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## **Development and coordination of a health care services program for foster children in a shelter care population**

Rebecca Lynne Allen Spradling

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DEVELOPMENT AND COORDINATION OF A HEALTH CARE SERVICES  
PROGRAM FOR FOSTER CHILDREN IN A SHELTER CARE POPULATION

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A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Science  
in  
Nursing

---

by  
Rebecca Lynne Allen Spradling  
June 2002

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by  
Rebecca Lynne Allen Spradling  
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## ABSTRACT

This is a pilot project designed to coordinate health care services by implementing a program of direct nursing service and referral to a population of shelter care parents in San Bernardino County. The project applied Helvie's Energy Theory (1998) to the foster child population that transitioned through short-term placement in a six-month period. The program was designed to provide support, referral services, and training to the shelter care parents. The project coordinator provided intercession and assistance by problem solving various issues experienced by foster parents when attempting to access initial medical and dental examinations and follow up care through the health care system. The project was then transitioned to existing staff and subsequently adapted to other foster child populations and programs.

## ACKNOWLEDGMENTS

I would like to acknowledge the undying and ever present support of my committee chair, committee members, classmates, and especially, my family.

DEDICATION

To Mom and Dad, thank you.

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## CHAPTER ONE

### INTRODUCTION

The Foster Care System is our society's modern day replacement for orphanages. Battestilli (1997) points out that when families cannot or will not provide appropriate and safe care for their minor children, the government, through county agencies, intercedes on behalf of the affected children and places them in out of home care. The foster children then become the responsibility of and therefore, dependent upon government agencies and services for all aspects of care (Battestilli, 1997). There are approximately 750,000 children in the Foster Care System throughout the nation (Sims, Dubowitz, & Szilagyi, 2001) with a 2001 federal budget over five billion dollars (Child Welfare League of America, 2001) to provide basic care and services. San Bernardino County currently accounts for over 6,000 children in foster home placements (California Department of Social Services, 2000). Most of these children have been spontaneously removed from their homes, primary caregivers, and usual health care providers for reasons ranging from neglect and caretaker absence to physical and sexual abuse.

Foster children in San Bernardino County do not have coordinated health care services when they are initially placed in foster care. It is important to ensure that an effective Health Care Services program is in place in order to improve the coordination of health care services and the health status of children entering the foster care population.

#### Purpose of the Project

The most important reasons for this project are to support Health Promotion of children entering foster care, ensure that children receive all health care services needed, prevent the trauma of duplication of immunizations, and reduce disruption of health care as children move through the Foster Care System. There is currently no process in place to ensure that these needs are met within the San Bernardino County Shelter Care program.

Problems with the current provision of health care services include lack of consistency in; communication with shelter care parents, caseworker resulting in fragmented care, and documentation and communication of health information.

Specific health services needed by these children include physical examinations, dental care, immunizations, documentation, and communication of services received.

#### Background Information

Most counties in Southern California utilize a reception facility for immediate, emergency placements of children into the foster care environment. These facilities provide a one-stop shopping advantage for assessments and services including physical, dental, and mental health examinations. However, children are often stockpiled while waiting for an available and appropriate out-of-home placement, creating an overcrowded and institution-like setting.

San Bernardino County's Department of Children's Services does not currently have a facility for this purpose. In an effort to avoid an institutional atmosphere and provide a more normal family-type environment, San Bernardino County has relied on a shelter care home system for emergency, short-term placements. Shelter care placements are designed to accommodate children for thirty days or less. The reason for this is to allow time to put support and services in place to correct deficiencies with the primary caregiver or environment the child was removed

from in order to return the child home or to conduct background checks on available and appropriate family members for placement. Shelter care parents are available twenty-four hours a day, seven days a week to receive children into their homes. These dedicated individuals endeavor to meet all emergency and basic needs of the children entrusted to their care. The number of shelter care homes has remained at twelve for some time, with very little turnover, as most foster parents are not able or willing to meet the ongoing requirements of availability and training required for shelter care licensing. However, this has resulted in these foster children not benefiting from coordinated health care services when they are initially placed in shelter care homes and often a second disruption after leaving shelter care placement.

Both of these systems, formal facilities and shelter care, are considered short-term and temporary. All children will require at least one subsequent move at the end of thirty days because they will move to a more long-term placement, relative placement, or return to their parents. In the current process, children do not have the benefit of a stable, consistent agency caseworker. At the time the temporary placement changes, a new Social Worker will be assigned. When children remain

in the Foster Care System, they usually experience a turnover of caseworkers due to reassignment, promotion, transfer, and attrition. This vagabond existence without the benefit of a stable or consistent case manager makes this a very high risk and vulnerable population. These conditions fragment health care services, disrupt the continuum of health care, and create a breakdown in communication between substitute care providers, agency personnel, birth parents, and health care providers.

All information about foster children is documented and maintained in the mandated, statewide database called the Child Welfare System/Child Management System (CWS/CMS). The CWS/CMS database produces all documents necessary for case management of foster children. The document produced that monitors, tracks, and communicates health care is the Health and Education Passport (HEP). This document is the primary collaborative means of communication and documentation between the Public Health Nurses out-stationed in the Department of Children's Services offices, assigned Department of Children's Services Social Work staff, birth parents, and foster care parents relinquishing or receiving children.

According to the Healthy People Initiative 2010 (2000), basic primary prevention for children begins with

immunizations. Preschool children entering the Foster Care System are often behind in scheduled immunizations. School age children cannot immediately enter a new school if immunization history is not available. Both populations are at risk for disruption, omission, and duplication of immunizations. The Immunization Tracking System is a county-wide database recording all immunizations provided by the Public Health Department, Child Health and Disability Prevention health care providers, and many other participating pediatrician's offices located throughout San Bernardino County. Shelter care parents have complained that the Public Health Department will not provide immunization history directly to them without charging for the service; therefore, most shelter care parents do not acquire the information.

