analysis of the supplemental record review for several monitoring periods and found DFC's review and tracking methods to be reliable for determining whether children were clinically on schedule with their EPSDT exams. As noted in the following report:
http://www.dcf.state.nj.us/opma/rer/Documents/Charlie_and_Nadine_H._v._Christie_Monitoring_Report_XVI_11_4_15.pdf

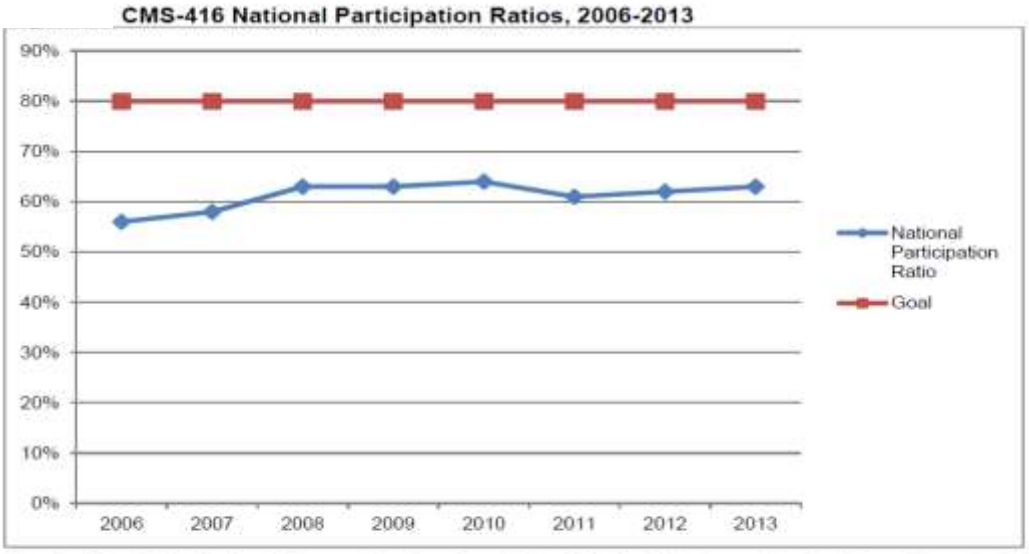
[28] 2017 EPSDT data for children under and over age two is unavailable for this report.

A six-year overview of EPSDT data for the same time period for children over the age of two revealed similar findings as the younger children. Majority of the children in placement over the age of two were clinically on schedule with their EPSDT exams (see Figure 6). Historically, children ages two and older also maintained steady performance of at least 91% or more of the children being clinically on schedule with their EPSDT exams during this time frame.

Figure 6



In comparing, EPSDT data up to 2013 from the Centers for Medicare and Medicaid Services (CMS) revealed a notable finding, children in CP&P placement fared better than children nationwide in the general population. These findings are reflected in the figure below.[29]



Note: As of June 2014, data from 2012 were missing from Connecticut and data from 2013 were missing from Arizona, Connecticut, Florida, Maryland, Maine, Missouri, New Hampshire, and North Carolina.

Source: OIG analysis of CMS-416 reports, 2006–2013.

[29] https://oig.hhs.gov/oei/reports/oei-05-13-00690.pdf. (accessed October 4, 2017).

Immunizations

Immunizations are a significant prevention tool for child health and well-being. New Jersey requires immunizations for children entering school, licensed child care facilities and school-age programs. AAP and the Center for Disease Control provides guidelines for best practices and how to assess immunization schedule compliance for children in out-of-home placement[30]. As part of ensuring consistency in a child's access to quality care, including preventive care, CP&P requires children entering placement to be up-to-date with their immunizations. As a result, CP&P staff engages the biological parents, family, and/or caregivers for children entering placement to acquire information to verify the status of a child's immunizations.

