Pediatric Community Forum

“Pediatric Support for Children in Foster Care”

Presenter:

Kristine Fortin, MD, MPH, FAAP
Attending Physician, Children’s Hospital of Philadelphia
Medical Director, Fostering Health Program at Safe Space: Center for Child Protection and Health, Children’s Hospital of Philadelphia
Executive Committee Member of the AAP Council on Foster Care Adoption and Kinship Care
Chair of PA AAP Foster and Kinship Care Committee

Session Learning Objectives:

As a result of participation in this activity, participants will be able to:

- Review AAP pediatrician guidance in supporting children in foster care and their families
- Discuss unique barriers to health care among children in foster care
- Develop strategies to assess and address trauma symptoms during office visits

This webinar will begin at 8:00 PM EST

CME/CEU is available for the live webinar. Information on how to obtain credit will be emailed to all participants following the webinar.
PEDIATRIC SUPPORT FOR CHILDREN IN FOSTER CARE

Kristine Fortin MD MPH

PA AAP Let’s Talk Webinar
02/16/2022
CASE PART 1: YOU ARE RUNNING LATE

New patient appointment
• No information available in chart

You ask an open ended “how are you?”
• Reported issues with sleeping, bedwetting, behaviors, cough

Past medical and family history
• Unknown as new foster parent

Caring for a child in foster care
WHY THIS TOPIC?

Prevalent
• >14,000 PA children in foster care¹
• Complex health care needs

Unique
• Health care needs and access barriers

Rewarding

Transferable skills


You are nice here

Thank-you for helping
OUTLINE

Background information

AAP guidelines for health care of children in foster care

Helping parents and children in foster care respond to trauma experiences

Barriers to care

Disproportionality

PA AAP committee on children in foster care
CASE PART 2: YOU ARE CARING FOR A CHILD IN FOSTER CARE

Follow-up questions after learning your patient is in foster care?

Type of placement
Duration of placement
Reason for placement
Prior placements
Case manager contact information
Visitation with parents
## REASONS FOR FOSTER CARE PLACEMENT IN THE USA

<table>
<thead>
<tr>
<th>Reason</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect</td>
<td>64</td>
</tr>
<tr>
<td>Parent drug / alcohol abuse</td>
<td>41</td>
</tr>
<tr>
<td>Caretaker inability to cope</td>
<td>13</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>13</td>
</tr>
<tr>
<td>Housing</td>
<td>9</td>
</tr>
<tr>
<td>Child behavior problem</td>
<td>8</td>
</tr>
<tr>
<td>Parent incarceration</td>
<td>6</td>
</tr>
<tr>
<td>Abandonment</td>
<td>5</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>4</td>
</tr>
</tbody>
</table>

## TYPES OF FOSTER CARE PLACEMENTS

<table>
<thead>
<tr>
<th>Placement type</th>
<th>Pertinent legislation</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kinship care</td>
<td>• Adoption and Safe Families Act (1997)</td>
<td>• Improved behavioral health outcomes</td>
</tr>
<tr>
<td>Placement with kin (family, friend)</td>
<td>• Family First Prevention Services Act (2018)</td>
<td>• Less disruptions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sometimes without child welfare involvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support services</td>
</tr>
<tr>
<td>Foster care</td>
<td>• Child and Family Services Improvement and Innovation Act (2011)</td>
<td>• No prior knowledge of child’s history</td>
</tr>
<tr>
<td>Congregate care, group home</td>
<td>• Family First Prevention Services Act (2018)</td>
<td>• Placement with family if possible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Standards, reviews</td>
</tr>
</tbody>
</table>
KINSHIP NAVIGATOR PROGRAMS

https://www.kinconnector.org/

https://aese.psu.edu/outreach/intergenerational/program-areas/kinship/programs
TYPES OF FOSTER CARE PLACEMENTS

Prevalence of placement types in the US

- 45% Foster home (non-relative)
- 34% Kinship foster home
- 11% Group home / institution
- 10% Other