The California State Code requires that all children entering foster care receive a physical examination within thirty days and children three years and over must receive a dental examination within those same thirty days (Manual of Policies & Procedures, 1997). Annual physical and dental examinations are mandated for as long as the child remains in foster care. By ensuring that these examinations take place, children that have or develop disease or injury will benefit from early diagnosis and

prompt treatment. This secondary preventive aspect will reduce the duration and intensity of illness or injury (Stanhope & Lancaster, 1988).

Hopefully, children that have or develop a need for tertiary prevention activities can be identified immediately to keep disabilities at a minimum. Providing accurate, timely information may enable children that have or develop disease or injury to benefit from early diagnosis and prompt treatment.

The opportunity for relinquishing parents or foster parents to communicate or collaborate with receiving parents or foster parents rarely occurs. A relinquishing foster parent would probably inform the Social Worker about any pending appointments, but may not relate all details. The Social Worker might overlook mentioning such information to the receiving foster parent after transporting and attempting to establish the children in their new location. If previously scheduled appointments are not kept during the transition from one placement to the next, the receiving foster parent must schedule new appointments that will further delay the child receiving needed care. When no immunization history is provided, health care providers have no choice but to restart the process following an accelerated schedule. Providing



accurate and timely information to parents and foster care parents also decreases the chance that foster children will be unnecessarily traumatized with duplicated immunizations. It may also reduce the health care system bearing the expense of duplicated, unnecessary immunizations.

The State of California periodically performs audits for each county on the CWS/CMS system to determine, among other things, compliance with the physical and dental examination requirements. The most recent comprehensive state audit results demonstrated a 40% medical/dental compliance for San Bernardino County which fell dramatically below the state's accepted standard of 90% compliance. Because of this shortfall, the Department of Children's Services now conducts quarterly, random, internal audits. One hundred cases are randomly selected for each audit. The audit looks at the CWS/CMS database to determine when the child's last physical and dental examination occurred and whether documentation exists in the system to indicate that an HEP was provided to the foster parent in the current placement. If this information cannot be found in the database, then the auditors review the child's hard-copy file. Audit results are subsequently provided for the computerized results as

well as the case file results. Aside from the overall results of the audit, there is also significance in the disparity between what exists in the hard-copy file that is not documented in the CWS/CMS database. The difference in these two might indicate a failure in the process being utilized to provide or document initial health services to the shelter care population. Children are a vulnerable population whose needs must always be addressed and met through an adult. Children enter the foster system because an adult has failed them in some way. It is imperative to try to break this cycle of failure when children enter the shelter care environment.

Project Scope, Significance to  
Nursing, and Limitations

Scope

The Advanced Practice Nurse (APN) will attend six regularly scheduled shelter care parents meetings in an effort to provide support to the aggregate group and indirectly facilitate appropriate medical and dental care to this high-risk group of foster children. The scope of this project will include:

1. An analysis of previously collected data from a work environment survey to determine the health

care services currently received by the children  
in the shelter care population

2. Development and implementation of a coordinated process to improve the provision of health care services for children in the shelter care population and setting
3. An evaluation of this program and process

#### Significance to Nursing

It is vital to promote health and ensure health care services are delivered to foster children in the shelter care population. Advanced Practice Nurses are experts in the application of nursing science to practice and in managing functional problems to meet the distinctively different needs of individuals, groups, and communities (Lyon, 1996). Comprehensive nursing process and project design focuses on families, groups and populations, and encompasses primary, secondary, and tertiary levels of prevention (Computer-based Patient Record, 1995). The project coordinator's knowledge and skills must remain focused on prevention when designing and implementing process interventions and programs to improve community health, access to services, and disease prevention (Computer-based Patient Record, 1995; American Nursing Association [ANA], 1997).

Preventive health nursing can target high-risk populations to facilitate all levels of preventive care. This process will help ensure foster children, a high-risk and vulnerable population; access appropriate health care services when entering shelter care.

#### Limitations

Budgetary constraints within the Department of Children's Services and the Public Health Department limit the activities and resources available for this proposed project. Another limitation of this project was the use of the data from the employer's assessment and evaluation tool because its reliability and validity are not established.

The massive size of San Bernardino County will limit face-to-face contact with the shelter care parents to the once a month, regularly scheduled meetings. The shelter care families are located throughout the entire region and this will limit direct contact with the target population. These geographic constraints will limit the between meeting contacts to telephone, fax, and mail services only.

## CHAPTER, TWO

### REVIEW OF THE LITERATURE

#### Introduction

The theoretical framework for this project looks at Erikson's (1963) stages of development theory in relationship to children's basic needs, Helvie's (1998) energy theory, Family Systems Theory, and literature related to the foster care system. The literature is sparse and sporadic related to health care needs of a foster care shelter population.

#### Theory

##### Erikson's Developmental Theory

In 1963 Erikson related children's needs to stages of development identified as trust versus mistrust for infancy, autonomy versus shame and doubt for toddlers, initiative versus guilt for early childhood, industry versus inferiority for middle childhood, and identity and repudiation versus identity confusion for adolescence. Adulthood is divided into three stages with developmental tasks for each as well. Erikson's theory is a psychosocial theory with stages that span the life cycle and emphasizes the development of the individual within a social context. Each issue becomes a portion of the developmental history

of the person and influences the successful resolution of each subsequent stage. New events and stresses, such as being removed from home, may cause regression of individuals by disrupting a stage previously balanced.

Due to the spontaneous removal of children from their home, combined with the often negative and belligerent reaction of their relinquishing primary caregivers, very little is known about the health status or health history of foster children.

#### Helvie's Energy Theory

Application of Helvie's (1998) Community Health Nursing Energy Theory could be applied to children entering the foster care system and describe them as experiencing a low level of health or an imbalance of energies related to the continuity of health care. School-age children would also potentially experience an imbalance within the education subsystem. When children are removed from their parents, they are usually placed with substitute caregivers that know nothing about their education history, health history, or health status. Almost without exception, their health care is altered because they will not receive health care from the providers they used while at home.