Figure 7

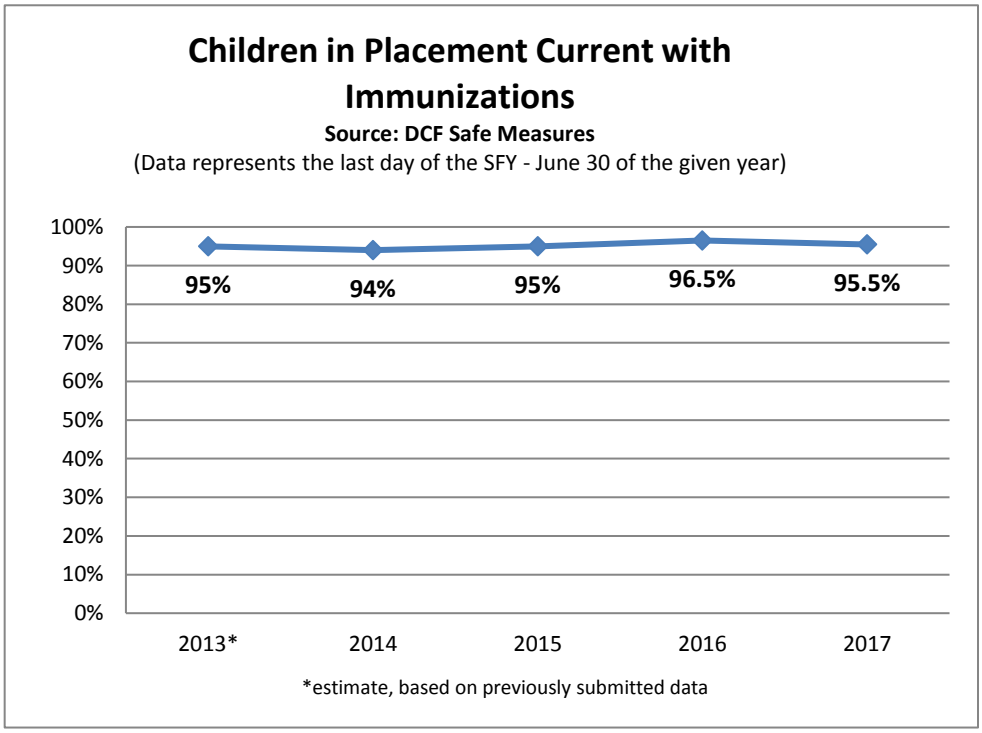


Figure 7 provides an analysis of immunizations from 2013 through 2017. The data revealed an average of 95 percent of the children in placement were current with their immunizations from 2013 through 2017. In the Charlie and Nadine H. v. Christie Federal Monitoring Report XVI it was noted that children in CP&P placement exceeded the 90 percent immunization rates set for states by the Center for Disease Control and Prevention.[31] Additionally, children in CP&P placement achieved similar immunization rates as

[30] https://www.aap.org/en-us/Documents/immunizationschedule2017.pdf
[31] http://www.dcf.state.nj.us/opma/rer/Documents/Charlie_and_Nadine_H._v._Christie_Monitoring_Report_XVI_11_4_15.pdf

all of the children in New Jersey public schools from pre-K to sixth grade.[32] CHU nurses are responsible for documenting the immunization status as updated health information is received for children in placement. This practice has helped the department to sustain steady progress in ensuring that children in CP&P placement are current with their immunizations.

National data on immunizations is typically reported based on individual vaccines, which makes it difficult to complete a comparison to CP&P findings pertaining to children in placement. However, based on reported national findings there are several areas where children in CP&P placement fare better than children in the general population on being current with immunizations.[33,34,35,36]

[32] ibid

[33] https://www.cdc.gov/vaccines/imz-managers/coverage/childvaxview/data-reports/3-series/dashboard/2014.html

[34] https://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tables/14/tab03_antigen_state_2014.pdf

[35] https://www.cdc.gov/vaccines/imz-managers/coverage/childvaxview/data-reports/3-series/trend/index.html

