CME

The role of primary care in improving health outcomes in young foster children

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ABSTRACT

Children removed from their biological families because of abuse, neglect, and/or violence have increased healthcare needs and are susceptible to poor health outcomes compared with children who are not in the child welfare system. Developmental delays occur in about 75% of children in foster care. Up to 80% of children entering out-of-home care have at least one physical health problem and more than 40% experience educational challenges. In most US states, newly removed children are required to have a medical evaluation shortly after placement in a foster or kinship family. The initial evaluation is important for identifying urgent concerns and developing a rapport with children who may not have had regular medical care. In addition, the child's complete social, trauma, and medical history may be unknown because of system barriers such as inconsistent medical care by biological parents, privacy laws protecting records, and unavailability of birth histories and biological parents' medical and psychosocial histories. As a result, a series of visits is required to fully evaluate the child's development and healthcare needs. This article provides guidance for physician associates/assistants who provide care to children in foster care.

Keywords: anticipatory guidance, foster care, adverse childhood experiences, trauma-informed care, child abuse, pediatric primary care

A 2-year-old girl presents to the primary care provider (PCP) with her foster mother for a well-child examination. She was removed from her biological mother's care 1 week ago when her younger sister was diagnosed with neonatal abstinence syndrome following in utero exposure to heroin. The foster mother reports that the child struggles to express her needs and appears easily frustrated. When frustrated, she hits others or breaks things. She has been clingy, preferring to be held by the foster mother. Sleep has been challenging; even with a consistent bedtime routine, a night light, and white noise machine, the child struggles to fall asleep and cries out two or three times per night.

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THE HEALTH EFFECTS OF FOSTER CARE

In 2023, the United States had nearly 200,000 licensed foster homes, with an estimated 342,981 children and youth in foster care.[1,2] Trended national data from the Adoption and Foster Care Analysis and Reporting System, part of the federal Administration for Children and Families, demonstrate that the number of children in foster care across the United States increased from 396,000 in 2013 to a high of 437,000 in 2017 and 2018 before slowly declining to 369,000 in 2022.[3]

Up to 80% of children entering out-of-home care have at least one physical health problem.[4] A 2021 study showed that 75% of children in foster care younger than age 36 months had a failing Ages and Stages Questionnaire (ASQ) score.[5] In addition to physical problems, children in foster care also experience high rates of mental health problems and educational challenges.[4] Experiencing adverse childhood experiences (ACEs) such as abuse, neglect, and family dysfunction has been associated with poor outcomes for children. Analyzing data from the 2016 National Survey of Children's Health, Webster observed that the incidence of special health needs (developmental delay, increased need for services or therapy, regular medication use) increased proportionally to the number of ACEs the child had experienced.[6]

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Learning objectives

- Discuss the national prevalence and common health challenges of children in foster care.
- Describe the team of people involved in the care of children removed from their biological parents.
- Contrast typical neurodevelopment of young children with the neurodiversity that characterizes children in foster care.
- Identify key elements of primary care for foster children.

Key points

- Children in foster care commonly experience developmental delays.
- Familiarity with the various child welfare workers in addition to the foster or kinship and biological parents involved in the life of the foster child is important in their care.
- Primary care office visits are critical for evaluating the physical, cognitive, emotional, and developmental needs of children in foster care.
- The AAP has developed a trauma toolbox and Bright Futures guidelines to support PCPs in caring for children with a history of ACEs.

Whether the children lived in foster care was not captured in the study, but the ACEs (poverty, parental divorce, incarceration, substance abuse, mental illness, death of a household member, and exposure to various types of violence) are common among children removed from the care of one or both biological parents.[7]

THE LANGUAGE AND PEOPLE OF FOSTER CARE

A glossary of child welfare terms and definitions may be found at www.childwelfare.gov/glossary/glossarya, the website for the Child Welfare Information Gateway of the US Department of Health and Human Services.