There is the potential for a second episode of imbalance when the children leave shelter care settings to return to their parents or for the next placement. The goal of nursing interventions described by Helvie would be to establish or regain balanced energies. A barrier to regaining an energy balance in health care can also be experienced by the shelter care parents when trying to access medical information, health care, and education information from public agencies and health care providers.

#### Family Systems Theory

Family Systems Theory describes how individuals function within a family group. Broderick and Smith (1979) demonstrated that Family Systems Theory identifies relationship building and communication as key elements of normal family functioning within which each member develops and grows. Broderick and Smith (1979) identified that family members establish patterns of response that develop into processes. The conclusion of this theory is that the family unit is very important to all children, is dynamic, and greater than the sum of its individual members. These concepts are absent or dysfunctional within the shelter care transitional period being addressed in this project.

## Foster Care

The majority of research concerning foster children focuses on the long term effects of the foster care system. Most statistical information is a snapshot in time or a compilation of activities or events. Very few studies, nursing or otherwise, investigate or describe initial health care upon entering the Foster Care System. Literature reviewed about the Foster Care System encompassed articles about health care processes; services to foster parents; and tracking, monitoring, and communicating health care received or needed by foster children. Most studies reviewed concluded that some type of health passport, preferably computerized, was the mechanism of choice.

### Health Care Process

Chernoff, Combes-Orme, Risley-Curtiss, and Heisler (1994) conducted a study of a group of children, from birth to eighteen, entering foster care over a two-year period. The children had complete health examinations when they entered foster care. They found that over 90% of the children had an abnormality in at least one body system and more than half needed medical, dental, or mental health referrals. Half of these referrals were completed in a reasonable timeframe, but 44% of urgent dental and



mental health referrals occurred after thirty days of request. The authors concluded that the findings support the need to design and implement better models and programs of health care delivery and monitoring for foster children. These findings support the need of monitoring health care and facilitating follow up appointments with the design and implementation of this proposed project.

Rosebach, Lewis, and Quinn (2000) conducted a two-year retrospective study for the United States Department of Health and Human Services to examine health issues of children in foster care. Medicaid eligibility and claims records were reviewed from California, Florida, and Pennsylvania. Overall, the study found that, compared to other children receiving Medicaid, foster children use behavior health services more, are more likely to be diagnosed with mental health or substance abuse conditions, are more likely to receive preventive and dental care, are less likely to be continuously enrolled in Medicaid, and require improved coordination of services. Further, the data collection for California determined that 54-60% of foster children received comprehensive assessments reimbursed by Medicaid within two months of placement. Average monthly expenditure for foster children in California was \$154 for each child,

which was lower than the other two states involved in the study. As supported in other studies, this study also found that states differ in the use of Medicaid moneys to serve children in foster care, that foster children need improved coordination of services (Rosebach, et al, 2000), that foster children require tailored case management, and that the majority of foster children are not receiving the standard of care recommended by the Child Welfare League of America (1988). Data collection for California was based on 1994-1995 records. All information was considered episodic in that there is no information available about number of visits that may be follow-up visits or referrals. The authors recommend a subsequent study to obtain more recent data to determine if California is improving in meeting the recommended standard of care for its foster children. Hopefully, this proposed project will improve coordination of services for children entering foster care in San Bernardino County.

#### Services to Foster Parents

Gottesman's (2001) perspective is a review of studies related to the effect of welfare reform, poverty, public policy, and laws related to the foster care system and children entering into placements. Neglect as a result of poverty is identified as the leading cause of removal of

children from their homes. A correlation is drawn between increased levels of family poverty and increased levels of children entering out-of-home care. Another area of concern cited is the quality of the environment in foster homes. The author points out that public policy and legal decisions are based on rights of involved adults and availability of placement, rather than establishing a stimulating, nurturing environment for the children and the powerful effects it can have on development. The review also demonstrates a possible relationship between the education level of substitute caregivers with school performance and developmental progress of foster children. Other concerns cited related to foster parents' education level were an inability to employ strategies to support development, an inability to access resources, and a direct relationship to the educational success of the children in their care. The first and foremost conclusion of this study is the prevention of family failure. In the event family maintenance fails or isn't truly an option, the author recommends a legal perception shift to the individual child and away from parental rights. Implications for process change in the shelter care environment center around supporting foster caregivers, child advocacy roles at court and in the home, revising

public policies and changing laws. For the purposes of this proposed project, the project coordinator will assist and support shelter care parents in accessing resources for needed care.

Zlotnick, Kronstadt, and Klee (1999) conducted a study of effective case management interventions for children newly placed in foster care. The purpose was to identify the services needed and determine which required the most intensive case management activities. Their findings indicate that services to foster parents required more case management expertise than those aimed at foster children. This study supports the need of a program that provides foster parents regular access to nursing resources for referral and problem solving assistance.

Landsman, Groza, Tyler, and Malone (2001) conducted a three-year quasi-experimental treatment demonstration project called Reasonable Efforts to Permanency through Adoption and Reunification Endeavors (REPARE). The REPARE theoretical model emphasized empowerment, family development, and community development, while infusing family support principles in the residential foster care setting. The primary outcome evaluated was stability of placement. Results of the study indicate that 59.1% of the REPARE group versus 37.8% of the control group maintained

stable placements six months after discharge. Conclusion of the study was that REPARE children were more likely than those in the comparison group to achieve stability whether children remained in foster care or were reunified with their parents. Monitoring and summarizing all health care will promote stability while providing a continuum of health care for foster children whether in out-of-home placement, relative placement, or return to their birth parents. Empowerment of foster parents through training while providing support, accurate health status information, and appropriate referrals is a key component of this proposed program.

Baum, Crase, and Crase (2001) conducted a one-year, longitudinal study to investigate the reasons individuals decide to become or not become foster parents. The participants were foster parent applicants that were interviewed and surveyed at one week, six months and one year after receiving pre-service training to attempt to determine its value and influence on their decision about foster care parenting. Their findings demonstrate the positive influence of quality training that includes an orientation to the agency requirements, an understanding of the philosophy of foster care, and preparation for situations such as children with special health care needs

on participants' decisions whether or not to pursue licensing. The authors also reported that a positive attitude, effective speaking skills, and the ability to facilitate group discussions were necessary attributes of trainers. This study illustrates the importance of a program that includes providing training to foster parents.

