

FINAL REPORT AND ABSTRACT

1. PROJECT IDENTIFICATION

Project Title: Healthy Tomorrows Partnership for Children Program

Children's Medical Services & Advocacy Center (The Center)

Project Number: H17MC23544

Project Director: Jerrold B. Binney, President & CEO

Grantee Organization: Children's Aid and Family Services, Inc.

Address: 200 Robin Road, Paramus, NJ 07652

Phone Number: 201 261 2800

E-mail Address: jbinney@cafsnj.org

Home Page: www.cafsnj.org

Project Period: 03/01/2012-02/28/2017

Total Amount of Grant Awarded: \$218,725

FINAL REPORT AND ABSTRACT

Narrative:

1. PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD HEALTH (MCH) PROGRAMS:

Grant funding from the Healthy Tomorrows Partnership for Children program was awarded in 2012 to support the Medical Services & Advocacy Center (MSAC) that was launched by Children's Aid and Family Services in 2011 to serve the special healthcare needs of children in its foster care and adoption programs. Children with special healthcare needs are one of the

priority populations for this grant program. Our program used a hybrid medical home model of direct care and coordination of care to ensure access to consistent, high quality health care for children and teenagers in foster care who have had histories of severe abuse, neglect and trauma: Children's Aid and Family Services is one of New Jersey's foremost leaders in providing residential and therapeutic services to this population. The program model was developed with the support and encouragement of the AAP New Jersey Chapter which recognized, as we did, that the special healthcare needs of these children were not being adequately addressed and that no one else was examining potential solutions to this issue. Children in the child welfare system received Medicaid-funded services and at the time we were developing the program (2008-2010), there were very few Medicaid providers in northern New Jersey, where our children were living. Things changed with the advent of Medicaid Managed Care and each of our children could be connected to a primary care provider. But significant challenges remained to ensure that the quality and consistency of care for this very vulnerable population were achieved. Between inception of the idea and initial implementation in 2011, prior to the grant award, we made adjustments to the original model to reflect changes in health insurance coverage and to focus on direct care and healthcare coordination rather than our original intention to be primary care providers; these modifications to the proposal originally submitted to HRSA were presented and approved in a Revised Scope of Work following notification of the grant award.

Because of the nature of the abuse and trauma the children served by the MSAC had suffered, they had usually been in at least 6 and not infrequently, in as many as 15, prior temporary foster care placements before being referred to Children's Aid and Family Services for the type of

specialty therapeutic foster care services the agency provides. As a result, they had rarely seen the same provider more than once; their medical records were scattered and often misplaced so no medical history was available to the next provider; they were often over- or under-vaccinated; many had been prescribed for conditions that they didn't have; while others had undiagnosed and often chronic conditions. Further, since many were on psychotropic medications for various mental and behavioral health challenges, other complications such as obesity and medication conflicts were also impacting these children. Children's Aid and Family Services determined that employing an in-house medical team to pay attention to these details, including: providing physical exams at intake through outreach to collect medical histories; following up on outstanding lab results; creating a formal health care management plan and linking each child with the most appropriate sub-specialists in conjunction with their primary care provider; educating our direct care staff on the children's healthcare needs; liaising with our psychiatric and clinical team to provide coordinated care; and having the expertise to advocate for systemic changes within the state child welfare system were among the core objectives of our program. Our overarching goals were to improve the healthcare of the children we served while they were in our care; to create a comprehensive medical care plan for each child that they and/or their caregiver could follow once leaving Children's Aid and Family Services for a lower or higher level of care, for a long-term foster care or adoptive home, or when "aging" out of care; and to establish best practices and outreach/advocacy to better inform general medical providers, the social work field, and all those involved in the care and placement of children in foster care in New Jersey to improve the quality and consistency of care needed for children with special healthcare needs. In setting up and developing the model, we liaised extensively with the NJ

Department for Children & Families, the NJ AAP Chapter, and with a dedicated advisory board that included Dr. Lori Garg, Medical Director of the NJ Title V agency, Children with Special Healthcare Needs Program (CSHCN), part of the NJ Department of Health and Senior Services, Division of Family Health Services, and Dr. Wayne Yankus, a prominent local pediatrician who is active in the NJ AAP Chapter as well as active with the AAP at a national level. The medical team we employed were highly experienced pediatric care providers and had a wealth of expertise in working with troubled and vulnerable children and teens involved in the child welfare system. They used the AAP's Bright Futures Guidelines and resources to provide prevention and health promotion education to the children and their professional and/or family caregivers. The team also participated regularly in webinars, conferences and other continuing education opportunities coordinated by the AAP in New Jersey and New York throughout the duration of the project, and worked closely with Karla Palmer, the Healthy Tomorrows Program Coordinator, who has been provided regular program reports and has visited the program. Additionally, Elizabeth Mason, the primary contact for the program at CAFS through August 2016, was a speaker on a sustainability webinar coordinated by Ms. Palmer (July 25, 2013: How to mine, map and mobilize relational assets and strengths in your networks), and the MSAC program was highlighted in several AAP publications. The MSAC is the only program of its type in New Jersey.