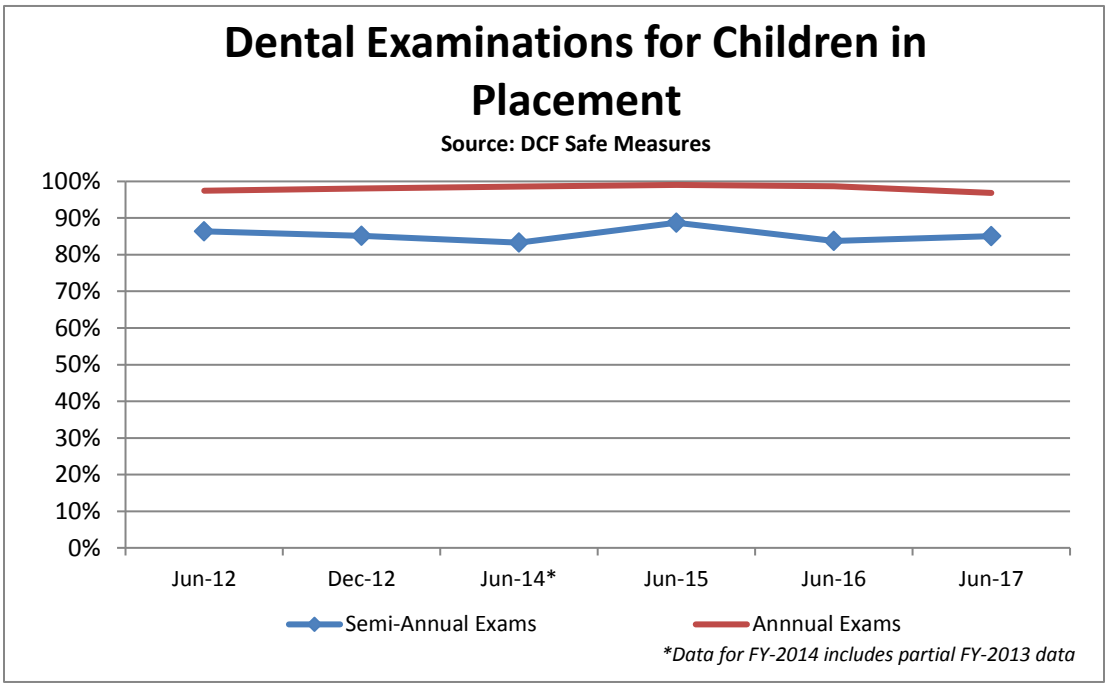
[36] https://www26.state.nj.us/doh-shad/topic/Immunization.html?PrinterFriendly=x

Dental Examinations

Dental and oral health care examinations are important components of routine health care and case management for children in out-of-home placement. According to the AAP, nationally it is difficult to access dental and oral health care services and exams for children and youth in foster care. AAP estimates that approximately 35 percent of children enter placement with significant dental and/or oral health issues.[37] CP&P understands the importance of children having access to and being provided quality oral health care services. CHU nurses and staff work with the Medicaid HMO partners to identify resources in an effort to ensure children entering placement are provided appropriate dental and oral health examinations on a consistent basis to address any related issues.

Figure 8[38] provides a six-year analysis of semi-annual and annual dental exams for children in CP&P placement. The data revealed that DCF has maintained steady performance, on average 98.3% of children in placement received an annual dental examination.

Figure 8



[37] https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Oral-Health.aspx (accessed September 19, 2017).

[38] Partial data for FY 2014 due to the change in the federal monitor reporting schedule that was altered to accommodate delays related to Hurricane Sandy.

Chapter 3

Child Mental Health Measures for Children in Out-of-Home Placement

Being involved with the child welfare system can impact a child. Children who enter out-of-home placement may be especially vulnerable because they have experienced at least one traumatic life-changing event: being removed from their caregivers.[39] As a result, many child welfare systems have realized the importance of screening for trauma and mental health issues for children in placement. Accordingly, child welfare advocates and child health policymakers endorse early mental health screening and assessment for children and youth following removal from their homes.[40] Screening for mental and behavioral health needs and trauma symptoms related to entering placement determines if a child should be referred for further assessment and treatment for trauma and/or other mental or behavioral health conditions. In understanding and acknowledging the impact of these factors, DCF recognized the significance of integrating trauma-informed and mental health best practices such as screening and assessment into case practice.