Lemieux (2001) conducted a case study of a mentally retarded mother interacting with the foster care system after the birth of her child. The significance of this study relates to the quality of professional relationships and the connection to positive intervention outcomes. Although this article is written from a social work perspective, it is applicable to this project as the philosophies of empowerment, advocacy, and inclusion discussed are key to advanced practice nursing and easily transfer to the interactions between the project coordinator and shelter care foster parents planned in this project.

#### Tracking, Monitoring, and Communicating Health Care

Ensign (2001) reports a lack of information about foster care adolescents in emergency shelters or group homes. She attributes this to the fact that most studies

are cross-sectional for current caseloads or for specific subgroups and do not differentiate children newly placed in shelter care from those in long-term, out-of-home care. The purpose of the study was to assess access to health care for shelter-based foster care adolescents in Baltimore, Maryland. This study was conducted by reviewing health passports and interviewing shelter care staff from two emergency shelters. Findings showed that shelter-based youth experience worse access to health care than those in non-shelter-based settings and that staff was unaware of health care recommendations. The most frequent deficits involved lack of documentation of immunizations and follow up dental care. Specific cases are cited that involved duplicated immunizations and adverse outcomes such as oral surgery because of prolonged delays in dental care. Another issue raised by this study was that of education levels of substitute care providers, whether they were facility staff or relative caregivers. Suggested solutions of the study include expediting insurance for children entering care and creating computerized health passports with easy to understand terminology. This study emphasizes the importance of providing an HEP to substitute care providers. Nurses are those relied upon to monitor health status, coordinate health care, and perform as the

front-line health care professional interacting with high-risk foster care youth. The nursing roles and related activities suggested by this study also support the program plan of providing shelter care parents regular and direct access to nursing services.

Risley-Curtiss and Kronenfeld (2001) conducted a descriptive study about health care policies and services in forty-six state, public, out-of-home care placement agencies. Data was analyzed using frequencies. Findings determined that states used different criteria to set standards of care, that there is no interstate consistency about consent or medical/dental treatment, that there is a wide variance in state laws regarding health care for children in out-of-home care, and that often different criteria and policies applied to children placed with relative caregivers. In some states, it was the substitute care provider's responsibility to arrange and provide transportation for medical and dental visits. In other states, the responsibility belonged to the caseworker or a combination of caseworker and foster parent. Funding streams also varied from state to state, especially for those children that did not qualify or immediately qualify for federal funding sources. Another major obstacle reported in this study is the time involved in processing



Medicaid eligibility. Although the Child Welfare League of America (1988) recommends a medical person or centralized unit with medical personnel to oversee health care of foster children, only seventeen states reported using a person or unit with only half of those seventeen states utilizing medical oversight. Half of the states reported using a medical passport. Some states utilized computerized documents; others used paper systems or other ways. Only eight states used a computerized tracking system to monitor the delivery of health care services. Other barriers to providing a continuum of care cited include caseworker and caregiver turnover, lack of training, and lack of advocacy by caring adults. The authors conclude that serious deficiencies persist even though almost all states surveyed have some type of written policy. These findings support the need for change of the current process and implementation of a program related to documenting health care and providing that documentation to shelter care parents in a timely fashion.

CHAPTER THREE  
GOALS AND OBJECTIVES

Introduction

Planning for the actual project followed the applicable Phases of Helvie's (1998) Multi-level Intervention Model. As suggested, Phase I identifies health goals and objectives to assist the shelter care population in re-establishing a balance of energy when entering the Foster Care System.

Goal One and Objectives

The first goal of this project is to assess the health care services currently received by children in the San Bernardino County foster care shelter population. The objectives planned to meet this goal include:

1. Attend monthly meeting of shelter care parents to obtain access to information;
2. Analyze the related data collected and provided by the agency from the work environment to obtain information related to current health care services;
3. Use the analyzed data to determine services and plan trainings needed by the shelter care parents.

## Goal Two and Objectives

The second goal of this project is to develop a coordinated program to improve the provision of health care services for children in the shelter care population and to implement it in this setting. The planned objectives for this goal include:

1. Use the analyzed data to develop a new program that facilitates an effective coordination of health services;
2. Develop a problem tracking tool to ensure coordination of the process;
3. Ensure that health care providers work to help foster parents keep scheduled medical and dental appointments;
4. Provide shelter care parents an immunization history from the Public Health Immunization Tracking System;
5. Provide a HEP to shelter care parents in a timely fashion;
6. Provide training opportunities to the shelter care parents related to available health care services for foster children;
7. Revise the job description of the Public Health Nurses out-stationed in the Department of

Children's Services to provide ongoing shelter care population support;

8. Train Public Health Nurses to assist shelter care parents and facilitate access to health care services for children entering their home.

### Goal Three and Objectives

The third and final goal of the project is to evaluate the new process to determine effectiveness of the provision of health care services after implementation of the program. The planned objectives to meet this goal include:

1. Use the data from the Department of Children's Services quarterly audit to document differences from initiation of project coordinator's program to completion of the project;
2. Communicate with staff about the effectiveness of the new process and describe the program's impact from the perspective of the shelter care parents.

These goals and objectives focus on developing a process to meet requirements already in place within the Foster Care System utilizing services and mechanisms readily available. No program funds are necessary.

CHAPTER FOUR  
METHODOLOGY AND RESULTS

Introduction

Stakeholders of the project were identified as the Department of Children's Services and the Department of Public Health. The community being served was identified as the shelter care population, consisting of licensed shelter care parents and targeting the foster children entering their care. It was then necessary to discuss the proposed project with the Social Work supervisor and gain verbal agency permission, which was accomplished. Written agency permission was also secured. The project coordinator's nursing supervisor also approved the project. The proposed project was readily accepted by both agencies as they share the vision of optimizing health care to foster children.