2. GOALS AND OBJECTIVES:

The Medical Services & Advocacy Center was staffed by a part-time pediatrician, Anne Armstrong-Coben, MD and a full-time pediatric Advanced Nurse Practitioner. Dr. Armstrong-

Coben, Assistant Professor of Pediatrics at Columbia University was the key architect of the MSAC program model and worked with Children's Aid and Family Services in a voluntary capacity to develop the Center prior to being hired to oversee it. For several years Dr. Armstrong-Coben had worked for Covenant House in New Jersey, overseeing a clinic for children and teens who were homeless, so she had a strong understanding of the needs of the children we serve. The MSAC uses the medical home model to provide intake assessment/exams, medical triage, acute care and health care case management for children in Children's Aid and Family Services' specialty therapeutic foster care programs to improve the healthcare outcomes of this population. The specific goals and objectives for this project:

Goal 1: To improve child health by providing access to high quality, coordinated healthcare to all children in agency (CAFS) foster care programs.

Objective 1: CAFS medical staff provides preventative care to all program residents within the first six months and will coordinate all components of direct health care for these same youths for the duration of their care.

Objective 2: Project staff will develop collaborative relationships with community providers of specialty medical care as needed.

Objective 3: There will be written or verbal communication with all pertinent medical providers prior to a child seeing that provider. All children will have an updated "Problem List" and plan to address issues, plus an updated "Medication List" that includes psychotropic as well as other medications.

Commentary: The essential premise that underpins all aspects of the program is the belief that children in foster care – a population recognized for having special healthcare needs - deserve

the right to the same high-quality healthcare as our own children and grandchildren. The existing system in New Jersey was failing these highly vulnerable children on multiple levels, so a multi-faceted approach was identified as being critical to achieving desired results. From the outset, medical staff were hired who had experience in working with children with special health care needs and had the skills to provide direct care and case management as well as a commitment to providing health education and advocacy. They tenaciously tracked down missing medical records; triaged medical issues; and developed medication lists and problems list that could be made available for medical visits. Additionally, they created comprehensive healthcare management plans so that for the first time, each of these children had a medical record that would be available to them and to their care givers when they transferred from agency care. They educated agency staff on health care best practices and provided a host of preventative and other health education to staff and caregivers so that the children were surrounded by caring adults who were more fully informed and who knew how to support the medical needs of these children. They made referrals to sub-specialists as needed and developed relationships with each child's primary care providers to ensure consistency of care. And they reached out to community providers and state child welfare staff to provide education and improve understanding of the special healthcare needs of children in foster care so that our children received the best possible care and that other children would benefit from the knowledge that had been shared.

Ensuring we hired medical staff who were especially skilled in working with children with special healthcare needs was key. They were able to spend the time needed to build trust and rapport with children who have often "shut down" following trauma and who have significant

difficulty with trusting adults. Many of the children in CAFS care have experienced physical and sexual abuse, and medical exams can be particularly traumatic. Having staff on site who have been able to take the time to support these children and to really understand their challenges has been a significant factor in improving their healthcare outcomes. Primary care visits typically last only a few minutes and are sporadic, so the child doesn't have the same level of comfort sharing their problems and the provider also lacks the ability to gain as much knowledge of factors that may be significant in impact on the child's health. The combination of our staff, working in collaboration with the primary providers, has been a very effective way to address these challenges. From the outset, the program model was developed based on AAP best practices. These included creating "rounds" to discuss cases with the psychiatrists and case management discussions with clinical and direct care staff to ensure a truly multi-disciplinary approach to care coordination. The intention throughout this project was to find an Electronic Record System to track all aspects of the children's medical care. As outlined below, and was documented and discussed with HRSA and AAP staff throughout the early years of the project, it proved challenging to identify an affordable, HIPAA-compliant system that combined the type of data tracking CAFS required for both medical and mental health documentation, since the clinical aspects of CAFS' work are extensive. Early systems tended to focus on either medical or behavioral health, with the result that the other discipline either had insufficient tracking capability or required expensive and extensive build out. Tracking outcomes was thus more challenging. In early 2017, a system was purchased, and this will allow this last objective to be fulfilled.

Goal 2: To ensure that a child's ongoing medical needs are a key component of

discharge/transition plans established for youth in agency placements.

Objective 1: Center staff will ensure that the child's Medical History Summary and the public agency's Child Medical Passport is complete and updated within 30 days of the child's planned discharge/transition from a CAFS placement.

Objective 2: All parents with whom children in CAFS placement are expected to fully reunify will be invited by Center staff to participate in the child's medical appointments prior to discharge.

Objective 3: Center staff will ensure that medical records are provided to the legal guardian upon a child's discharge and all required medical follow ups are identified and explained.

