
Mandates for Collaboration: Health Care and Child Welfare Policy and Practice Reforms Create the Platform for Improved Health for Children in Foster Care

Sarah Zlotnik, MSW, MSPH,^{a,b} Leigh Wilson, MSW,^{a,b} Philip Scribano, DO, MSCE,^{a,c,d}
Joanne N. Wood, MD, MSHP,^{a,b,c,d} and Kathleen Noonan, JD^{a,b,d}

Improving the health of children in foster care requires close collaboration between pediatrics and the child welfare system. Propelled by recent health care and child welfare policy reforms, there is a strong foundation for more accountable, collaborative models of care. Over the last 2 decades health care reforms have driven greater accountability in outcomes, access to care, and integrated services for children in foster care. Concurrently, changes in child welfare legislation have expanded the responsibility of child welfare agencies in ensuring child health. Bolstered by federal legislation, numerous jurisdictions are developing innovative cross-system workforce and payment strategies to improve health care delivery and health care outcomes for children in foster care, including:

(1) hiring child welfare medical directors, (2) embedding nurses in child welfare agencies, (3) establishing specialized health care clinics, and (4) developing tailored child welfare managed care organizations. As pediatricians engage in cross-system efforts, they should keep in mind the following common elements to enhance their impact: embed staff with health expertise within child welfare settings, identify long-term sustainable funding mechanisms, and implement models for effective information sharing. Now is an opportune time for pediatricians to help strengthen health care provision for children involved with child welfare.

Curr Probl Pediatr Adolesc Health Care 2015;45:316-322

Introduction

Improving the health of children in child welfare requires close collaboration between the health care and child welfare systems. For decades, pediatricians have played an integral role working with child protective services (CPS) in the initial identification, evaluation, and diagnosis of child maltreatment. Despite the complex health needs of this population, concerted partnership between health care and child welfare systems, was historically largely limited to the CPS investigation period. However,

propelled by recent health care and child welfare policy reforms, there are new mandates for accountability and integrated responses fostering greater collaboration between the health care and child welfare systems for the duration of time a child is involved in child welfare.

This article aims to provide a road map for health care systems looking to improve health care delivery and health care outcomes for children served by the child welfare system and in particular children in foster care. The first section provides the national health care and child welfare policy context. In particular, this section highlights recent trends in health care reform that foster greater accountability in outcomes, access to care, and integrated services for children in foster care. Concurrently, recent mandates in child welfare legislation require child welfare systems to ensure children in their care receive appropriate health care services. Reinforced by this policy environment, the next section discusses innovative workforce and financing strategies that jurisdictions have adopted to improve health care delivery and health care outcomes for children in foster care. The article concludes with recommendations on how jurisdictions can bolster the success of these cross-system efforts.

From the ^aDivision of General Pediatrics, The Children's Hospital of Philadelphia, Philadelphia, PA; ^bPolicyLab, The Children's Hospital of Philadelphia, Philadelphia, PA; ^cSafe Place: Center for Child Protection and Health, The Children's Hospital of Philadelphia, Philadelphia, PA; and ^dDepartment of Pediatrics, Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA.

Note: This article is adapted from a State Policy Advocacy Reform Center issue brief—Zlotnik S, Scribano P, Wood J, Noonan K. Improving child well-being: Strengthening collaboration between the child welfare and health care systems. First Focus, State Policy Advocacy Reform Center, Washington, DC; 2013.

Curr Probl Pediatr Adolesc Health Care 2015;45:316-322

1538-5442/\$ - see front matter

© 2015 Published by Mosby, Inc.

<http://dx.doi.org/10.1016/j.cppeds.2015.08.006>

National Policy Context

Health Care Policy Reforms Strengthen Medical Care for Children in Child Welfare

Recent health care reforms have focused on increased accountability of medical systems for health outcomes, greater access to care including mental health services, and improved integration of services. Some of these key reforms included provisions specifically focused on children in foster care. Other legislative actions, although not targeted to children in foster care, will significantly impact this population. Concurrent with national policy changes, the American Academy of Pediatrics (AAP) developed recommended standards of health care for children in foster care that are shaping the development of health care policy and service provision.

Accountability for Health Outcomes

Medical systems are facing increasing pressure to assume responsibility for the health outcomes of their patients and to develop a more patient-centered care delivery system with a focus on overall well-being, and a larger emphasis on preventative health and mental health services. Children in foster care are categorically eligible for Medicaid through Title IV-E of the Social Security Act, and are closely impacted by transformations in Medicaid related to accountability. In 2009, two federal laws shifted focus toward the accountability of health care systems, through measures on data tracking and measurement. The 2009 *Children's Health Insurance Program Reauthorization Act* established a federally funded program to develop and track new measures in health care delivery, including targeted measures for children in foster care.¹ In the same year, the *American Recovery and Reinvestment Act of 2009* contained the *Health Information Technology for Economic and Clinical Health (HITECH)* provisions.² *HITECH* encouraged the meaningful use of health information technology particularly within Medicaid, for the purposes of patient-centered care and innovative population health initiatives. The provisions incentivized providers to expand their use of electronic health records and implement new data security measures, which strengthened the potential

for cross-systems data sharing and collaboration. The next year, the 2010 *Patient Protection and Affordable Care Act (ACA)* created incentives and rules for health care systems to view themselves as responsible for overall patient health rather than individual episodes of health care.³

Access to Care

A key part of the *ACA* was increased health care accessibility for children in child welfare, including children in foster care. The *ACA* directly expanded Medicaid eligibility for children involved with child welfare until 26 years of age regardless of income. Youth qualify if they were under the responsibility of the state when they turned 18 years of age (or older if the state's federal foster care assistance extends beyond that age), and if they were enrolled in Medicaid while in foster care. Additionally, the law increased health care accessibility by prohibiting insurance plans from denying coverage based on pre-existing conditions, especially important for children in child welfare, who are more likely than their peers to experience chronic health conditions.³

Parallel to increasing access to medical coverage, federal legislation over the last decade has also strengthened regulation around the importance of mental health coverage. Mental health parity was first established in the 1996 *Mental Health Parity Act*, which required large group insurance plans to offer the same annual and lifetime dollar limits to mental health coverage as offered for medical and surgical coverage.⁴ The 2008 *Mental Health Parity and Addiction Equity Act* strengthened its predecessor by requiring group insurance plans, including Medicaid, to offer the same financial requirements and treatment limitations for mental health and substance use benefits, as for medical and surgical services.⁵ However, insurers were not required to provide coverage for mental health and substance use services until the 2010 *ACA* named mental health and substance use as one of 10 essential health benefits. Although enforcement has been slow and varied across states, mental health parity will ultimately benefit a high percentage of children in child welfare and their parents who rely on Medicaid for mental health services.

A key part of the ACA was increased health care accessibility for children in child welfare.

Download English Version:

<https://daneshyari.com/en/article/4152461>

Download Persian Version:

<https://daneshyari.com/article/4152461>

[Daneshyari.com](https://daneshyari.com)