The federal foster care program is authorized by the Social Security Act, Title IV, Part E, and managed by the states. The title of the government agency responsible for removing children from their legal parent into the care of the state varies from state to state. Some examples include Child Protective Services (CPS), Department of Child Services (DCS), Department of Children and Family Services, Department of Health and Human Services, and Department of Human Services.[7] When children have been removed from their homes because of abuse or neglect, placement options include moving them to a foster family, kinship family, or a group home setting. Their care and the services they receive are monitored by CPS workers and the court. Though the policies guiding out-of-home care vary from state to state, involvement of the biological parents in case planning and reunification with the parents or another biological relative receive top priority. Foster families are trained and licensed to provide care for children and are provided with financial support to assist in that care. Kinship families are biological relatives or other adults who have an established bond with the child. Like foster families, kinship families must pass background checks, but may not receive financial support unless they undergo foster parent training and become licensed. Group home (residential) placement generally occurs when the child's behaviors or needs preclude safe placement in a foster or kinship home or when no other options are available.

In addition to foster or kinship families, states assign various professionals to participate in the care of the foster child. These professionals may include a family case manager from CPS; guardian *ad litem*; and court-appointed special advocate; as well as play, occupational, physical, developmental, or speech therapists. Medically fragile children also may be under the care of several subspecialists in addition to their PCP. Because of the complexity of managing multiple physical, developmental, and mental health problems, and because the PCP is responsible for coordination of the child's medical needs, the PCP (often a physician associate/assistant) must be aware of all the specialists caring for the foster child.

CHILDHOOD NEURODEVELOPMENT

Children have a known trajectory of growth and neurologic development, including three natural periods during which they are most susceptible to change.

- Attachment develops during the first year. The attachment theory suggests that basic trust or attachment develops when a caregiver responds to a young child's basic needs.[6]
- During adolescence, the brain experiences changes and the child develops their identity.
- The transition to adulthood is the final period of development and a crucial time in which the child develops self-efficacy, purpose, meaning, and experiences opportunities for success.[8]

During early childhood (the first 5 years of life), the brain is rapidly developing, and a child not only grows in size but also in complexity of function.[8] During these years, a child learns to sit, crawl, walk, climb, run, smile, coo, talk, recognize colors, count, identify body parts, and play with peers. This period of time, when rapid neurologic development is occurring, is a critical time to monitor appropriate developmental skills. Experiencing trauma during this rapid growth period can impair development and adversely affect the child in later years.[6]

NEURODEVELOPMENT IN FOSTER CHILDREN

Removal from the care of biological parents and placement in foster care is associated with altered neurodevelopment in children.[5] Any neglect, abuse, or household or environmental threats experienced by children before entering foster care results in ongoing neurohormonal release that impairs their physical and emotional health. Insecure attachment was

identified in 43% and mental health problems in 39% of the pooled sample.[9] Children with one household challenge ACE had 55% greater odds of developmental delay and those with three or more ACEs had three times the odds of developmental delays, compared with a reference group with no ACEs.[6]

THE WELL-CHILD VISIT

The American Academy of Pediatrics (AAP) has established a periodicity schedule of well-child visits in its Bright Futures guidelines that should be followed by all PCPs caring for children.[10] The well-child visit is an opportunity to assess growth; social development; neurodevelopment; medical needs; perform a risk assessment; give anticipatory guidance; update immunizations; and to respond to the medical, social, and neurodevelopmental needs of a child. The primary care of a foster child is best provided by a PCP or medical home provider who has built a therapeutic relationship with the child to ensure that all health problems are addressed and tracked and to coordinate medical care.[11] A PCP provides consistent care for the child and has a relationship with the child and the family.

Developmental screenings and growth assessments should be obtained during every well-child visit. The neurodevelopmental evaluation documents the child's level of development in language, motor, visual-spatial, attention, and social domains.[10] The ASQ is a commonly used screening tool for PCPs to assess child development.[12] The parents or guardians complete the screening form, which includes a series of questions about fine and gross motor development, communication, and intellectual development.[12]

Although developmental surveillance is important for each well-child visit, formal screenings such as the ASQ are recommended by Bright Futures and AAP for children at certain ages, and for those with a history of trauma or red flags on the surveillance (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf). The ASQ is recommended at ages 9, 18, and 30 months.[10] At 18 and 24 months, a screening for autism spectrum disorder also is recommended. At ages 4 to 5 years, before school entry, special emphasis is placed on developmental surveillance with a screening administered for any concerns. At any other age, if the PCP or caregiver has a concern about the child's development, the PCP should administer a nonroutine age-appropriate developmental screening, such as the 36-month-old ASQ.[13]