As a trauma-informed agency, addressing the mental health needs of children entering placement is an important component of CP&P's case practice model and core values. As a result, each child who enters out-of-home placement in New Jersey receives an initial mental health screening by a qualified professional.

[39] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2014). *Integrating Safety, Permanency and Well-Being Series: Screening, Assessing Monitoring Outcomes and Using Evidenced-Based Interventions to Improve the Well-Being of Children in Child Welfare.* Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/wp2_screening_assesing_monitoring.pdf

[40] https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Mental-and-Behavioral-Health.aspx

Children entering placement are screened utilizing at least one of the three following options:

Mental Health Screening Options
1. Screening by a CHU Nurse utilizing the Bright Futures Pediatric Symptoms Checklist[41]
2. Screening by the physician/health care practitioner conducting the CME utilizing their identified developmental screening tool or
3. Screening by a CP&P caseworker using a tool developed by DCF, which has been adapted from the Mental Health Screening Tool developed in California.[42]

Children identified through the screening process with possible trauma and/or mental or behavioral health needs are referred for further assessment to identify the most appropriate therapeutic service(s). These services include, but are not limited to therapy, mentoring support and, when applicable and under strict guidance, medication[43] concurrent with other therapeutic interventions. There are times, when a child's mental and/or behavioral health needs are identified early enough after placement, or when a child's overall needs and/or risk of adverse trauma reactions are so complex, that assessment and intervention by professionals specially trained in child abuse and neglect is warranted. In these situations, DCF engages the state's Regional Diagnostic and Treatment Centers (RDTCs) to provide a mental health assessment.

DCF has strengthened its interdepartmental partnership between the department's Division of Children's System of Care (CSOC) and CP&P by ensuring youth and resource/kinship parents have necessary supports to increase the potential for the stability and security of children/youth in out-of-home placement. CSOC is the division, under the auspices of DCF that is responsible for providing services to youth under 21 with behavioral health challenges, intellectual and/or developmental disabilities, and/or substance use challenges. As part of the expansion of services

[41] https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf
[42] http://www.cebc4cw.org/assessment-tool/the-mental-health-screening-tool/
[43] http://www.nj.gov/dcf/providers/contracting/childhealth/. An updated version of this policy will be published in the Fall of 2017.

through CSOC, the department began a new partnership with the state's providers of Mobile Response and Stabilization Services (MRSS) to provide services to children and resource caregivers at the immediate time of placement. MRSS is CSOC's urgent response component. The MRSS providers offer 24/7 response to children/youth experiencing crisis as defined by their families with a goal of stabilization by providing supports and services within system of care framework. MRSS is provided to children and licensed resource and kinship caregivers at the immediate time of placement given the traumatic circumstances that by definition surround placement. This process requires CP&P staff members to contact CSOC's Contracted System Administrator (CSA), which is CSOC's single point of entry and access to care, to refer all children/youth ages three through 18 that are being placed in resource or kinship care. The purpose of this is to connect children/youth and caregivers to their local MRSS provider, if the Care Management Organization (CMO) is not already involved with the child at the time of placement. The main goal of MRSS is to stabilize and mitigate the trauma for children/youth at time of placement by offering support and education to children/youth and licensed resource and kinship caregivers. Stabilization at the initial placement is also key. Stabilization is an important factor in avoiding the re-traumatization that can occur from further changes to placement.

Mobile response is delivered to children/youth experiencing escalating emotional symptoms, behaviors or traumatic circumstances which have compromised or impacted their ability to function at their baseline within their family, living situation, school and/or community environments. These crises arise from situations, events, and/or circumstances that are unable to be resolved with the usual resources and coping abilities and jeopardize the development of adaptive social and emotional skills. These children/youth, without intervention, could likely require a higher intensity of intervention to address their needs and/or prevent further decline in life functioning. Without MRSS, children/youth may be at risk of psychiatric hospitalization, out-of-home treatment, legal charges, or, loss of their living arrangement, including out-of-home placement through CP&P. In particular, children/youth who have experienced implicit or explicit trauma may be at increased risk for an acute decline in their baseline functioning or for being in jeopardy of a change in their current living environment.