FOSTER CARE CASE MANAGEMENT

Varies by county, child

Child welfare
• Child welfare agency case manager, supervisor
• Foster care agency
• Nurse

Child advocates
• Guardian ad luedum
• Advocate attorneys
• CASA (Court Appointed Special Advocate)
FOSTER CARE EXITS

Reason for foster care discharge (US)

- Reunification: 48%
- Adoption: 25%
- Guardianship: 10%
- Emancipation: 7%
- Other: 9%

Visits
Parental rights
Medical care involvement

CASE PART 2: FOSTER CARE HISTORY

Type of placement: Non-relative
Duration of placement: 1 month
Reason for placement: Substance abuse, housing
Prior placements: >2
Case manager contact information: Foster care agency contact
Visitation with parents: Supervised, weekly
PLACEMENT INSTABILITY

Definition: move placements while in foster care
Associated with negative outcomes

• Behavioral health
• Academics
• Attachment
• Permanency

Placement instability
63% increase in behavior problems
PLACEMENT INSTABILITY

Associated factors
Child characteristics
• Older
• Behavioral health
• Medical diagnoses
Placement
• Congregate care > non-relative > kinship
• Number of children

Resource family
• Social supports
• Understanding of need to adapt

Organizational factors
• Staff turnover
CASE PART 3: WHERE DO I START?

Issues raised with open ended question how are you?

• Medical
  • cough

• Behavioral health, trauma symptoms
  • sleeping, bedwetting, behaviors
GUIDELINES FOR CARE

Children entering foster care are ideally seen “early and often”
REFERENCES

American Academy of Pediatrics clinical report

Pediatrician Guidance in Supporting Families of Children Who Are Adopted, Fostered, or in Kinship Care

Pediatrics 2020;146(6):e20020034629

https://publications.aap.org/pediatrics/article/146/6/e2020034629/33590/Pediatrician-Guidance-in-Supporting-Families-of?searchresult=1
REFERENCES

Fostering Health textbook

## COMPONENTS OF HEALTH CARE SERVICES

<table>
<thead>
<tr>
<th>Component</th>
<th>Timing</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial health screening</td>
<td>Within 72 hours of placement</td>
<td>• Ensure all medications, referrals in place</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Physical exam including signs of abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support transition</td>
</tr>
<tr>
<td>Comprehensive health assessment</td>
<td>Within 30 days</td>
<td>• Medical, dental, mental health, developmental, educational needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Health plan for child, caregivers and child welfare professionals</td>
</tr>
</tbody>
</table>

SKIN EXAM

TEN-4-FACESp
Bruising Clinical Decision Rule

When is bruising concerning for abuse?
If any of the 3 components (Regions, Ages, Patterns) are observed in a child under 4 years of age, strongly consider seeking evaluation by a medical provider with expertise in child abuse.

- Torso
- Ears
- Neck

FACES
- Frenulum
- Angle of Jaw
- Cheeks (fleshy part)
- Eyelids
- Subconjunctivae (whites of the eyes)

- 4 months and younger
  - Any bruise, anywhere

Patterned bruising

- Bruises in specific patterns like slap, grab or loop marks

See the signs
Unexplained bruises in these areas most often result from physical assault.

TEN-4-FACESp is not to diagnose abuse but to function as a screening tool to improve the recognition of potentially abused children with bruising who require further evaluation.

TEN-4-FACESp was developed and validated by Dr. Mary Clyde Pierce and colleagues. It is published and available for FREE download at luriechildrens.org/ten-4-facesp.
## COMPONENTS OF HEALTH CARE SERVICES

<table>
<thead>
<tr>
<th>Component</th>
<th>Timing</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive assessment follow-up</td>
<td>30 days after comprehensive assessment</td>
<td>• New issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Follow-up on recommendations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Refine health plan</td>
</tr>
<tr>
<td>Periodic health care</td>
<td>0-6 months</td>
<td>• Monitor health, emotional wellbeing, development</td>
</tr>
<tr>
<td></td>
<td>• monthly</td>
<td>• Adjustment to foster family, visitation, transitions</td>
</tr>
<tr>
<td></td>
<td>6-24 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• every 3 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;2 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• at least every 6 months</td>
<td></td>
</tr>
</tbody>
</table>