Identifying psychosocial problems in children is an important aspect of well-child care, and is especially important for foster children, who are at increased risk for psychosocial problems.[4,14] To identify psychosocial problems, PCPs should consider administering a well-studied screening tool such as the Survey of Well-being of Young Children (SWYC).[14] The SWYC assesses developmental, social, and emotional domains of psychosocial health from birth to age 5 years, as well as family context. The screening does not diagnose mental health disorders, but only identifies problems or concerns that may need to be addressed.[10] Implementing a comprehensive psychosocial screening in primary care is both feasible and can help target referrals to address psychosocial health needs. PCPs should be aware of the increased risk of attachment issues and disorders in young foster children related to family instability. Foster parents are trained in the effects of trauma and insecure attachment in children, but PCPs who understand insecure attachment and the effects of trauma on children will be in a better position to help parents and patients interpret and respond to the behaviors and needs of the foster children in their care.[4] The AAP offers a resource called the Trauma Toolbox for Primary Care to help PCPs learn about trauma-informed care and develop skills in treating children who have experienced trauma.[15,16] In addition to taking a careful psychosocial history of the child and current caregivers, PCPs should assess the quality of interaction and the level of connection between the child and caregiver.[17] Evidence of a caregiver-child connection includes the child making visual contact with the parent for reassurance, the child bringing an object of interest to the parent, and the parent responding with praise for the child.[10]

Providing acute, chronic, and preventive care for children in foster care can be challenging for several reasons. The foster child will come to the appointment or well-child check with a foster or kinship parent who may be unaware of the child's needs, developmental skills, or delays. When the child enters foster care, the foster or kinship parent chooses a PCP who is either local or known to them, but who may not be the child's usual PCP. Transfer of medical records may not be possible if the child did not receive regular medical care or may be delayed if appropriate contact information for those records has not been provided by the biological parents.[10] Development may need to be assessed over a series of visits after the foster parent has had time to observe the child's development. The developmental screening questionnaire also can be sent home with the foster parents so that they may complete it over a few weeks as the child's development is observed in a home setting. When there is uncertainty about developmental delay in a foster child, for example because of a new placement, close follow-up (within 30 days) and screening sent home with the foster parent may be needed to review the developmental screening again. Because of the high occurrence of ACEs in foster children, the risk for developmental delays is high.[6] Prompt intervention and referrals are key to addressing developmental, emotional, or physical health concerns, particularly when the length of the foster placement is uncertain.[6]

The AAP and the Child Welfare League of America (CWLA) have developed standards of care for foster children.[18] These standards, along with Bright Futures, help PCPs navigate the complex needs of children in foster care. The AAP and CWLA standards recommend that children in foster care be evaluated within 72 hours of placement to be assessed for signs of abuse and neglect, the presence of acute or chronic illness, and for signs of mental health problems.[18] In addition, the

initial visit will monitor adjustment to foster care, and ensure that the child has all the necessary medical equipment and medications. A comprehensive admission health visit or well-child visit is recommended within 30 days of entry into foster care. At this visit, dental and mental health evaluations should be performed, as well as developmental screening for children under age 6 years, and an educational evaluation for children age 5 years and older. The PCP is essential in performing some of these and coordinating the rest of the comprehensive evaluation. A follow-up visit, ideally by the same PCP, is recommended within 60 to 90 days of placement.[18] The standards also recommend seeing foster children in primary care more often than the AAP periodicity schedule. Children in foster care should be seen monthly through age 6 months, every 3 months for ages 6 to 24 months, and every 6 months for ages 24 months to 21 years.[18]

Other factors that will affect the primary care visit include whether the biological parents are present at the visit, if biological siblings are placed in the same home, and whether the out-of-home care is being provided by a licensed foster parent or kinship parent. Although licensed foster parents usually have had training about the effects of trauma on young children, a kinship parent may lack education on common behaviors for foster children and trauma-informed parenting.[18]