Commentary: In addition to ensuring these children received high quality care while in CAFS placements, we were committed to ensuring that this was just the first step in giving them the ability to manage their health care once they had discharged or transitioned from CAFS care. Developing ongoing medical summaries was key to this process and allows each child/young adult and his or her caregiver as appropriate, the ability to manage and advocate for their healthcare needs. The state of New Jersey's Division for Child Protection and Permanency began to develop Child Health Passports on a phased basis, so our team worked in collaboration to ensure appropriate information was shared for the central record as well as a more individualized care plan being created and discussed with the child and/or caregiver at a local level. At the time of writing this report, these Passports are still in development and do not fulfil the role of providing a comprehensive medical history for each child in care.

The types of caregivers we work with includes professional staff, foster and adoptive parents,

and birth parents, some of whom are in complex relationships with their children and others who are in the process of reunifying after a period of separation. Navigating and accessing all adult parties is not always feasible or desirable, but wherever it is appropriate, the child's medical histories have been shared and discussed, to ensure the child continues to experience positive outcomes.

Goal 3: To increase community pediatrician knowledge of the special healthcare needs of children in foster care while simultaneously providing health education to foster and adoptive parents.

Objective 1: In the first three months of the project begin work with project partners on a needs assessment of the most pertinent topics for community training.

Objective 2: Provide training opportunities for community pediatric providers: based on the initial needs assessment and subsequent feedback, these will be provided on an individualized basis.

Objective 3: provide health education and support to children's current caregivers, and, when feasible, to the children's parents (birth/adoptive) each year. Many of the birth parents are very dysfunctional which makes the latter goal more challenging: working with reunifying birth families is the priority.

Commentary: From the outset, MSAC staff has worked collaboratively with a broad range of community providers to ensure the best medical care is accessible to the children in CAFS' care.

The team, along with members of the MSAC advisory board (which includes several pediatricians and nurses), was proactive in reaching out to local providers to explain the Center's work and objectives, and offering to be a resource and education provider regarding

the special healthcare needs of children in foster care. A group training was held that was open to these providers as well as CAFS staff and caregivers, but it proved challenging to schedule additional trainings, so these were developed on an individualized basis. Several trainings were also coordinated for pediatric medical residents at Columbia University Medical Center that included site visits to MSAC as well as agency group homes and provided the opportunity to interact with foster parents. It is important to note that many education efforts were also conducted on a one-on-one basis with family members and caregivers too. Each of these initiatives has helped to broaden understanding and appreciation of the special health care needs of children in foster care and created greater awareness of how to address these needs.

Goal 4: To meet or exceed HRSA's expectations for grantees for culturally competent programs, family and community partnerships for service delivery, and program sustainability as federal funding ends.

Objective 1: Expand CAFS advisory board to include at least two additional parents and 2 additional caregivers within year one of the project.

Objective 2: Ensure that all Center staff complete agency training on working in a culturally competent manner in the first 6-9 months of employment.

Objective 3: Integrate need for program sustainability throughout program development by involving Agency Board and key leadership in project goals, showcasing program success stories in CAFS publications and involving the advisory board in fundraising.

Commentary: CAFS is fully committed to cultural competency and all staff receive regular trainings on this. CAFS is also accredited by the Council on Accreditation which provides an additional layer of verification regarding commitment to and compliance with cultural

competency. Dr. Armstrong-Coben also teaches this subject at Columbia University Medical Center. Dr. Armstrong-Coben is bi-lingual in Spanish and CAFS staff is culturally reflective of the most significant populations served. The MSAC advisory board has been key to the program's success. The group includes medical practitioners, including our Title V and AAP representatives, as well as funders and foster parents. Meetings have been held regularly and each has included an educational discussion on a relevant topic (e.g. toxic stress, PTSD, food insecurity) so that all are informed on issues that impact the population served. All members have been active in fundraising, which has included direct mail appeals, grant applications to private and corporate foundations, and several dedicated fundraising events, including several held in conjunction with golfers on the PGA TOUR and their wives. The advisory board members have been tireless ambassadors for the program and have had the full support of the agency's leadership at both staff and board levels. These efforts have raised the visibility and credibility of the program and allowed it to have more impact; equally, they have ensured that the program has been fully resourced during the full five years of the project.

3. METHODOLOGY:

A medical director, Dr. Anne Armstrong-Coben and a pediatric APN, Kathy Courain, were hired to oversee program development and to coordinate medical healthcare services for the children served. Having the right staff in place has been critical to the project's success. This team was responsible for initiating and sustaining a medical program based on AAP best practices, to improve the consistency and quality of medical care for all children in CAFS placements.

