CARE4KIDS
COMPREHENSIVE INITIAL HEALTH ASSESSMENT REQUIREMENTS

Each child shall have a Comprehensive Initial Health Assessment within 30 days of enrollment in the PIHP. Ideally, the pediatric nurse practitioner or a primary care physician who performs the comprehensive initial health assessment continues to follow the child throughout his/her stay in foster care. The child/adolescent, out-of-home care provider(s), Bureau of Milwaukee Child Welfare (BMCW) or county child welfare agency caseworker, health care coordinator and birth parent(s) should be encouraged to attend the comprehensive initial health assessment whenever possible.

The basic format of the 30-day Comprehensive Health Assessment is similar to a well-child exam, based on the age of the child. There are additional components which are unique, and related to the child's placement in out-of-home care. This outline will serve as a framework for the visit. It includes the required EPSDT (Early Periodic Screening Diagnosis and Treatment) components as well as recommendations from the AAP on foster care. The additional elements that are **required reporting for Care4Kids are highlighted in yellow**.

Components of the Comprehensive Initial Health Assessment include:

A. A review of the child's available medical, behavioral, developmental, and social history (including results from the Child and Adolescent Needs and Strengths if available) to guide the provision of health care services.

1. Review of information from the Comprehensive Health Care Plan (CHCP) obtained from the *Care4Kids* Health Care Coordination team prior to the visit.

B. A standard medical review of systems.

B Complete unclothed physical examination (including genital examination).

C. Close inspection for and documentation of any signs of child abuse, neglect, or maltreatment. Those primary care practitioners with limited experience in this area should refer to the child protective center as necessary if a physical or sexual abuse exam is indicated.

D. Developmental screen for younger children (those ≤ 5 years of age).
Measurement tools are not specified because they will vary depending upon the child's age and developmental stage. However, a developmental screening should include measurement of the following domains using whatever standardized tool the practitioner deems most appropriate:

1. Gross motor skills.
2. Fine motor skills.
3. Cognition.
4. Expressive and receptive language skills.

5. Social interactions.
6. Activities of daily living (ADL) skills.

A developmental assessment by a pediatric therapist(s) (physical, occupational, speech) should occur as soon as possible if problems are suspected. Children under three years of age can be referred to the Birth to 3 Early Intervention Program for evaluation.

Ongoing developmental surveillance should be incorporated at every well-child preventive visit to identify developmental concerns that may have surfaced since the child entered foster care. In addition, it is strongly recommended that a valid developmental screening test be administered regularly at the 9-, 18-, and 30-month visits.

E. Behavioral/mental health screen for children over five years of age and adolescents. Mental Health screening tools are not specified because they will vary based on the child's age.

*Note: the Child and Adolescent Needs and Strengths (CANS) will be administered by the child welfare case manager to all children within 30 days of entering out-of-home care. If available at the time of the comprehensive initial health assessment, the results from the CANS should be reviewed. This review should including any requests for consideration of further behavioral health evaluation, treatment or therapy based on either the results of the CANS, or on identified behavioral/mental health concerns of the child welfare agency, child, family or foster caregiver.

F. Growth and nutritional assessment including measurement of height, weight, BMI (and head circumference for children <3 years old).

G. Immunization review.

H. Hearing/vision screen with referral as indicated.

I. Dental/oral inspection with referral as indicated.

J. Adolescent survey (discussion with adolescents) to include at a minimum:

1. Family relationships (foster and birth).
2. Alcohol/drug/tobacco use.
3. Sexual activity/sexual orientation.
4. Pelvic examination and family planning counseling services for sexually active females as soon as possible.
5. Prevention of sexually transmitted diseases (STDs) and birth control.
6. School performance.
7. Educational/career plans.
8. Physical activity/exercise/hobbies.

K. Screening lab tests based on the age and condition of the child (e.g., CBC, lead level, U/A, HIV testing if positive risk assessment and consent obtained).

L. Anticipatory guidance including education and counseling on topics specific to out-of-home care:

1. General adjustments to new home, grief and loss issues.
2. Behavioral problems that may have surfaced (adjustment reactions, opposition behavior, depression, anger, attention or impulse control problems, etc.).
3. Sleep problems.
4. Appetite/unusual eating habits.
5. Enuresis/encopresis.
6. School problems behavioral/academic.
7. Interaction with other children in the home.
8. Contact with birth family including difficulties around visits.