IMMUNIZATIONS

Immunizations
• Delays, missing records

Catch up immunization schedule
https://www.cdc.gov/vaccines/schedules/hcp/imz/catchup.html

Registries
• names, spelling
Parents
LABORATORY SCREENING

Laboratory screening
• Recent studies favor targeted testing\textsuperscript{1,2}
• Bright Futures tests per age, missed testing
• Risk factors (sexual abuse, exposures)

CHOP clinical pathway
https://www.chop.edu/clinical-pathway/foster-care-medical-evaluation-clinical-pathway

### CASE PART 3: WHERE DO I START?

| Initial health screening | • Ensure all medications, referrals in place  
|                         | • Physical exam including signs of abuse  
|                         | • Support transition |

**Additional past medical history:**
- Asthma, supposed to be on Flovent
- Skin exam: eczema
RESOURCES TO SUPPORT FAMILIES

AAP Safe and Sound
Downloadable guides about trauma and how caregivers can help
• Parents
• Teachers
• Childcare providers
• Other adults (coaches, friend’s parents)

### Behaviors That Make Sense If You Know That There Has Been Trauma

- Not sleeping
- Eating a lot (so your body has energy)
- Being ready to run or fight
- Being easily distracted (so you can keep looking for danger)

These are all ways to protect yourself if you are scared.

### How the Body Works When There Is Danger

- The heart races
- The muscles get ready to freeze, run, or fight
- The body gets organs ready to deal with injury
- The brain is not ready to learn, because it’s busy with fear
- The parts of the brain that send alarms to the body and brain are turned on
- The parts of the brain that help you calm down are turned off

This state is only supposed to last for 20 minutes, because actual danger will either hurt you or go away in a short time.

### How the Brain and Body Change When There Is Danger All the Time

- The body is more likely to get sick or get asthma
- Learning is difficult all the time, because the fear keeps the brain from using its learning centers
- The brain’s alarm system stays on or turns on too easily
- It’s hard to get the brain and body to calm down so that the child can sleep, learn, play, or be a friend

The body doesn’t turn off these reactions because the danger is too bad or happens too often.

### What These Changes May Look Like

- ADHD (attention-deficit/hyperactivity disorder)
- Learning problems
- Aggression
- Anger problems
- Depression
- Sleep disorders
- Anxiety and nervousness
- Withdrawal or anti-social behavior
## Guidance: Children With No Trauma History vs. Children With History of Trauma (Chart 2 of 2)