MSAC conducted a thorough needs assessment and successfully advocated with the state of New

Jersey to obtain a special license exemption from New Jersey's corporate practice of medicine laws to be able to offer direct care to the children in an agency facility. They also secured the cooperation of State child welfare personnel to collaborate on the sharing of information necessary to improve healthcare coordination and record keeping to improve healthcare outcomes for children in CAFS programs. The ability to provide immediate direct care for early diagnosis of medical problems such as ear infections and rashes has been invaluable in reducing the number of visits to community pediatricians and the Emergency Room. In instances in which children do not have insurance and have not been linked to a PCP, the team has also served as primary care providers for non-urgent treatment.

The team worked closely with the public agency Child Health Units and the staff psychiatrists through individual case staffings and the integration of child service plans so that all involved in the coordination of care shared common understanding and common goals. In conjunction with our advisory board they developed outreach and advocacy that have helped reframe the discussion about how the healthcare needs of children in child welfare systems in New Jersey need to be changed, and practices they developed are now being explored for replication elsewhere. The MSAC program was truly innovative and is still the only such program of its type in New Jersey. As outlined above, most of the time has been spent on direct healthcare and on healthcare coordination for children in the agency's foster care programs. The program has cost between \$250,000 to \$300,000 a year to run, most of which are employee-related expenses and costs of the dedicated clinic space (a private consultation room, a draped medical exam area, a waiting area, and a meeting/community education area) at the agency's offices at 200 Robin

Road, Paramus, NJ. In the final year of the project, an intern was hired to do more administrative and data entry tasks so that the APN could spend more time on direct care. In the absence of an EHR system, a variety of forms and checklists were created to manage information and ensure procedures were followed for all clients. These included: a MSAC Intake and Assessment form; an Annual Medical Exam form; a TB Risk Assessment Tool; and a Medical Test Consent form. The MSAC team conducts 20-40 comprehensive medical exams a month; 100-150 phone or in person consults and attends an average of 30-50 client clinics with other members of the caregiving/clinical team.

4. EVALUATION:

We collect basic demographic information; process outcomes for tracking medical needs, home visits, interface with other providers and contributions to Medical Summaries; the number and focus of trainings. We were in regular communication with our program officer and partners about the most methodical way to evaluate the various aspects of our project since we didn't have an EHR system or any way to benchmark the healthcare outcomes of our children against those of other children in foster care in the state. The State of New Jersey's child welfare system requires us to submit regular clinical reports electronically but does not share even aggregated data to enable benchmarking. They do not have an EHR system and one of the key factors that impacted the delay in purchasing our own system was a concern that it might not be compatible with the state's system once they moved ahead with one. For a while we used a free online system until it was no longer HIPAA-compliant, and this allowed us to track improvements but not for a consistent length of time. Program goals were presented to the agency's Outcomes

Committee which is part of CAFS' continuous quality improvement (CQI) process designed to track outcomes for clients in all programs. CQI reports are also made available to external reviewers during the reaccreditation process every four years, ensuring that procedures are tracked and verified. Most of our clients are with us for only a few months (some for only a few days or weeks) and we have no way of comparing pre- and post- placement data either. In many instances children arrive having been removed from a home on an emergency basis and there is no medical information readily available. For the most part, our outcomes are anecdotal – positive feedback from trainings, client surveys, and outreach by former clients who stay in touch and to reach out for advice from our medical team; and individual client success stories. This has been the source of much frustration. In 2017, an EHR system has been purchased and we anticipate moving forward that we will be able to monitor the impact of a variety of similarities and variables in condition and intervention, that will allow us to adopt a more rigorous, research-based approach to inform our care practices.

5. RESULTS/OUTCOMES:

During the five years of the project a total of 565 children and teenagers were served by this project: 75 Hispanic; 1 American Indian/Alaskan; 11 Asian; 288 African American; 119 White; 55 Multi racial; 17 Unrecorded. All goals were achieved.

The biggest challenge we faced was in tracking outcomes in a systematic and meaningful way. When we launched, all medical records of our children were in paper charts and the documentation of their health history was fragmented or non-existent so the priority was to

develop a centralized medical summary for each child as we explored options for an Electronic Health Record system that would serve all the agency's needs, not just medical. Because of numerous issues, including budget, this was delayed. In the interim, MSAC began to use a free online EHR, PracticeFusion, to collate information and pilot cross communication with the psychiatric team. However, as HIPAA standards became more rigorous, we were advised to discontinue use of this system. Research for a more viable and sustainable alternative has been lengthy and ongoing, but CAFS is now contracted with CareLogic and implementation of this EHR system began in the spring of 2017.

