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Innovative Pediatric Nursing Role: Public Health Nurses in Child Welfare

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The role of a pediatric public health nurse (PHN) practicing health case management in a child welfare agency was developed to meet the increasing health care demands and severe health problems of children in foster care. Federal and state government appropriated monies to fund this role to alleviate the difficulties in coordinating health care between the child welfare system and health care providers. Informal observations of the PHN in a large metropolitan child welfare agency in California were categorized using the Minnesota Public Health Intervention Model. Nurses functioning in this role are part of a team, with social workers, to promote the safety of children in foster care and to assure that health is part of a safe environment.

The role of pediatric Public Health Nurses (PHNs) in child welfare agencies was developed to improve the health care and health outcomes of children in foster care. This new nursing role in health case management offers nurses the opportunity to interface with the legal, political, and organizational world of foster care to advocate for children in protective custody. PHNs have joined the social workers in child welfare agencies to help meet the challenges of caring for children with serious physical and psychological problems. Social workers are not trained in the language or practice of health delivery and have difficulty dealing with the extensive health problems of foster children (Carlson, 1996; Simms, Freundlich, Battistelli, & Kaufman, 1999; Smart, Russell, & Custodio, 1998). Thus, the social worker is the legal case manager within the foster care system and the PHN provides health counseling, referrals, and consultation to the foster care-

givers, health care providers, and the social workers.

This article describes the impetus for the new nursing role as a result of recognition of the health problems of an expanding population of children in foster care, delineates the historical beginnings of the role in California, and summarizes informal observations of nurses in the role. The pediatric PHNs, also called foster care nurses, were observed performing their job functions within a large county child welfare organization in California. The Minnesota Public Health Nursing Intervention Model provided a framework for the observations. The foster care nurses have the potential to change the face of health care delivery to the foster care pediatric population, but must function within the confines of a case management role within non-healthcare setting, the child welfare agency. Working within the organizational context of the child welfare agencies has proven difficult for nurses because the organizational goal of safety does not always include health (Schneiderman, 2005).

Foster Care

Foster care is the temporary, planned placement of children away from their parents to strengthen families and improve the quality of life of the child. Foster care can occur in a relative's home, with a non-relative caregiver, or in a group home. Child Welfare agencies are governmental agencies that take responsibility for

the health, education, and well being of foster children while providing counseling and support for the parents, with the final goal of family reunification. If it is determined after a legal investigation that it is in the child's best interest not to reunite with their parents, parental rights are terminated and adoption is considered. When reunion or adoption is not possible, some children remain permanently in the foster care system until they reach adulthood (Schor, 1988).

The foster care population has increased 44% over the last two decades, and children in foster care have increasingly more serious health problems (Leslie et al., 2003). The child welfare system is responsible for the education, health, and welfare of over 580,000 children in the United States, with California having 91,000 foster children, approximately 16% of the U.S. foster care population (Rivera, 2004; Leslie et al., 2003). The increase of children in foster care is the result of a myriad of circumstances, most notably poverty among families, drug and alcohol abuse in the home, and the inability of parents to care for "special needs" children (Schneiderman, 2003).

Health needs within the foster care population. Accompanied by this increase in numbers is strong evidence to support the idea that foster care children have higher than expected rates of chronic illness (Barton, 1999; Kools & Kennedy, 2003; Schor, 1988). Most children entering the system have not had their physical, emotional, or medical needs met (O'Hara, Church, & Blatt, 1998).

Once in the foster care system, children often do not receive adequate and timely health care. The child welfare system has failed to take charge of the health and welfare of foster children, partly due to the disorganization within the system and partly due to the lack of coordination between the health care system and child welfare system. The lack of comprehensive, preventive medical

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Table 1. Health Passports

Complete passports contain:

Demographic information	History prior to entering foster care	Present health/education information
Child's name Date of birth Sex Race Language	Birth history Immunization history History of health problems and/or hospitalizations Previous schools attended Names of health care providers	Height and weight Immunization record Medical problems Dental problems Laboratory results Results of hearing and vision tests Names and addresses of present health care providers Follow-up needed on health problems Information obtained from school records

Source: Adapted from Lindsay, Chadwick, Landsverk, & Pierce, 1993.

care for foster children has resulted from a multitude of factors including (a) foster care providers with poor preparation to maneuver within a fragmented system, (b) social workers overburdened with high case-loads and lack of health training, and (c) an uncoordinated medical record system resulting in errors in immunization and under-treatment for chronic conditions. Physicians have documented the poor health and inadequate health care of these children and have tried to alert policymakers about possible solutions (Bass, Shields, & Behrman, 2004; Halfon, English, Allen, & DeWoody, 1994; National Research Council & Institute of Medicine, 2004).