Triability and reversibility were not issues in the planning of this project due to the immediate acceptance of the Department of Children's Services Administration and the Department of Public Health Administration.

Planning started with assessing the needs of the Department of Children's Services and the related needs of shelter care parents. Department of Children's Services

needs were determined by the audit results and state licensing requirements cited earlier. Shelter care parents needs were determined from the survey previously collected as a work requirement. The Shelter Care Coordinator in the Department of Children's Services originally collected the data. This data was never analyzing or utilizing do to the fact that the Coordinator left San Bernardino County employment.

The survey tool was designed by the Shelter Care Coordinator to assess knowledge base, determine needs related to short-term shelter placements, and to assess the process in place. The two-part survey included demographics, the frequency and type of health issues experienced with the foster children brought to their homes, and questions to establish their knowledge base concerning health requirements. Instructions were included that asked participants to write in specific health problems experienced with foster children and requests for future training.

The second portion of the questionnaire asked participants to answer frequency questions using a five-point Likert scale with one equaling "never" and five equaling "always". There was also an option to answer "not

applicable". A sample of the Shelter Care Coordinator's survey can be found in Appendix A.

The Shelter Care Coordinator had provided the initial survey to the individuals at a regularly scheduled shelter care meeting. Most of the shelter care homes were represented and completed the survey.

Goal One: Assess Current  
Health Care Services

In order to assess the current process, as identified in the first goal, the project coordinator analyzed the data that had been collected and began attending the shelter care meetings. It was projected that six months was an adequate time frame to implement and evaluate the effectiveness of the activities and program. A project calendar is illustrated in Appendix B.

The project coordinator provided an overview of the purpose of the project to the shelter care parents. Further explanation of the nursing services available to all foster parents was provided and questions were encouraged. Blank forms for future medical and dental examination reports with the project coordinator's business cards, and stamped, addressed return envelopes were also provided. Some of the shelter homes were on respite or agency hold at the time of the original data

collection. The decision was made to include all shelter care families in the program and provide all services and activities since the data collection compiled by the employer was only utilized as a guide for program development.

### Results

Analysis of the data provided a profile of the shelter care parents and their households. Demographic information completed by the shelter care parents revealed that most of the shelter care parents were in the 50-59 year age group and had been foster parents for between four and ten years. Participants' education levels ranged from eight to fourteen years. Responses showed a range of licensing for three to six foster children with one or two biological children living at home ranging in age from two to twenty-four. Usual length of stay was 30-45 days. Responses also revealed that of the foster children who had transitioned through these homes in the previous 90 days, only about 78% had medical examinations.

The majority of respondents did not identify health care providers utilized. A current list of Child Health and Disability Prevention (CHDP) providers and facilities was provided because some assessment surveys indicated participants did not know health care providers in their



geographic area. All CHDP providers will bill Medi-Cal and Denti-Cal for examinations provided to foster children.

The data related to dental care was inconclusive. In total, 11% of the children suspected to be over three years of age and requiring dental examinations were reported as having seen a dentist.

Many of the surveys provided by the agency had requests for training about emotional and behavioral needs of foster children. Several specifically requested training about psychotropic medication, side effects, and administration.

Several of the shelter care parents left the portion of the survey that asked about licensing requirements blank. This was interpreted to mean that they were unfamiliar with the requirements or just felt it did not need to be answered.

The project coordinator attended and was available for six, consecutive, monthly, scheduled meetings during the project timeframe for consult and referral. Telephone access to the project coordinator was also encouraged. The regular appearance of the project coordinator initiated a familiarity and subsequently established a rapport with the shelter parent population. During the month following

introduction of the project, no shelter care parents requested assistance from the project coordinator.

#### Goal Two: Program Development

The HEP summarizes and tracks birth history, school enrollment, diagnosed conditions, medications, immunizations, medical equipment, service providers, and medical and dental examinations that occur during the foster care experience. It was mutually agreed upon by the Department of Children's Services and the Public Health Department that the HEP remained the best vehicle to coordinate health services by communicating immunization history, health history, and health status to shelter care parents; therefore no tool development was required for this part of the project.

The HEP was introduced to the shelter care parents and emphasized as the primary means of coordination and communication between health care providers, Social Workers, relinquishing and receiving parents and foster parents, and nursing staff. Utilizing the HEP also assists the Department of Children's Services by improving mandated state compliance within the CWS/CMS database and making the information available to current and future Social Workers assigned to the children's cases. Since any

Three requests for follow up dental care were received. Two of these children were under three years of age, but had severe dental caries. All three children had received the initial dental examination and had scheduled appointments with oral surgery that were to occur after transition to the next placement. All three were completed successfully.

Three requests fell into the other category. One child needed Kaiser Inland Empire Health Care changed to straight Medi-Cal in order to receive survey scans ordered by the Children's Assessment Center related to suspected child abuse. Another child needed a psychotropic medication prescription refilled. A sibling group of three children needed assistance in obtaining routine health care.

Immunizations. Primary prevention services are available to all foster children for immunizations, medical care, and dental care. In order to achieve the portion of this health goal that consisted of providing immunization records from the county's tracking system to the shelter care parents, the project coordinator, employed by the Department of Children's Services and the Public Health Department, retrieved immunization history from an unofficial networking process and provided it to

the shelter care parents without scheduling an appointment or charging a fee. The project coordinator responded to six requests and retrieved a total of 60 immunizations records from the Public Health Department Immunization Tracking System. All retrieved immunizations were recorded in the CWS/CMS database; HEPs were created, and provided to the foster parents. The primary means of communicating the information to the shelter care parents was the HEP. A copy was also provided to each assigned Social Worker.

Foster Parent Training. Training needs were determined from the analyzed data and audit results. During the six months of the project, the project coordinator provided informal training to the shelter care parents related to growth and development and physical and dental examination requirements for foster children.