<table>
<thead>
<tr>
<th>Child's Behavior</th>
<th>Response for Children With NO Trauma History</th>
<th>Response for Children With Trauma History</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eating</strong></td>
<td>(see guidance under Toddlers)</td>
<td>(see guidance under Toddlers)</td>
</tr>
<tr>
<td><strong>Disorganized Sleep</strong></td>
<td>(see guidance under Toddlers)</td>
<td>(see guidance under Toddlers)</td>
</tr>
<tr>
<td><strong>Anger, Frustration</strong></td>
<td>Teach the child to &quot;use your words!&quot; to learn what she is feeling. Teach her how to let others know what she is feeling.</td>
<td>The child may not be able to use words for her feelings yet, and that can make her frustration worse. Look for when the frustration is starting. Then show the child how to use her body to calm down (jump, shake, wiggle, breath deeply). Teach her acceptable ways to show anger (like stomping feet or drawing a picture)</td>
</tr>
<tr>
<td><strong>Disorganization</strong></td>
<td>Set up ways to keep things organized. Charts, reminders, and routines help.</td>
<td>Same as &quot;No Trauma&quot; column. Also, the child may need extra reminders of what to expect. Offer simple and specific directions. (Instead of &quot;go get a shirt,&quot; try &quot;go get your blue shirt.&quot;)</td>
</tr>
<tr>
<td><strong>Depression, Anxiety, Withdrawal</strong></td>
<td>The child has started to be more withdrawn and anxious. This can be normal for teenagers. Talk to the teen about how to calm himself down and how to name his feelings. Discuss other ways to handle problems.</td>
<td>Treats who have had trauma may need help with calming down. They can use all 5 senses to help relax — sight, sound, smell, touch, and taste. (look at calming pictures, listen to relaxing music, use nice-smelling soap, squeeze a stress ball, chew on ice.)</td>
</tr>
<tr>
<td><strong>Frequent Aches and Pains</strong></td>
<td>Don't pay too much attention to it. Talk about what happened before the stomachache or headache, which might be the reason for the pain.</td>
<td>This may be happening because the child is reminded of past trauma. She may need more help to try to calm down with breathing, relaxation, massage, and talking about feelings.</td>
</tr>
<tr>
<td><strong>Strong Emotions, Emotions Beyond What the Situation Would Warrant</strong></td>
<td>This can be normal for teenagers. Talk to the teen about how to calm himself down and how to name his feelings. Discuss other ways to handle problems.</td>
<td>Teens who have had trauma may need help with calming down. They can use all 5 senses to help relax — sight, sound, smell, touch, and taste. (look at calming pictures, listen to relaxing music, use nice-smelling soap, squeeze a stress ball, chew on ice.)</td>
</tr>
<tr>
<td><strong>Impulsive Actions</strong></td>
<td>Teens normally are impulsive. Sometimes just having to live with the new (like breaking a favorite item) is a good way to learn. When the teen is calm, talk with her about ways to think things through. Use examples of bad choices people make from movies, or TV, and talk about other ways she could have acted.</td>
<td>The teen may not make the link between what she does and the results. She may need help to make the link.</td>
</tr>
</tbody>
</table>
CASE PART 4: PREPARE FOR NEXT STEPS

Schedule patient for comprehensive visit
How to prepare?

Primary care tools to help care for children in foster care

PREPARING YOUR PRACTICE
FOSTER CARE FRIENDLY PRACTICE

Language
• Child in foster care versus foster child
• Ask youth what they call their caregivers

Medical home

Foster Care Alumni of America
PREPARING - KNOWLEDGE

Local resources
Child welfare agency
Needs of children in foster care
• Health
• Development / education
• Impacts of trauma
HEALTH

Children with special health care needs
• 30 – 80% chronic health problems
• 25% ≥3 chronic health problems

Same conditions as peers
Exposures
Lack of care
• preventive
• chronic conditions

Common health problems
Abnormal vision screen
Obesity
Asthma
Dermatologic conditions
Dental caries
Immunization delay

Prevalence of developmental concerns up to 2/3

Prevalence of fetal alcohol spectrum disorders: 16.9%
• AAP Screening for Prenatal Alcohol Exposure