M. Referrals to dental, mental health, Birth to Three, or other medical services as appropriate.

N. Assess "goodness of fit" between the child and the out-of-home care family.

O. Review of all current medications, with distinct identification and documentation of any psychotropic medications, including clear identification of antipsychotic medications.

Based in part on AAP, District II, NYS

Items which must be documented <u>that are unique to children in Care4Kids</u> include the following:

1. Receipt and review of the Comprehensive Health Care Plan
2. Developmental screen completed (Y/N) and any recommendations resulting from that screen;
3. Mental health screen completed (Y/N) and any recommendations resulting from that screen;
4. Oral health screen completed(Y/N) and any recommendations resulting from that screen;
5. Immunizations Up to Date or lagging
6. Lead testing performed (as appropriate)
7. Identification if child is on atypical antipsychotic medication; if so, metabolic screening ordered (Glucose, lipids, liver function tests, and BMI noted)

SPECIAL CONSIDERATIONS FOR CHILDREN 0-3 YEARS

Make note of reason for entry into foster care, if it is pertinent
Who is attending visit with patient: Foster parent, child welfare, biological parent, etc. Is foster parent related to child?
Current concerns of caregiver/adult accompanying child (Chief Complaint)

Social Screening and Information Relevant to Foster Care

Safe sleep screening for infants
Appropriate car seat available for child
How has the adjustment been to the foster home?
How long has child been in this home?
Second hand smoke exposure?
Does the child have visits? With whom (sibs and/or parent)
How is the child's behavior after a visit with biological family?

Temperament, Development and Behavior Relevant to Foster Care

Does foster parent have concerns with how child is getting along with other children in the home?
Does the child exhibit appropriate level of stranger anxiety?
Document the relationship between foster parent and child (does foster parent attempt to soothe and calm child, does child seem comfortable with foster parent, etc)
Does the caregiver feel the child's behavior is beyond their scope (or comfort level) to manage or discipline?
Does the child have difficulties with feeding or unusual habits (children in foster care may exhibit behaviors such as food hoarding, restricted food preferences, searching trash for food scraps, rapid eating, lack of satiety, loss of appetite, or PICA)?
Does the child have constipation, encopresis, enuresis, regression of toileting skills or refusal to toilet train?
Does the child have difficulty falling asleep, difficulty staying asleep, nightmares?

Equipment child came with

E.g. braces, nebulizer machine, feeding tubes, etc

SPECIAL CONSIDERATIONS FOR CHILDREN 4-11 YEARS

Make note of reason for entry into foster care, if it is pertinent
Who is attending visit with patient: Foster parent, child welfare, biological parent, etc. Is foster parent related to child?
Current concerns of caregiver/adult accompanying child (Chief Complaint)

Social Screening and Information Relevant to Foster Care
Appropriate car restraint utilization by child (as applicable)?
How has the adjustment been to the foster home?
How long has child been in this home?
Second hand smoke exposure?
Does the child have visits? With whom (sibs and/or parent)
How is the child's behavior after a visit with biological family?

Temperament, Development and Behavior Relevant to Foster Care
Does foster parent have concerns with how child is getting along with other children in the home? At school?
Document the relationship between foster parent and child (does foster parent attempt to soothe and calm child, does child seem comfortable with foster parent, etc)
Does the child have difficulties with eating or unusual habits (children in foster care may exhibit behaviors such as food hoarding, restricted food preferences, searching trash for food scraps, rapid eating, lack of satiety, loss of appetite, or PICA)?
Does the child have constipation, encopresis, enuresis, regression of toileting skills or refusal to toilet train?
Does the child have difficulty falling asleep, difficulty staying asleep, nightmares?
What grade is the child in school? Is this a new school for child since foster care?
Does the child seem to be achieving in school? If not, does it seem due to difficulties with learning, refusal to participate in school due to behavior issues, seems not able to do the work being asked of the child, or other issues?
Has the child failed a grade previously?
Does the child have an active IEP (receiving services), 504 or other individualized learning plan?
Does the caregiver feel the child's behavior is beyond their scope (or comfort level) to manage or discipline?
Is the child currently seeing a therapist, or other mental health provider? If not has there been discussion about this by the child welfare worker?
Are there trauma / grief / loss associated behaviors?
Are there sexualized behaviors?
Identify one positive quality about the child

Equipment child came with
E.g. braces, nebulizer machine, feeding tubes, etc