MRSS services are available 24 hours per day, 7 days a week, year round and provide:

- On-site intervention for immediate de-escalation of presenting emotional symptoms and/or behaviors;
- Assessment, planning, skill building, psychoeducation and resource linkages to stabilize presenting needs;
- Assistance to the children/youth and families in returning to baseline (routine) functioning or prevention of escalation; and
- Provision of prevention strategies and resources to cope with presenting emotional symptoms, behaviors and existing circumstances and avoid future crises.

MRSS is delivered by applying crisis intervention principles and core CSOC values and principles within the described program model. The associated services are strengths-based, child/youth centered, family driven, community based, trauma informed, and culturally and linguistically mindful. The connection to mobile services has been a stabilizing factor for children in out-of-home placement.

Mental Health Screening

CP&P recognizes the trauma children may experience when removed from their homes and understands background information can be limited. As a method of best practice, each child entering a CP&P out-of-home placement receives a mental health screening to determine if a mental health assessment is needed. The table below provides an overview of screening practices for children entering placement over the last six state fiscal years, based on information from the CHU health care case records. From July 2011 through June 2017 an average of 99 percent of the children identified as being eligible received a mental health screening (children under 2 years of age or receiving mental health services at the time of placement are not screened).

Table 3

Health Care Case record Review - Screening for Mental Health Needs						
SFY	**2011**	**2012**	**2013-2014**	**2015**	**2016**	**2017**
Sample Size	659	669	1078	675	634	664
Children Not Eligible to receive a MH Screening (Children < age 2 years; Children Receiving MH Services at the Time of Placement).	247 (37%)	279 (42%)	455 (42%)	292 (43%)	266 (42%)	264 (40%)
Children Requiring a MH Screening	412	390	623	383	368	400
Eligible Children Screened for MH Needs	99%	99%	99%	100%	100%	99%
Overview of CHU screening practices FY11-17, based on Health Care Case Record Review						

Mental Health Assessment

Mental health assessments provide a comprehensive and detailed evaluation of a child's current mental health state. Consequently, assessments help determine what follow-up care and treatment a child may need. Children already receiving mental or behavioral health or psychiatric services at the time of placement are assumed to be receiving regular screening, re-evaluation, and treatment as part of their services. However, additional concerns may present themselves that may warrant a referral for mental health assessment following placement to assist with ensuring appropriate services and supports are being provided to each child. Table 4 provides a six-year overview of the number and percentages of children identified with a mental health need who received a mental health assessment.

DCF has maintained steady performance of ensuring eligible children receive a mental health assessment. It is important to note the department's performance has improved over time for this measure. An analysis of the data also revealed that on average 93 percent of the eligible children identified with a mental health need from 2011 to 2017 received a mental health assessment (see Table 4). DCF leadership, CP&P and CHU staff make continuous efforts to ensure children with an identified need are provided with appropriate mental health assessments and services.

Table 4

Health Care Case record Review - Mental Health Assessment						
SFY	**2011**	**2012**	**2013-2014**	**2015**	**2016**	**2017**
Children Screened for MH Needs	407	386	615	382	368	394
Total Number of Children Requiring a MH Assessment	268	253	393	238	249	238
Total MH Assessments Completed	242	230	363	218	241	228
Percentage of MH Assessments Completed for Children Requiring a MH Assessment	**90%**	**91%**	**92%**	**92%**	**97%**	**96%**

Follow-Up Care and Treatment

Mental health assessments are a means to verify if children in placement need follow-up care or treatment related to their trauma and/or mental and behavioral health care needs. Additionally, the assessments provide insight that allows CHU nurses and CP&P staff to ensure children in placement receive appropriate treatment and access follow-up care.