Overlap between trauma symptoms and other diagnoses

Vasileva et al. Trauma, Violence & Abuse 2018;19(4):223-458
<table>
<thead>
<tr>
<th>Educational Experience or Outcome</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of youth in foster care who change schools when first entering care</td>
<td>31% - 75%&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>% of 17- to 18-year-olds who experienced 5 or more school changes</td>
<td>34.2%&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Likelihood of being absent from school</td>
<td>About twice that of other students&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Likelihood of 17- to 18-year-old youth in foster care having out-of-school suspension</td>
<td>About twice that of other students&lt;sup&gt;5&lt;/sup&gt; (In one study the rate was 24% vs. national general population rate of 7%)&lt;sup&gt;6&lt;/sup&gt;</td>
</tr>
<tr>
<td>Likelihood of 17- to 18-year-old youth in foster care being expelled</td>
<td>About 3 times that of other students&lt;sup&gt;7&lt;/sup&gt;</td>
</tr>
<tr>
<td>Reading level of 17- to 18-year-olds in foster care</td>
<td>Average level 7&lt;sup&gt;th&lt;/sup&gt; grade 44% at high school level or higher&lt;sup&gt;8&lt;/sup&gt;</td>
</tr>
<tr>
<td>% of youth in foster care receiving special education services</td>
<td>35.6%&lt;sup&gt;9&lt;/sup&gt; - 47.3%&lt;sup&gt;10&lt;/sup&gt;</td>
</tr>
<tr>
<td>% of 17- to 18-year-old youth in foster care who want to go to college</td>
<td>70%&lt;sup&gt;11&lt;/sup&gt; - 84%&lt;sup&gt;12&lt;/sup&gt;</td>
</tr>
<tr>
<td>% of youth in foster care who complete high school by age 18 (via a diploma or GED)</td>
<td>Colorado: 41.8%&lt;sup&gt;13&lt;/sup&gt; Midwest Study (age 19): 63%&lt;sup&gt;14&lt;/sup&gt;</td>
</tr>
<tr>
<td>% of youth in foster care who complete high school by age 21</td>
<td>65% by age 21&lt;sup&gt;15&lt;/sup&gt; (National data) (Compared with 86% among all youth ages 18-24&lt;sup&gt;16&lt;/sup&gt;)</td>
</tr>
<tr>
<td>% of youth in foster care who graduated from high school who enrolled in college at some level</td>
<td>31.8%&lt;sup&gt;17&lt;/sup&gt; - 45.3%&lt;sup&gt;18&lt;/sup&gt; (Compared with national college enrollment rate of 69.2% in 2015, which is slightly below national record high of 70.2% in 2009)&lt;sup&gt;19&lt;/sup&gt;</td>
</tr>
<tr>
<td>% of foster care alumni who attain a bachelor’s degree</td>
<td>3 – 10.8%&lt;sup&gt;20&lt;/sup&gt; (Compared with national college completion rate of a BA or higher of 32.5%)&lt;sup&gt;21&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
TRAUMA INFORMED CARE RESOURCES

AAP guide for pediatricians
• Helping foster and adoptive families cope with trauma

[Link to AAP guide]
https://downloads.aap.org/AAP/PDF/Foster%20Care/hfca_foster_trauma_guide.pdf
AAP clinical report on trauma informed care
https://publications.aap.org/pediatrics/article/148/2/e2021052580/179745/Trauma-Informed-Care

Forkey et al. Childhood trauma & resilience: A practical guide
ASSESSMENT

Trauma experiences and foster care
• Reason for placement
• Same as other children
• Foster care placement
• Transitions
• Visitation changes

Trauma symptoms
• Sleep
• Enuresis
• Food
• Behaviors at home and school
  • Avoidance, internalizing
  • Hypervigilance
• Attachment

Resilience
Strengths
Goals
Ability to adapt
Positive, secure relationships
SIBLINGS

Fostering Connections to Success and Increasing Adoptions Act of 2008

Camp To Belong River Valley

https://www.ctbrivervalley.org/
STANDARDIZED SCREENERS

National Child Traumatic Stress Network review of trauma screens

Examples:

- CAPS
- CPSS
- PEDS
- UCLA

STANDARDIZED SCREENERS

Care Process Model

• Pediatric Traumatic Stress Screening Tool (PTSS)
  • Adapted from UCLA Brief Trauma Screen

How much of the time during the past month...