Difficulties in meeting health care needs. The solutions to the health care crisis for children in foster care include a call for system-wide improvement of identification, treatment, and follow-up for children with physical, developmental, and emotional problems. One solution that seems to be the most widely documented and used in the United States is the health passport, an individual record of health problems, treatments, health plan of care, and educational information (Chipungu & Bent-Goodley, 2004; Lindsay, Chadwick, Landsverk, & Pierce, 1993) (see Table 1). Foster parents should have updated copies of the health passport to take with them to health and mental providers, to enable the provider to have accurate information about the foster child and so that new information can be entered by the provider on the passport. The foster parent needs to update the child social worker or foster care nurse, and this

new information added to the computerized passport.

The American Academy of Pediatrics (1994) published standards for health care services for foster children as well as a guidebook by a pediatric task force, but these standards are not met universally because of the lack of coordination between health care, child welfare, and the schools. The guidebook contains practical information to help pediatricians provide comprehensive health care to this vulnerable population. Practice parameters for physical, developmental, and mental health care as well as child abuse and neglect are included. The guidebook also contains information on medical consents, confidentiality, and financing of health care. The guidebook concludes with the American Academy of Pediatrics' foster care policy statements on health care, developmental issues for young children, and identification and care of HIV-exposed and HIV-infected children (Task Force on Health Care for Children in Foster Care, 2005).

California lacks a statewide system to provide health care to foster children (Institute for Research on Women and Families, 1998). The long-term effort on the part of child advocates all over the country to both increase society's and the health care system's awareness of health care needs of foster children and their families has led to increased allocations of funds, specifically for nurses. For example, California appropriated money in the year 2000, matched on a federal level, to hire more PHNs to help implement a better-coordinated and responsive system (Almqvist,

Cambaliza, Johnson, & Ward, 2001). In California, PHNs are registered nurses with a baccalaureate degree and classroom/clinical education in community health nursing with certification from the state. Geppert, Marrufo, and Rapoport (2004) found that Medicaid use by foster children increased slightly (between 1% to 3%) for counties that had a higher percentage of public health nurses per foster child after the first year of implementation of the nursing program in California. They attributed this increase in use to the success that nurses had in encouraging foster parents to seek preventive care in terms of well child visits, and encouraging the use of specialty providers for children with chronic illness.

Foster Care Nurse Role Development

Foster care nurses have worked in the Child Welfare Department in Los Angeles County since the 1990s. Prior to the new funding initiative, Ruptier (1997) wrote about locating PHNs in the Department of Social Services in San Diego, California, to work with social workers to increase preventive services to foster children, to document existing health problems, and to increase medical treatment for existing health problems. Smart (1999) noted that the Child Welfare Offices in Los Angeles County began employing PHNs when funding through the federal Early Periodic Screening, Diagnosis, and Treatment (EPDST) program, administered by Child Health and Disability Prevention (CHDP) program in California, became available. This EPSDT-CHDP program ensured comprehensive health care services for Medicaid eligible children and those children within 200% of the federal poverty level. Almost all foster children qualified for these services.

Poverty thresholds are federal poverty measures that are weighted average poverty levels and are used by the United States government to determine financial eligibility for certain federal programs, such as food stamps, low-income home energy assistance, and children's health insurance programs (United States Department of Health and Human Services, nd). The poverty level is published in the Federal Register each year and includes the 48 contiguous states as well as the District of Columbia (Alaska and Hawaii have higher levels). The 2004 guidelines are stated in terms of the size of family unit, e.g., for a family unit of one the poverty level is \$9,310; fam-

ily unit of four is \$18,850 and for a family unit of eight is \$31,570. For the family unit of four, the child would be eligible for EPSDT-CHDP if the family's income was at most \$37,700.

When Smart (1999) studied foster care nurses in Los Angeles County, there were only 20 nurses working in the child welfare agency, compared to the 100 nurses now employed as a result of the new 2000 funding. Smart found that because of funding streams that the nurses had to adhere to narrowly defined case management functions. The PHN program began with funding from the federally mandated EPSDT program, which was administered by the State of California as CHDP. The state administration defined the practice boundaries rather than the local child welfare department. The PHNs provided consultation services, which included (a) 23% of their time reviewing and assessing cases to determine a child's health needs and assisting the CSW with development of a health case plan; (b) 13% of their time trying to obtain accurate and complete health information; (c) 14% of their time following cases to see if care was received for identified health problems; (d) 11% of their time interpreting medical terminology for the CSW or caregiver; and (e) 8% of their time notifying health care providers, CSWs, or caregivers when the child was due for basic health care.