Health care case management to ensure access to follow-up care and services are essential to meet the mental and behavioral health care needs of children in placement on a continuous basis. Table 5 shows that from July 2011 through June 2016, majority of the eligible children received the follow-up care recommended from their mental health assessment. The percentage rates for follow-up care and treatment have remained steady during this time period.

Table 5

Health Care Case record Review - Follow-Up Care - Mental/Behavioral Health						
SFY	**2011**	**2012**	**2013-2014**	**2015**	**2016**	**2017**
Children Requiring MH Assessment	268	253	393	238	249	238
Children who Received a MH Assessment	90%	91%	92%	92%	97%	96%
Records Indicating MH Assessment the Need for Additional Treatment/Services	n/a	88%	96%	94%	96%	93%
Records with Evidence of Additional Treatment as Recommended	n/a	82%	82%	82%	86%	84%
All Treatment Received	n/a	66%	63%	59%	80%	79%
Some Treatment Received	n/a	16%	19%	23%	6%	5%
Records Without Evidence of Treatment Following a MH Assessment	n/a	18%	18%	18%	14%	16%*
*Includes 10% where treatment was not provided due to refusal of youth (7%) or because services were not available at the time (3%).						

Conclusion

Since the early stages of child welfare reform in New Jersey, DCF has recognized the importance of ensuring that the basic health care needs of all children involved with the department are met. Since the restructuring of the health care delivery system and release of the Coordinated Health Care Plan, service delivery and physical and behavioral health care outcomes for children in out-of-home placement have improved. These improvements have been successfully maintained over time.

The working collaboration between DCF and Rutgers has allowed the Child Health Program and individual Child Health Units to build upon their strengths. The commitment of these two entities to provide continuous high standards in health care case management and access to quality health care has helped ensure the overall needs of children in placement are met. The addition and integration of qualified health professionals into CP&P case practice has been influential in meeting child health care target measures. The performance reflected in the child health measures demonstrates the success of DCF's approach to meeting the needs of children in out-of-home placement.

New Jersey will continue its commitment to ensure the physical and behavioral health care needs of children in placement are met by maintaining and supporting the infrastructure of health care case management services built over the last ten years. Local office collaboration with the child health nurses has strengthened our capacity to manage health care for all children in placement and helped the department navigate the health care provider and payer systems. The nurses have had great success ensuring the majority of children in placement receive required assessments, supports, and services, as well as remaining current with EPSDT and dental exams and immunizations. In fact, as highlighted earlier in the report, there were areas (i.e., EPSDT exams and immunizations) where children in CP&P placement fared equally or better than children nationwide in the general population. Through the department's continuous quality improvement plan, department leadership and staff are able to identify strengths and improvements to ensure a greater today and even better tomorrow for the children and families served by DCF.

Appendix A

Child Health Program Timeline

- **1983-1985** Division of Youth and Family Services (DYFS) in-house "Child Health Medical Unit" established in DYFS Central Office, Trenton (Chief pediatrician and senior social work staff).
- **1985-1989** DYFS started hiring nurses as independent pediatric consultants, located in local DYFS offices. The nurses provided expertise and guidance and follow-up and home care of drug-exposed infants, triage in child abuse and neglect before referral to chief pediatrician, and assisted with meeting the health care needs of medically fragile children coming into foster care.
- **1989-1990** Request for an appropriation for nursing services in the state child welfare budget was submitted and approved.
- **1998-2000** DYFS sent out a Request for Proposal (RFP) to provide nursing services within DYFS Local Offices
- **Prior to 2000** Nursing consultation services, (Independent Nurse Consultants) existed within Division of Youth and Family Services (DYFS) through contracts with individual nurses.
- **2000** University of Medicine and Dentistry of New Jersey (UMDNJ) / award François-Xavier Bagnoud Center (FXBC)/School of Nursing (SN) was awarded a contract to provide nursing services to DYFS Local Offices for the Northern 2/3 of the state (14 of the 21 counties in NJ).
    - Professional Nurse Consultants (PNC) is awarded a contract to provide nursing services to the Southern 1/3 of the state (7 of the 21 counties in NJ)
- **2000-2007** UMDNJ / FXBC /CHP develops a coordinated program approach to provide child health nursing services within NJ child welfare DYFS Local Offices.
- **Apr 2007** DCF requests CHP to submit a proposal for Health Care Case Management of all children in DYFS who are in out-of-home placement (OOH) settings.
    - Requires the establishment of a Child Health Unit (CHU) in each DYFS Local Office.
- **Jul 2007** UMDNJ/FXBC/School of Nursing (SN)/CHP awarded for statewide program
    - DCF replaces CHP contract with a Memorandum of Understanding (MOU). The MOU expands CHP scope of responsibility to include all 21 counties (Statewide) in NJ and requires CHP to:
    - Establish Child Health Units in all 47 DYFS Local Offices
    - Provide Health Care case management (HCCM) services to all children in Out of Home (OOH) placement