<table>
<thead>
<tr>
<th>Question</th>
<th>None</th>
<th>Little</th>
<th>Some</th>
<th>Much</th>
<th>Most</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  I have bad dreams about what happened or other bad dreams.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2  I have trouble going to sleep, waking up often, or getting back to sleep.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3  I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I don't want them to.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4  When something reminds me of what happened I have strong feelings in my body, my heart beats fast, and I have headaches or stomach aches.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5  When something reminds me of what happened I get very upset, afraid, or sad.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6  I have trouble concentrating or paying attention.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7  I get upset easily or get into arguments or physical fights.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8  I try to stay away from people, places, or things that remind me about what happened.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9  I have trouble feeling happiness or love.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10 I try not to think about or have feelings about what happened.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11 I have thoughts like &quot;I will never be able to trust other people.&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12 I feel alone even when I'm around other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

*Over the last 2 weeks, how often have you been bothered by thoughts that you would be better off dead or hurting yourself in some way?*

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### CARE PROCESS MODEL

**Brief in office intervention**

**Referrals**

<table>
<thead>
<tr>
<th>How much of the time during the past month...</th>
<th>None</th>
<th>Little</th>
<th>Some</th>
<th>Much</th>
<th>Most</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 My child has bad dreams about what happened or other bad dreams.</td>
<td>Sleep problems</td>
<td>Both</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 My child has trouble going to sleep, waking up often, or has trouble getting back to sleep.</td>
<td>Hypervigilance and intrusive symptoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 My child has upsetting thoughts, pictures, or sounds of what happened come to mind when he/she doesn’t want them to.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 When something reminds my child of what happened, he/she has strong feelings in his/her body, like his/her heart beats fast, headaches, or stomach aches.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 When something reminds my child of what happened, he/she gets very upset, afraid, or sad.</td>
<td></td>
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<td>6 My child has trouble concentrating or paying attention.</td>
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<td>7 My child gets upset easily or gets into arguments or physical fights.</td>
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<td>8 My child tries to stay away from people, places, or things that remind him/her about what happened.</td>
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<td>9 My child has trouble feeling happiness or love.</td>
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<td>10 My child tries not to think about or have feelings about what happened.</td>
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<td>11 My child has thoughts like “I will never be able to trust other people.”</td>
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<td>12 My child feels alone even when he/she is around other people.</td>
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</tbody>
</table>

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**Children’s Hospital of Philadelphia**
Prioritize sleep

• Impact on behavioral health, learning, relationships

Pediatrician’s Practical Approach to Sleep Disturbances in Children Who Have Experienced Trauma
Brooks R. Keeshin, MD; Steven J. Berkowitz, MD; and Robert S. Pynoos, MD

SLEEP IN-OFFICE INTERVENTION

Education
• Impacts of trauma on sleep, routine, avoidance of caffeine / fluids

Safety
• Nightlight
• Proximity to caregivers
• Safety items

Trauma reminders
• Decrease
• Coping skills

Differences in approach to non-trauma related sleep issues
RESOURCES FOR FAMILIES

Elmo belly breathing app

Breathe, Think, Do with Sesame
Sesame Street

* * * * 4.6 • 103 ratings
Free

Screenshots

Children's Hospital of Philadelphia
RESOURCES FOR FAMILIES – VETERANS AFFAIRS

PTSD Coach

Download on the App Store

GET IT ON Google Play

SYMPTOMS

TOOLS

FAVORITES

YOUR OWN TOOL

AMBIENT SOUNDS

BODY SCAN

CHANGE YOUR PERSPECTIVE

CONNECT WITH OTHERS

DEEP BREATHING

GROUNDING

INSPIRING QUOTES

Message

Track

Learn

Support
CASE PART 4: FOLLOW-UP AND BARRIERS

Visit for comprehensive health assessment

• Asthma
  • Cough resolved with Flovent
• Dentist
  • Not able to see due to insurance issue
• Counseling
  • Waitlist
BARRIERS TO MEDICAL CARE
BARRIERS

Same as other patients
Lack of information about past medical history
Fragmented care
• Prior to foster care entry
• Transitions in foster care (entry, placement changes, staff turnover, reunification)
Sharing information across systems
Consents
Social needs
PSYCHOTROPIC MEDICATIONS

Compared to peers with Medicaid coverage

- Rates up to 4.5x higher
- Concomitant use including medications from same class