Despite this, we have daily examples of how our provision of care is improving the healthcare outcomes of these children. Some examples include:

- MSAC staff noted that many of the children in our care are overweight or obese. By chart review it was discovered that many of these children gained weight while with us, because our group home staff was cooking more traditional “comfort” food rather than a nutritionally balanced diet. MSAC staff provided resources and ideas on how to prepare healthier and more nutritious meals and ran health education classes for staff and the children focusing on “My Plate” to explain portion sizes. The team also worked with staff to devise meal plans. The new program has had a positive impact on the weight of children in the homes has been positive. It has also motivated many employees to be more aware of the value of pursuing healthy lifestyle habits.
- MSAC staff provided education to caregivers about enuresis (bedwetting), a normal part of some children's developmental behaviors. They also helped to identify instances in

which bedwetting was triggered by stress and helped to teach coping and calming techniques, where feasible, as alternatives to medication solutions.

- We have experienced numerous examples of children coming into care who have been given a “normal” physical exam prior to intake but once examined by the MSAC team have been found to have infections, horrendous skin conditions and other ailments such as foreign bodies in the ear, which have been the cause of considerable anxiety and pain. In one instance, a girl who had been raped by a man who was HIV-positive, had never been given the results of her HIV test and was beside herself with worry. Our nurse tracked down the result promptly and reassured the girl that she her result was negative. Our staff has been able to have immediate impact in improving the quality of life of these children.

Other outcomes of note that have improved the medical care of this population:

- CAFS has better informed staff and caregivers. Because of their training in anticipatory guidance and familiarity with the Bright Futures Guidelines, staff members are able to see areas of potential safety concern. They have also helped educate other caregivers on how to improve the safety of home environments.
- MSAC developed a committed group of high quality community Primary Care Providers (PCPs) who have been sensitive to the special healthcare needs of our children.
- MSAC has raised greater awareness of special healthcare needs for children in foster care more broadly by coordinating regular onsite trainings for pediatric residents of Columbia University Medical Center. These trainings have outlined the AAP guidelines for children in foster care; relevant policy issues; and have included meetings with foster parents and

visits to agency group homes so they can see the environments in which these children live. These trainings have been very enthusiastically received and a number of the residents have delivered presentations to their peers on related topics, as outlined in Item 7 below.

- Probably our proudest achievement is that the efforts of MSAC have been recognized by NJ child welfare officials in the Department of Children and Families. When we first launched our program, while we gained the necessary collaboration, the initial reception of the NJ child welfare leadership was fairly lukewarm as it was perceived that the medical needs of children in the state system were being fully addressed. As our project progressed and we were in a position to demonstrate that many children were being failed by the system's lack of attention to tracking and record keeping, state officials began to examine our model and to seek guidance on what could be done to replicate and expand our approach so that more children across New Jersey could benefit from more thorough medical case management. A series of discussions has been underway between agency representatives and state officials since spring 2016 and we believe that systems change will be likely in the coming years.

6. PUBLICATIONS/PRODUCTS:

- CAFS newsletter, Spring 2012 "Healing Creates Hope" article on MSAC written by Sheila Riccardi of CAFS, 200 Robin Road, Paramus, NJ 07652/201 261 [2800/](tel:2012612800)
sriccardi@cafsnj.org. Audience: agency supporters.
- Flyer and brochure on the program. Audience: employees; foster parents; medical

providers; donors.

- Internal forms used to serve clients, including: Medical Test Consent; TB Risk Assessment Tool; Annual Medical Exam Form; MSAC Intake & Assessment Tool; Medications List; Medical Summary. Audience: CAFS staff and external medical providers.
- Article on MSAC in the newsletter of the Todd Ouida Children's Foundation, 2013. www.mybuddytodd.org Audience: general community.
- Article/interview on MSAC in the Community Pediatrics Newsletter of the AAP, August 2013. www.aap.org Audience: medical professionals.
- Article on MSAC in The Ridgewood News, May 31, 2013, by Bryan Wassel, wassel@northjersey.com. Audience: general consumer.
- Article in Ridgewood News, 2014 by Lucy Probert, www.northjerseymedia.com. Audience: general consumer.
- Article in CAFS newsletter: "Creating Healthy Futures", 2013. Written by Sheila Riccardi of CAFS, 200 Robin Road, Paramus, NJ 07652/201 261 [2800/](tel:2012612800)
sriccardi@cafsnj.org Audience: CAFS supporters.
- Article in Town Journal about MSAC fundraising event, Sept. 4, 2014. There were various photo stories in magazines and newspapers in northern NJ about this event. Audience: general consumer.
- Feature on MSAC in Connections, Columbia Women's and Children's Health newsletter, Spring 2015. Audience: medical professionals.
- Article on MSAC in newsletter of the Community Foundation of New Jersey,

2016. Written by Sheila Riccardi of CAFS, 200 Robin Road, Paramus, NJ 07652/
201 261 [2800/sriccardi@cafsnj.org](mailto:sriccardi@cafsnj.org). Audience: general/philanthropists.