- **Aug-Dec 2007** CHP begins working with DCF on a roll-out plan for implementation of HCCM and establishment of CHU's across the state.
  - Dec. 2007 - CHP staff total 37
  - Sep. 2008 - CHP staff total 232

- **Jan 2008-Jan 2012** UMDNJ/FXBC/SN/CHP awarded the contract for the statewide child health program.
  - Assume the responsibility of the southern portion of the state
  - Expand the CHP leadership team
  - Expand the hiring pool
  - Case reviews, development and implementation of CHU's to provide HCCM.
  - The CHP has developed a comprehensive and coordinated response through HCCM to ensure that these specific health care needs of children in OOH are being met.
- **Jan 2012-Present** Rutgers University/SN/FXBC/CHP current status
  - Full staffing of CHU's
  - 2014, UMDNJ mergers with Rutgers, The State University of New Jersey
    - Refinement of nursing model: comprehensive and coordinated response through HCCM to ensure that these specific health care needs of children in OOH are being met.

Appendix B

Expanded CHP Nursing Services: A CHP nurse is assigned to and involved in a foster child's case and provided expanded nursing services. Expanded nursing services involve assessing health, identifying, advocating and planning for health care needs, coordinating health care services, monitoring health status, educating on health/health care needs, and evaluating the health/health care outcomes.

Expanded CHP Nursing Services / Activities	
Health Care Outcomes	**Nursing Services/Activities**
Pre-Placement Medical Assessments (PPA)	▪ Nurses complete a required health assessment of a portion of the children entering placement into foster care and review assessments done by other providers.
Comprehensive Medical Exams (CME)	▪ Nurses assess the need for, schedule, coordinate, facilitate, and monitor follow-up CME recommendations to assure children in foster care have their health care needs identified and met.
Mental Health Assessments	▪ Nurses complete a mental health screening utilizing the Pediatric System Checklist for children in foster care at every home visit.
Medical Health Passports	▪ Nurses complete and maintain a Health Passport for each child entering foster care, a health summary that informs and updates foster parents, child welfare staff, and primary/specialty providers regarding the health history, current health status, and ongoing health care needs of children in their care.
Early and Periodic Screening, Diagnostic, And Treatment (EPSDT)/ Well Child Exams	▪ Nurses assess the need for, schedule, coordinate, and facilitate EPSDT/well child exams to assure children in foster care receive timely EPSDT visits and specialty appointments.
Semi-Annual Dental Exams	▪ Nurses assess the need for, schedule, coordinate, and facilitate semi-annual dental exams to assure children in foster care are up-to-date with their dental care.
Follow-up Health and Mental Health Care Needs	▪ Nurses ensure timely, accessible, and appropriate follow-up care and treatment. Nurses visit foster homes at a frequency based on the child's health care needs. They support and educate foster parents, evaluate the child's adjustment to the home, and assess the foster parent's ability to meet the child's health and mental health care needs.
Immunizations	▪ Nurses assess the need for, schedule, coordinate, and facilitate immunizations to assure children in foster care are up-to-date regarding their immunization status.