2011
dosReis et al. Pediatrics 2011;128:e1459

2021
Davis et al. BMC Psychiatry (2021) 21:303
https://doi.org/10.1186/s12888-021-03309-9

Antipsychotic Treatment Among Youth in Foster Care

RESEARCH

High-level psychotropic polypharmacy: a retrospective comparison of children in foster care to their peers on Medicaid

Deborah Winders Davis1,*, W. David Lohr1,*, Yana Feygin1, Liza Cree2, Kahir Jawad1, V. Faye Jones1, P. Gail Williams1, Jennifer Le1, Marie Trace1 and Natalie Pasquenza1
PSYCHOTROPIC MEDICATIONS

Review patient medications
Health insurance providers

To learn more:
AAP Clinical Report: Children exposed to maltreatment: Assessment and the role of psychotropic medication.
Pediatrics 2020;145(2):e20193751
• Consider complex trauma in assessment and treatment plan
Systems solutions
Monitoring mechanisms
• Example: Utah Psychototropic Oversight Program
  • Case review hotline, resources
CONSENT

Variables
• Agency policies
• Patient age
• Nature of the treatment
  • Routine versus non routine
  • Urgent versus non-urgent
• Parental rights
CONSENT

Foster care exits (USA)

- Parental rights: 48%
- Medical care involvement: 25%
- Adoption: 10%
- Guardianship: 9%
- Emancipation: 7%
- Other: 2%

CONSENT

Common scenario
• Routine care
  • General medical consent form signed by parents
• Non-routine care
  • Parents in cases where parental rights have not been terminated

Consult with child’s child welfare case manager for non-urgent non-routine care
SOCIAL NEEDS

Screening challenges
• Misconceptions
• Reporting

Needs
• Financial strain, transportation, work

Addressing needs
• Child welfare agency resources
• Universal resource information (handouts, after visit summary)
DISPROPORTIONALITY

Race / Ethnicity of PA children < 18 years, 2019

- White: 66.1%
- Black: 13.1%
- Hispanic: 12.8%
- ≥ 2 Races: 4%
- Asian: 3.9%

https://cwoutcomes.acf.hhs.gov/cwodatasite/pdf/pennsylvania.html
DISPROPORTIONALITY

Reports to child protective services
Outcome of reports
Outcomes in foster care
DISPROPORTIONALITY - REFERENCES

Web
• Child Welfare Information Gateway – Practice to address racial disproportionality and disparities
  https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/

Article
• Detlaff et al. Racial disproportionality and disparities in the child welfare system: why do they exist and what can be done to address them? AAPSS 2021;692:253-294

Book
• Roberts D. *Shattered bonds: the color of child welfare*
DISPROPORTIONALITY

Survey of high school students\(^1\)
• LGB youth 2.4 x odds of foster care compared to heterosexual peers

Survey of LGBTQ youth in NYC group homes\(^2\)
• 100% reported verbal harassment (peers, staff, siblings)
• 70% physical violence

1. Fish et al. Child Abuse & Neglect 2019;203-211
3. Trevor Project: www.thetrevorproject.org/2021/05/12/research-brief-lgbtq-youth-with-a-history-of-foster-care
You continue to follow the patient over the next year
SUMMARY

Case example
- Information sharing
- Health care guidelines and delivery
- Barriers in supporting medical, developmental, behavioral needs
- Psychotropic medications
- Disproportionality
PA AAP FOSTER CARE COMMITTEE

• Establish current state, key issues, providers across counties
• Advocacy
• Education

Join us: Casey O'Neill coneill@paaap.org
Please submit your questions through the chat box!
Thank You!

• Instructions on how to claim credit for your participation in today’s Let’s Talk webinar “Pediatric Support for Children in Foster Care” will be emailed to all of today’s participants, along with a recording of the session and a copy of the slideshow.

• If you have any additional questions or issues, please email info@paaap.org.

• Our 2022 Pediatric Conference, which will take place on March 19th and 20th, 2022 at the Gettysburg Hotel in Gettysburg, Pennsylvania. Please contact us for information on how to register!