Because the data provided by the agency and audited documentation of dental care was consistently poor, the project coordinator contacted the Denti-Cal program for San Bernardino County. Collaboration with Denti-Cal Services revealed that trained staff was available to conduct field trainings upon request. The Public Health Nurse that administers the San Bernardino County Denti-Cal program was asked to provide a comprehensive presentation and answer questions for the group in May 2001. After her

presentation, she provided incentives, which included toothbrushes, toothpaste, and her telephone number. She encouraged foster parents to call her whenever they experienced a problem with access to care.

Another training planned as a result of the analysis of the information provided by the agency involved the rules, regulations, and licensing requirements related to foster children and health care. Community Care Licensing has agreed to provide a presentation concerning these issues; however, a date has not yet been determined.

Three requests for information about children with behavior and emotional problems and two requests for training about psychotropic medications were received. A Public Health Nurse specializing in psychotropic medication was scheduled for a later meeting. These trainings were scheduled beyond the time frame of this project.

Job Description. The job description of the Public Health Nurses in the Department of Children's Services office was modified to include this more personalized involvement with the shelter care population. The revision of the position description incorporates the new process into the Public Health program providing nursing service

to the Department of Children's Services. The new job description is provided in Appendix D.

Staff Training. Communication to the staff about the program and modified job description was presented at a monthly staff meeting attended by all Public Health Nurses out-stationed in the Department of Children's Services. Before the close of the preliminary six months of this project, the Public Health Nurse staff located at the meeting site assumed responsibility for attending the subsequent shelter care parents meetings and continuing the new program. A graphic representation of the activities of this process is provided in Appendix E.

#### Goal Three: Program Evaluation

Twelve requests for assistance with fourteen children were received. Each request was handled by the project coordinator.

#### Results

Audit Results. The internal audit for June 2001 reported a 71.43% combined compliance with CWS/CMS and hard copy files. This improvement cannot be explained solely with the activities of this project because these numbers represent the entire county. There remains a discrepancy between the database and file record and may

reflect a continued knowledge deficit or breakdown in communication between the Public Health Nurses and Social Workers.

Communication to Staff. A narrative summary of the process and program was presented at a monthly meeting of Public Health Nurses. Particular emphasis was placed on the positive response of the shelter care parents. The Public Health Nurses as a group are early adopters and always interested in ways to better serve foster children. They were very interested in participating in the new process and offered suggestions of other populations in their various offices that also might benefit by implementing a similar program and process.

CHAPTER FIVE  
EVALUATION OF IMPLEMENTATION  
PROCESS AND OUTCOMES

Evaluation

Agency constraints and other factors forced formal completion for the purposes of academic requirements in September 2001 and; therefore, only five months were devoted to the project before final evaluation was initiated.

The shelter care coordinator left county employment creating a vacancy in the position for the duration of the project. As a consequence of this vacancy, the Social Work Supervisor cancelled what would have been the final meeting for the purpose of this project and evaluation. Shelter care parents were upset about the coordinator's departure and possibly even more so about the cancellation. However, a weakness of this project is the early termination of the pilot period.

During the last meeting in the pilot period, several shelter care homes indicated they had arranged regular medical and dental providers. It could not be determined if the medical/dental providers were those provided in the original data; however this would indicate that at least



some of the shelter homes have acquired a dental provider and the children transitioning through their home received dental examinations. This evaluation reflects an increased compliance after implementation of the nursing program. In total, thirteen HEPs were provided to shelter care parents during this project time frame. Sixty immunizations for foster children entering the shelter care environment were retrieved from the Immunization Tracking System. All information input into the CWS/CMS database will be available to future substitute care providers, prospective adoptive parents, or birth parents if the children are returned home.

Of the shelter care parents that attended meetings during the project time frame, some did not request any nursing assistance. Those that did requested nursing support more than once. These requests indicate that the shelter care population finds access to nursing resources beneficial, particularly by those that have needed and used the resource. These responses are interpreted as successful outcomes.

Another measure of success for this project is reflected in the supervising Public Health Nurse's decision to continue the nursing program in the regularly scheduled shelter care parent meetings and to modify the

job description to include ongoing participation with the shelter care population. The Department of Children's Services supervisor also requested that nurses continue participating in the regularly scheduled meetings.

## CHAPTER SIX

### CONCLUSIONS AND RECOMMENDATIONS

#### Conclusions

Evaluating growth and development for foster children is outside the scope and abilities of this project, but might be considered for future projects. School records might be another source of immunization history for school-age children. School history and enrollment was also outside the realm of this project, but should be considered for future studies. Barriers related to confidentiality issues would require concentrated coordination between the school system and the other involved agencies. Another indicator related to the school subsystem would be number of school days missed as a result of relocation and lack of school records.

Another suggested project is one related to mental health issues. Any child removed from his familiar environment would benefit from crisis counseling. Evaluating children during the process of entry into foster care until stability is achieved might improve long-term outcomes for this vulnerable population.

The children transitioning through shelter care homes during the five months of this project achieved some

re-balance in continuity of health care more quickly than they would have if the nursing program had not been available to their foster parents and nurses had not intervened in their behalf.

The data for San Bernardino County has consistently improved during the internal audits indicating better compliance with health and dental examinations. While this is not conclusively as a result of this project and its activities, the project earns merit by the decision to continue providing and injecting nursing resources to this population and others.

There is little doubt that the children transitioning through shelter care homes for the duration of this project benefited from the services provided. Each of these children currently has a HEP initiated in the CWS/CMS database that is available to the assigned Social Worker and any subsequent workers that may be assigned. The agencies involved, Department of Children's Services and Public Health, have mutually decided to continue the involvement of nursing services with the shelter care parents and that portion of the foster child population. Public Health Nurses have undergone training to field shelter care problems telephonically and the job description has been revised as a result. Further

expansion into other segments of the foster care population, with adjustments and modifications is currently underway. Those shelter care parents that utilized nursing services, did so more than once.

#### Recommendations

The trainings requested and planned need to take place for the benefit of future placements and to demonstrate commitment and validity to the shelter care parents. An annual follow up questionnaire would assist nursing services in keeping future trainings and topics current to the needs of the participants. Other vulnerable populations within the foster care community might also benefit from more personal, direct nursing intervention.