7. DISSEMINATION/UTILIZATION OF RESULTS:

The MSAC team, under the leadership of Dr. Anne Armstrong-Coben, worked tirelessly to raise the bar for the quality and consistency of healthcare afforded to the children in this program and to advocate for this to be a best practice model to be replicated elsewhere in New Jersey so that all children in foster care are on a level playing field and have the opportunity to thrive. Much of this work has been done on an informal basis during one-on-one conversations to educate local providers about the special healthcare needs of this population. Many meetings have also been held with state child welfare officials to advocate on the importance of data tracking and sharing so that the healthcare needs of these children can be managed appropriately and in a timelier way, thereby reducing the distress clearly experienced by those who have failed to receive the type and level of care they need. By the summer of 2016, these advocacy efforts started to bear fruit and a series of meetings and conversations was underway between members of the MSAC team and the leadership of CAFS with the leadership members of the NJ Department of Children and Families to explore both closer collaboration with area offices of the NJ Division of Child Protection & Permanency, that would include new procedures and protocols on data collection and data sharing on medical information pertinent to improving healthcare management and outcomes of children in the child welfare system. While there is a long journey ahead, we are proud of this significant advance in thinking and the possibility it presents of widespread

systems change in the state in the future.

Another area of focus that will have longer term impact has been the four trainings coordinated for groups of pediatric residents of Columbia University Medical School designed to showcase the special healthcare needs of children in foster care and increase understanding by members of the pediatric medical profession of the types of challenges and issues pertinent to this population. We believe these sessions, held for groups of 6-8 residents each year, will increase the level of understanding about the examination and care management of children in foster care that will have much broader long-term impact that will also extend beyond New Jersey. Three short-term outcomes have already been achieved and are of note:

- Following some of these training sessions, several of the residents have organized fundraising drives to support the children in CAFS care.
- Dr. Armstrong-Coben mentored a 3rd year Columbia University Medical Center pediatric resident, Angela Anderson, who delivered a presentation on “The Special Healthcare Needs of Children in Foster Care” in a Chief of Service talk to more than 100 faculty, residents and students.
- Erica Cao, College of Physicians & Surgeons Class of 2018 and Steve Miller Fellow of Columbia University Medical Center, developed a “Send-A-Song” program on Empathy Advancement in Health Professional Students, in collaboration with Dr. Armstrong-Coben and other faculty members. In Send-A-Song, health professional students from Columbia University work with pre-

college students interested in the health professions from the Lang Youth Medical Program, a pipeline program which aims to interrupt cycles of intergenerational poverty in largely immigrant populations. The students work together to create personalized songs for foster children with medical and psychological needs. The pilot was conducted to benefit children in one of the group foster homes run by CAFS. Apart from the joy these children received by receiving a personalized song that had been written about the things they had requested, the students that participated in the program were all very moved by the experience. The results of the pilot were presented to faculty and students in 2016.

8. FUTURE PLANS/SUSTAINABILITY:

The work of MSAC will continue beyond the life of this grant project. Its work has been invaluable in affording the children in CAFS' foster care programs, who are some of the most abused and traumatized children in New Jersey's child welfare system, the opportunity to receive high quality medical care and a health care management record and plan as outlined above that are unprecedented in New Jersey. Since the program opened in 2011, an aggressive fundraising program, coupled with this grant award, have ensured that the program has been fully funded each year. Our intention is to continue to pursue private and public grant funding opportunities, gifts from corporations and individuals, and to raise money for MSAC via fundraising events.

There have been some changes to the program in recent months as a result of both staff turnover and new opportunities for Children's Aid and Family Services. Firstly, our initial medical team

of Dr. Armstrong-Coben and Kathy Courain APN, left the agency in December 2016 and January 2017 respectively. Secondly, the agency made a decision to relocate the MSAC medical suite to the newly consolidated Children's Services building that opened in Fair Lawn, New Jersey. It was agreed that the healthcare needs of our children would be even better served if MSAC were to move to the Children's Services facility which brings together all child welfare disciplines, including group home management, clinical and psychiatric support and case, alongside teams working with dually-diagnosed children and children with developmental disabilities, and community outreach specialists in substance abuse and mental health. The consolidation of services occurred in 2015 and has considerably aided cross-team communication and support and strengthened the multi-disciplinary team approach to care. As such, it made sense for MSAC to relocate there too to bring the team even closer and to aid the scheduling of visits by children and staff to a single location. This arrangement has the added benefit of saving costs as well, and is a key factor in the sustainability plan for MSAC moving forward. The new suite opened in the spring of 2017 following retrofitting of a sink to meet the requirements of a medical facility.

While we were very sorry to see the departure of our launch team who have done so much for the children in our care, we were delighted to hire Dr. Hugh Bases, a pediatrician with offices in Midland Park, NJ and in New York City, as our new Medical Director to oversee the MSAC program. Dr. Bases has been a practicing physician for more than 20 years and earned his MD from Albert Einstein College of Medicine. He completed his residency in general pediatrics at Montefiore Medical Center and his fellowship in Developmental-Behavioral Pediatrics at Yale University School of Medicine. He is Board Certified by the American Board of Pediatrics in

General Pediatrics and Developmental-Behavioral Pediatrics. He is also Clinical Assistant Director of Pediatrics at NYU Langone Medical Center and treats a wide range of developmental and behavioral disorders, including ADHD, behavioral disorders, autism and autism spectrum disorders, and intellectual disabilities. He has been joined by a new full-time nurse, Michelle Simmons, who has an extensive background as an RN Case Manager and Staff Nurse serving abused and neglected children with behavioral disorders in a variety of non-profit settings. This new team is highly experienced and dedicated to continuing the mission of MSAC.