ADMINISTRATIVE CONCERNS FOR PRIMARY CARE

The primary care team will need a copy of the child's placement letter and must accept Medicaid as the primary insurance. All diagnostic studies, laboratory tests, immunizations, and referrals will need to comply with Centers for Medicare and Medicaid Services (CMS) guidelines. This may include scheduling CMS-provided vaccinations at another office or the local health department. The office will need contact information for the foster parents, the family case manager, and the court-appointed special advocate, and a clear understanding of the legal access that the biological parents have to the child's protected health information. In addition, the office should collect the appropriate consent forms to release protected health information to CPS workers and the court-appointed special advocate or guardian *ad litem*. The front office staff must be aware of the more frequent scheduling needs of the foster child. In addition to medical appointments, children in foster care may have regular visits with physical, occupational, speech, or developmental therapists in addition to visits with a family case manager, a guardian *ad litem* or court-appointed special advocate, and various members of their biological families. To reduce stress on the foster family and strengthen adherence to the management plan, PCPs scheduling follow-up appointments or making referrals should aim to be as accommodating as possible to foster family scheduling needs. Consider scheduling at-home services for therapy for small children. As a best practice, the primary care office staff should schedule necessary appointments and follow-up visits for the foster child before the child leaves the primary care visit.

PROMOTING PROTECTIVE FACTORS

Anticipatory guidance includes educating foster or kinship parents about milestones, safety issues, and expected development, along with recommendations to promote protective factors. The promotion of strengths and protective factors is included in Bright Futures as a recommendation at every well-child visit.[10] Protective factors are positive experiences that help buffer children and families from the negative effects of ACEs. Protective factors include nurturing and attachment, knowledge of parenting and of child and youth development, personal resilience, social connections, concrete parental supports, and the social and emotional competence of children. The promotion of protective factors is recommended for all children at well-child visits to help reduce the risk of child abuse and neglect, but in foster children can help build resilience to further mitigate the effects of ACEs.[19] An example of the promotion of protective factors for a 12-month-old well-child visit is discussing daycare for the child; a social support network for the foster parent; and involvement in a faith-based community, recreational center, or volunteer organization.[10] This discussion could be tailored to the foster or kinship parent to include discussion of parenting resources available to them through DCS.

MANAGEMENT AND REFERRALS

Treatment referrals should be made at the time of the identification of any diagnoses, concerns, or delays. For diagnoses or concerns related to foster children and trauma, the AAP's trauma toolbox can help PCPs organize and make local referrals for behavioral therapy.[15] Wrap-around service teams for children in foster care may include social workers, marriage and family therapists, and licensed professional counselors. Children also may benefit from referrals for speech therapy, occupational therapy, and physical therapy, which often are provided at home for very young children in an early intervention program such as Indiana's First Steps (www.indianafirststeps.org). Children in foster care may have an attachment disorder. Specific therapies aimed at attachment disorders can help establish a bond between caregiver and child. One of these therapies includes video feedback with caregivers facilitated by a trained social worker. This involves a video recording, often in the caregiver's home, and consists of multiple sessions over several months. The feedback encourages the caregiver to become more aware of the child's behavior and respond positively to the child's cues. The program also includes information on how caregivers can regulate their emotions when interacting with the child.[17] The foster or kinship parents may benefit from counseling with a marriage and family therapist for their own self-care and to help them build healthful attachments with their chil-

dren.[19] For children with developmental delays, ensure proper follow-up either at the primary care office or at a pediatric specialist, such as a neurodevelopmental pediatrician, developmental-behavioral pediatrician, pediatric neurologist, or pediatric physiatrist.[13]

PCPs who care for foster children are encouraged to learn about their county's DCS policies and guidelines, local resources through the school system, local community resources, and the effects of ACEs on the health of children. Resources are available to help educate PCPs and foster and kinship parents about the effects of ACEs and about protective factors (**Table 1**). PCPs should consider having a resource page or books to share with foster and kinship parents.