## CHAPTER SEVEN

### IMPLICATIONS FOR COMMUNITY

#### NURSING

When the first immunization request came in, the project coordinator discussed the ongoing problem with the Public Health Nurse Supervisor. The supervisor and Program Manager began negotiating with the Public Health Department Administration for access to the Immunization Tracking System. Discussion is ongoing, but at present, agreement has been reached for a once a month immunization report for all children entering foster care under the age of six. This is an important implication for community nursing that stresses the importance of communication within the various nursing sections of public and community health.

The placement of the nursing discipline inside the Department of Children's Services environment is relatively new. Department of Children's Services has funded for these positions approximately six years. This project is an example of an innovation devised, designed, and implemented by nursing. Since the inception of this project, administration of the Department of Children's Services and Public Health have also decided to use this project as a prototype and implement a similar project

within the Independent Living Programs offered to foster children that are preparing to exit the Foster Care System. These are children 15½ and older. A pilot seminar for children on psychotropic medication was conducted in the last month of this project in an effort to improve compliance with recommended care and educate them about their diagnosis and treatment. The entire seminar was designed and presented by nursing staff. A Wellness Conference is in the preliminary planning stages utilizing a team of Public Health Nurses that volunteered to participate. The entire conference is to be designed and presented by nursing staff. The target population is the combined Independent Living Programs of the Department of Children's Services and Probation Placement.

The significant implication of this experience demonstrates that Advance Practice Nurses can assess systems outside of the nursing environment to design and implement solutions for health care problems. Agency response to the nursing activities of this project also supports the need of continually assessing, updating, and implementing trainings for and within the foster parent and child population.

APPENDIX A  
AGENCY QUESTIONNAIRE



**AGENCY SURVEY**

Code: \_\_\_\_\_

Geographic location of foster home: \_\_\_\_\_

Closest CPS office \_\_\_\_\_

How long have you been a foster parent in San Bernardino County? \_\_\_\_\_

Anywhere else? \_\_\_\_\_ How long? \_\_\_\_\_

How many foster children are you licensed for? \_\_\_\_\_ Boys or girls

Age range of children:

<3 \_\_\_\_\_ 3-6 \_\_\_\_\_ 7-12 \_\_\_\_\_ 12-18 \_\_\_\_\_

Your age:

<30 \_\_\_\_ 30-39 \_\_\_\_ 40-49 \_\_\_\_ 50-59 \_\_\_\_ 60-65 \_\_\_\_ >65 \_\_\_\_

Gender:

Male \_\_\_\_\_ Female \_\_\_\_\_

Your ethnicity \_\_\_\_\_

Years of education \_\_\_\_\_

How many other licensed foster parents live at the same location? \_\_\_\_\_

Other's age:

<30 \_\_\_\_ 30-39 \_\_\_\_ 40-49 \_\_\_\_ 50-59 \_\_\_\_ 60-65 \_\_\_\_ >65 \_\_\_\_

Gender:

Male \_\_\_\_\_ Female \_\_\_\_\_

Are there any non-foster children in the home?

Yes \_\_\_\_\_

Ages & gender:

Male \_\_\_\_\_

Female \_\_\_\_\_

How many foster children have been placed in your home in the:

Last 30 days \_\_\_\_\_

31-60 days \_\_\_\_\_ (do not include children from previous answer)

61-90 days \_\_\_\_\_ (do not include children from previous answer)

Age range of children:

<3 \_\_\_\_\_ 3-6 \_\_\_\_\_ 7-12 \_\_\_\_\_ 12-18 \_\_\_\_\_

What is the usual length of stay for foster children in your home?

1-7 days \_\_\_\_\_ 8-14 days \_\_\_\_\_ 15-21 days \_\_\_\_\_  
30-45 days \_\_\_\_\_ >45 days \_\_\_\_\_

Is there a regular health care provider that you use for foster children?

Yes \_\_\_ No \_\_\_

Name: \_\_\_\_\_

How long does it take to get an appointment? \_\_\_\_\_

Name of health care provider closest to your home \_\_\_\_\_

Do you have a regular dentist that you use for foster children?

Name: \_\_\_\_\_

How long does it take to get an appointment? \_\_\_\_\_

Name of dentist closest to your home \_\_\_\_\_

How many of the children listed above did you take to the doctor? \_\_\_\_\_

How many children listed above did you take to the dentist? \_\_\_\_\_

Did any of the children listed above have to be taken to the Emergency Room?

If so list the reasons:

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Please answer these questions using the following scale:

1 =Never, 2 =Almost never, 3 =Occasionally, 4 =Often, 5 =Always,  
NA =Doesn't apply

- \_\_\_\_\_ The foster children brought to my home have medical problems.
- \_\_\_\_\_ The foster children brought to my home have dental problems.
- \_\_\_\_\_ The foster children brought to my home have emotional problems.
- \_\_\_\_\_ The foster children brought to my home have behavior problems.
- \_\_\_\_\_ The foster children brought to my home have all their immunizations.
- \_\_\_\_\_ The foster children have a consent to treat form when they arrive.
- \_\_\_\_\_ The foster children have a Medi-Cal card when they arrive.
- \_\_\_\_\_ I was told the foster children brought to my home had medical problems.
- \_\_\_\_\_ I was told the foster children brought to my home had dental problems.
- \_\_\_\_\_ I was told the foster children brought to my home had emotional problems.
- \_\_\_\_\_ I was told the foster children brought to my home had behavior problems.
- \_\_\_\_\_ I was told the foster children brought to my home had all their immunizations.
- \_\_\_\_\_ I was instructed to take the foster children to see a doctor.
- \_\_\_\_\_ I was instructed to take the foster children to see a dentist.
- \_\_\_\_\_ I was provided an immunization record.
- \_\_\_\_\_ I was provided a Medi-Cal card.
- \_\_\_\_\_ I was provided the name of the child's doctor.
- \_\_\_\_\_ I was provided the name of the child's dentist.
- \_\_\_\_\_ I can refuse to accept a child for placement in my home.
- \_\_\_\_\_ I have refused to accept a child for placement in my home.
- \_\_\_\_\_ I should have refused to accept a child for placement in my home.
- \_\_\_\_\_ I have been asked to take more children than my license allows.