Another key factor for sustainability is the introduction this year of the agency's first Electronic Health Records system. This is expected to be fully operational by the summer of 2017 and will enable CAFS to improve tracking of client care and also integrate the care provided by our behavioral health staff with their medical care, thereby providing accurate "care mapping" for our clients. The EHR will also streamline our billing and provide a mechanism for efficiently tracking and producing outcomes to continually improve the quality of our programs and to produce reports for funding partners. A full-time EHR manager was hired in February and the agency has also entered into a consultancy relationship with Legacy Treatment Services, located in Hainesport, NJ, to help with the implementation process. Legacy is an agency very similar to CAFS and has considerable experience with the Care Logic (by Qualfacts) system we are using. This has been a considerable investment for CAFS and one which demonstrates its ongoing commitment to serving the medical and mental health needs of its clients. Advocacy is also continuing to encourage the NJ child welfare systems of care to establish a centralized EHR system which will enable the healthcare coordination of all children in the system to receive

improved care coordination and the opportunity for improved healthcare outcomes. With the continuation of advocacy efforts at state level we are also confident the Center and CAFS leadership will continue to create an environment for systems change in child welfare in New Jersey; while its work with other healthcare professionals will continue to resonate locally and nationally thanks to improved understanding of the special healthcare needs of children in foster care.

In conclusion, we fully anticipate that the continuation of the MSAC program will result in continued improvements to the healthcare outcomes of the children served, while the use of an EHR system will enable, for the first time, the start of a more rigorous and methodical approach to tracking outcomes. Additionally, longer term outcomes that will start to come to fruition in the coming years will be more sensitive treatment of children in foster care by pediatric practitioners and a wholesale change in the system of medical care coordination practiced at state level that will positively impact the health and well-being of future generations of children in the child welfare system in New Jersey.

- ANNOTATION

The Medical Services & Advocacy Center was established by Children's Aid and Family Services to ensure access to consistent, high quality medical care for children and teens in foster care who had histories of abuse, neglect and trauma. These children have typically been in multiple temporary placements before being referred to Children's Aid and Family Services for specialty therapeutic foster care services: the lack of a centralized medical records system in the state of New Jersey and the nature of emergency removals from family homes means that these children rarely come into care with complete medical histories. Further, they have been seen by multiple providers and their records are scattered; children are often undiagnosed or have been misdiagnosed due to these deficiencies. The goal of MSAC is to collate these histories, establish care plans and written summaries that can be used following discharge or transition from CAFS by focusing on healthcare case management, coupled with direct onsite care, health education of children and their caregivers, and medical advocacy via meetings with state officials, trainings and presentations. The Center's efforts and promotion of new best practice models have greatly improved the healthcare outcomes of those served, have been widely recognized and are starting to create systems change in the state; more broadly, awareness and understanding of the special healthcare needs of children in foster care has been raised significantly amongst pediatric health professionals in the region.

- KEY WORDS

Pediatric care

Special healthcare needs

Children

Foster Care

Children's Aid and Family Services

Primary Care

Medical Services

MSAC

Advocacy Center

Dr. Anne Armstrong

Columbia University Medical Center

Child welfare

New Jersey

Healthcare outcomes

Multi-disciplinary

Minorities

Healthcare disparities

Nursing

Best practice

Bright Futures

Underserved populations

ABSTRACT OF FINAL REPORT

Project: Children's Medical Services & Advocacy Center (The Center), H17MC23544

Grantee Organization: Children's Aid and Family Services, Inc.

Address: 200 Robin Road, Paramus, NJ 07652 Phone Number: 201 261 2800

E-mail Address: jbinney@cafsnj.org Home Page: www.cafsnj.org

Purpose of Project: Grant funding from the Healthy Tomorrows Partnership for Children program was awarded in 2012 to support the Medical Services & Advocacy Center (MSAC) launched by Children's Aid and Family Services (CAFS) to serve the special healthcare needs of children in its foster care and adoption programs. Children with special healthcare needs are one of the priority populations for this grant program. MSAC used a hybrid medical home model of direct care and coordination of care to ensure access to consistent, high quality health care for children and teenagers in foster care who have histories of severe abuse, neglect and trauma: CAFS is one of New Jersey's foremost providers of residential and therapeutic services to this population. These children have been in at least 6 and in as many as 15, prior temporary foster care placements before being referred to CAFS for specialty care. They rarely saw the same provider more than once; medical records were scattered and misplaced; they were often over- or under-vaccinated; others had undiagnosed and often chronic conditions. CAFS employed an in-house medical team to pay attention to these details, including: intake physical exams; outreach to collect medical histories; follow up on outstanding lab results; creating formal health care management plans and linking each child with sub-specialists in conjunction with their primary care provider; educating direct care staff on the children's healthcare needs; coordinating care with our psychiatric and clinical team; and advocating for systemic changes within the state child