CARING FOR THE CASE PATIENT

Although the case patient was scheduled for a well-child visit, the PCP must pay attention to potential acute needs, especially signs of physical abuse, and must address the foster mother's concerns. The child has only been in placement for 1 week, and the foster mother may not be aware of developmental milestones. This initial visit should focus on assessing any signs of abuse or neglect, acute or chronic illness, and any signs of mental illness. Consider discussing this with the foster mother, sending home a 24-month ASQ screening, and rescheduling a well-child visit in the next few weeks to attend to the well-child visit needs.[18]

At this initial visit, attention must be given to administrative tasks such as consent forms, contact information, medical information transfer requests, and immunizations record requests. A complete medical history needs to be obtained (if the foster mother knows it) or requested from the previous PCP. A family and social history should be obtained, including details about the social environment and any exposure to drugs, alcohol, or secondhand smoke. A thorough physical examination needs to be performed to assess for any signs of neglect or abuse. Because the child was removed from a biological mother who recently gave birth to an infant with illicit drugs in their system, consider ordering a drug screen for the case patient to assess for potential environmental exposure if the child is displaying symptoms of toxicity.[16]

Finally, discuss the foster mother's concerns about the child's behavior and sleep habits, and provide relevant anticipatory guidance or other strategies to help address that concern in a 2-year-old. Some of the child's behaviors, such as sleep difficulties, may be developmentally appropriate or related to the recent trauma of being removed from the biological parent. Bright Futures is a useful resource for parental education on sleep habits and routines for 2-year-olds and the promotion of protective factors at this age.[10] Another appointment should be scheduled within the next 3 weeks to perform a well-child examination, update immunizations, and review the developmental screening that the foster mother will have completed at home. A second follow-up visit should be scheduled within 60 to 90 days. While the child is in foster care, she should be seen at least every 6 months for preventive visits. The frequency of these visits will allow the PCP to monitor the progression of any developmental delays, new trauma-related behaviors, and address foster parent concerns such as hitting or breaking things and sleep issues. During these regular visits, the PCP also can monitor that appropriate follow-up on any referrals has occurred.

TABLE 1. Sample resources for foster and kinship families

Books
- *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma,* Bessel van der Kolk, MD
- *The Connected Parent: Real-Life Strategies for Building Trust and Attachment,* Karen Purvis, PhD, and Lisa Qualls
- *Raising Kids with Big, Baffling Behaviors: Brain-Body-Sensory Strategies That Really Work*, Robyn Gobbel, MSW
- *What Happened to You? Conversations on Trauma, Resilience & Healing,* Bruce D. Perry, MD, PhD, and Oprah Winfrey
- *The Deepest Well,* Nadine Burke Harris, MD

Movies and videos
- How childhood trauma affects health across a lifetime, www.youtube.com/watch?v=95ovIJ3dsNk
- Healing From Toxic Stress with Nadine Burke Harris, MD, www.youtube.com/watch?v=Ta5tbuFVkHY
- Bruce D. Perry, MD, PhD: Social & Emotional Development in Early Childhood, www.youtube.com/watch?v=vkJwFRAwDNE
- Dr. Bruce Perry—Early Brain Development: Reducing the Effects of Trauma, www.youtube.com/watch?v=Hp6fZrzgiHg
- Trust-Based Parenting Preview, www.youtube.com/watch?v=XGqwz8L6JBo

Websites
- Karyn Purvis Institute of Child Development, https://child.tcu.edu/blog_6_books_parents/#sthash.BRGchGWb.dpbs
- Centers for Disease Control and Prevention. Violence prevention: adverse childhood experiences, www.cdc.gov/violenceprevention/aces/index.html
- ACEs and toxic stress: Frequently asked questions, https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions
- Empowered to Connect, https://empoweredtoconnect.org
- PACES Connection, www.pacesconnection.com

Podcasts
- The Adoption Wise Podcast, https://adoptionwise.org/listen
- The TBRI podcast, https://child.tcu.edu/podcast/#sthash.AyFxDzJJ.dpbs
- The Baffling Behavior Show with Robyn Gobbel, https://robyngobbel.com/podcast

CONCLUSION

Primary care PAs who understand the effect that early adversity has on the health and well-being of a child, as well as the importance of screening for developmental delays, and who deliver trauma-informed care, will be tremendous assets to the foster parents, social workers, and others involved in helping the child heal. PCPs not only provide medical care for the foster child but also advocate for the child's physical and mental health and well-being. Evidence-based resources and expert consen-

sus guidelines through the AAP and Bright Futures, along with local community and state resources such as the DCS child welfare team, are available to PCPs who care for children in foster care. PCPs have a tremendous opportunity to serve as positive, caring adults and promote resilience and healing in the life of a child. **JAAPA**

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