True or False

- Foster children must have a physical when entering out of home placement.
- Foster children must have a dental exam when entering out of home placement.
- Medical/dental exams must occur within 30 days of initial placement.
- Medical/dental exams must occur within 60 days of initial placement.
- Medical/dental exams must occur within 90 days of initial placement.
- Shelter Care Parents are required to provide two complete outfits for each child after 14 days.

Please list subjects you would like to have training on in the next few months.

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Please list any diagnosed medical problems the children brought to you home have had.

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APPENDIX B  
PROJECT CALENDAR

CALENDAR FOR HEALTH CARE SERVICES PROJECT

MONTH:	APRIL	MAY	JUNE
ACTIVITIES:	Analyze data provided (survey)  Provide PHN information  Evaluate 3/01 audit	Provide documents, stamped, self-addressed envelopes, business cards  Denti-Cal presentation	1:1 with requesting shelter care parents  open forum, discussion
MONTH:	JULY	AUGUST	SEPTEMBER
ACTIVITIES:	Evaluate 6/01 audit  Presentation to PH for identified deficits and new process	Ongoing support & referrals  Modify job description	Meeting Cancelled  Train Public Health Nurses

CONCLUSION:

Involve Public Health Nurses  
Continue support & problem solving

FUTURE

Psychotropic medications

TRAINING:

Licensing requirements

APPENDIX C  
PROBLEM TRACKING TOOL

## PROBLEM TRACKING RECORD

To track unresolved issues & identify correction

### PROBLEM:

- No Medi-Cal card
- No consent to treat document
- Unable to accomplish physical exam
- Unable to accomplish dental exam
- No immunization history
- Other

### DESCRIBE:

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### SOLUTION (immediate):

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### SOLUTION (system):

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Childs initials: Age: \_\_\_\_\_

Regional office involved: \_\_\_\_\_

Outcome:

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Notes:

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Approximate time to resolve: \_\_\_\_\_

APPENDIX D  
JOB DESCRIPTION

## JOB DESCRIPTION

### PUBLIC HEALTH NURSE

### SPECIAL SERVICES

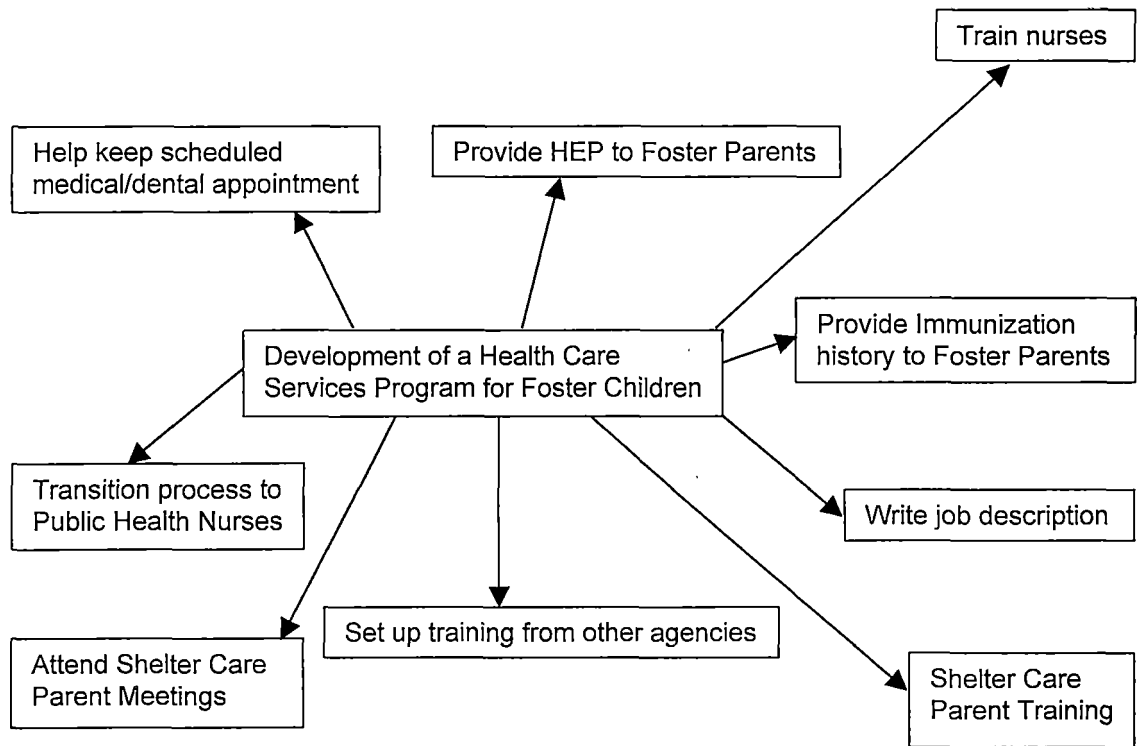
#### Job Description

The Public Health Nurse will work under the supervision of the supervising Public Health Nurse to operate an interagency, interdisciplinary program to assure that children entering shelter care placements receive preventive health care.

#### Foster Placement Duties:

1. Provide training to foster parents and social work staff regarding medical terminology, description of medical procedures, and medical equipment.
2. Participate in the assessment of current shelter care homes in relation to shelter parents' basic capabilities and the level of medical complexity the shelter parent is able to handle.
3. Provide child health and development consultation in-service and education to social work staff and shelter parents.
4. Review medical information, summarize and enter pertinent information into the CWS/CMS Health Passport for foster children to provide a mechanism for continuity of health care for children.
5. Monitor to see that health care problems receive appropriate and timely attention.
6. Participate in multi-disciplinary case consultations to provide explanations and recommendations regarding preventive and acute procedures, necessary care and appropriate interventions.

APPENDIX E  
ACTIVITIES GRAPHIC



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