welfare system. Our overarching goals were to improve the healthcare of the children we served while they were in our care; to create a comprehensive medical care plan for each child that they and/or their caregiver could follow once leaving CAFS for a lower or higher level of care, for a long-term foster care or adoptive home, or when “aging” out of care; and to establish best practices and outreach/advocacy to better inform general medical providers, the social work field, and all those involved in the care and placement of children in foster care in New Jersey to improve the quality and consistency of care needed for children with special healthcare needs. The MSAC is the only program of its type in New Jersey. In developing the model, we liaised extensively with the NJ Department for Children & Families, the NJ AAP Chapter, and with a dedicated advisory board that included NJ Title V and AAP representatives. The medical team used the AAP’s Bright Futures Guidelines and resources to provide prevention and health promotion education to the children and their professional and/or family caregivers. They also participated in webinars, conferences and other continuing education opportunities coordinated by the AAP in New Jersey and New York throughout the duration of the project.

Goals and Objectives: MSAC was staffed by a part-time pediatrician, Anne Armstrong-Coben, MD (Assistant Professor of Pediatrics at Columbia University) and a full-time pediatric Advanced Nurse Practitioner. Dr. Armstrong-Coben, was the key architect of the MSAC program model and worked with CAFS in a voluntary capacity to develop the Center prior to being hired to oversee it. Both had extensive experience in medical care for children with special healthcare needs. The four goals of this project were achieved: **(1)** Improve child health by providing access to high quality, coordinated healthcare to all children in agency (CAFS) foster care programs. **(2)** Ensure that a child’s ongoing medical needs are a key component of

discharge/transition plans established for youth in agency placements. (3) Increase community pediatrician knowledge of the special healthcare needs of children in foster care while simultaneously providing health education to foster and adoptive parents. (4) Meet or exceed HRSA's expectations for grantees for culturally competent programs, family and community partnerships for service delivery, and program sustainability as federal funding ends.

Methodology: MSAC used a medical home model. Members of the advisory board, including medical practitioners, funders and foster parents, have been active in fundraising and their efforts have ensured that the program has been fully resourced during the full five years of the project. They also helped develop outreach and advocacy that have helped reframe the discussion about how the healthcare needs of children in child welfare systems in New Jersey need to be changed. Practices developed by MSAC are now being explored by state child welfare officials for replication elsewhere.

Evaluation: CAFS collected basic demographic information; process outcomes for tracking medical needs, home visits, interface with other providers and contributions to Medical Summaries; the number and focus of trainings. In the absence of an EHR, outcomes are heavily anecdotal, e.g. positive feedback from trainings, client surveys, outreach by former clients, and individual client success stories.

Results/Outcomes: A total of 565 children and teenagers were served: 75 Hispanic; 1 American Indian/Alaskan; 11 Asian; 288 African American; 119 White; 55 Multi racial; 17 Unrecorded. Achievements included: introducing new meal plans into agency group homes following documentation of increased obesity amongst clients; improved understanding and treatment of enuresis; prompt identification and treatment at intake for children with existing conditions;

better informed caregivers; increased awareness in the pediatric profession of the healthcare needs of children in foster care; recognition at state level of the need for systems change to better serve the medical needs of this population.

Publications/Products: MSAC has been widely featured in a range of consumer and professional publications as well as agency newsletters. Internal documents include intake and exam forms and procedures.

Dissemination/Utilization of Results: Trainings of pediatric professionals have been coupled with meetings with state child welfare officials to advocate for the healthcare needs of these children to be managed more appropriately and in a timelier way. By 2016, these advocacy efforts started to bear fruit with exploration of new procedures and protocols on data collection and data sharing to improve healthcare management and outcomes of children in the child welfare system in New Jersey.

Future Plans/Sustainability: MSAC will continue its work, and we do not anticipate any funding difficulties given our fundraising track record to date. There have been some recent staffing changes and the medical suite has relocated in 2017, but the core program model remains unchanged. We anticipate that the program will result in continued improvements to the healthcare outcomes of the children served, while the use of an EHR system will enable, for the first time, a more rigorous and methodical approach to tracking outcomes. Longer term outcomes that will start to come to fruition in the coming years will be more sensitive treatment of children in foster care by pediatric practitioners and a wholesale change in the system of medical care coordination practiced at state level that will positively impact the health and well-being of future generations of children in the child welfare system in New Jersey.