With the new funding initiative in 2000, the case management role of the foster care nurses was defined for the entire state (California Department of Health Services, 1999). The foster care nursing program has four goals:

1. The health needs of children in protective services custody will be identified and addressed in a timely manner;
2. A comprehensive health plan will be developed, documented, and updated;
3. A pool of qualified providers will be available to provide needed health care in a timely manner; and
4. The child's health record will include the information to determine health needs and health status throughout his/her time in foster care.

Los Angeles County further defined areas of responsibility for the foster care nurses in terms of their relationship to CHDP, the local child welfare department, and the Social Worker/Probation Officers (Los Angeles Department of Health Service, nd).

The services provided by the entire team included accessing resources, health care planning and coordination, training/education, policy/procedure development, and transition from foster care. This document outlines the many disciplines that PHNs need to work with to accomplish the goals of the program. The PHN role includes interpretation of health care reports, developing health plans, referrals for needed care, and evaluation of placements in light of health care needs. The PHNs also were charged with educating other disciplines regarding the health care needs of children in foster care and with providing consultation with Child Welfare/Probation Departments regarding policy.

Theoretical Framework for Health Case Management Role

The difficulties meeting the health care needs of foster care children and the proposed solutions call for a more comprehensive way of looking at health and health care. Viewing health issues from a Social Ecological Model accounts for both the causes of illness and proposes new ways to promote holistic health, prevent illness, and treat patients. The emphasis is caring for individuals, families, and communities prior to their descent into illness (called upstream thinking) (Butterfield, 1990). This model takes into account age, gender, race, ethnicity, and socioeconomic differences that affect how individuals function and grow, and therefore directly and indirectly influence health risks and resources (Institute of Medicine, 2000). The environment (social, political, and economic) is an important part of the equation in determining health in the Social Ecological Model (Lomas, 1998). These demographic and societal issues are some of the same causes of the burgeoning population of foster care children.

The Public Health Interventions Model described by the Minnesota Department of Health (2000) operationalizes the Social Ecology Model for public health nurses, including foster care nurses. This intervention model focuses on the broad determinants of health such as income, social status, housing, food security, social support networks, education, neighborhood safety, cultural customs, and community capacity of support family, as well as on prevention. The social, political, and economic environments of the Social Ecological Health Model are the same as the broad determinants of

health in the Minnesota Model. The practice arena of the nursing interventions includes individual and family, community, and system-wide. The Minnesota Model is incorporated into the public health nursing practice model adopted by Los Angeles County Public Health Nursing Department (Smith & Bazini-Barakat, 2003).

The Public Health Intervention Model, often called the Wheel because of its shape, specifies 17 interventions that are independent functions of the public health nurse (see Table 2). The model focuses on populations, identification of the at-risk groups, and assessment of health status to determine health needs. The Wheel has five related categories. Case finding is part of the interventions of surveillance, disease investigation, outreach, and screening. Case management is related to referral and follow-up, counseling, and consultation. Community focuses interventions include collaboration, coalition building, and community organization. The fifth category of system-focused interventions includes advocacy, social marketing, and policy development and enforcement (Minnesota Department of Health, 2000).

The new foster care nurses have the opportunity to address some of the concerns raised in reports criticizing the existing system of health care delivery to foster care children within California (Department of Health Services: Little Hoover Commission Report, 1999; Institute for Research on Women and Families, 1998). The nurses' ability to meet the health care needs of this vulnerable population will depend on their ability to function in their case management role and chose applicable interventions. The Minnesota Public Health Intervention Model provides a powerful framework for nurses to deliver care to foster children.

Informal Observation of Foster Care Nurses

From December of 2002 through February of 2003, the author observed PHNs in Los Angeles County in their role as health case managers for the child welfare agency. Los Angeles County is one of the largest foster care systems in the United States (USC clinic, 2004). Six nurses were observed for a 4-hour period of time performing their job within the local child welfare offices. The nurses' activities were recorded and then categorized using the Minnesota Public

Table 2. Public Health Interventions

Minnesota Public Health Interventions (2000)	Definitions
1. Surveillance	Ongoing and systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event
2. Disease and Health Event Investigation	Systematic gathering and analysis of data regarding unexpected threats to the health of populations
3. Outreach	Finding those at risk, provide information about the nature of the risk, what can be done about it, and how services can be obtained
4. Case Finding	Locating individuals/families with identified risk factors and connecting them with resources
5. Screening	Identifying unrecognized health risk factors or asymptomatic disease conditions in populations
6. Referral and Follow-up	Assisting client(s) to use necessary resources to prevent or resolve problems or concerns
7. Case Management	Process that optimizes self-care capabilities of client(s) and the capacity of systems/communities for service provision
8. Delegated Functions	Direct-care tasks and functions performed under delegation from health care practitioners as allowed by law or as judged appropriate
9. Health Teaching	Process that enhances positive health and prevents illness through changing knowledge, attitudes, values, beliefs, behaviors, practice and skills
10. Counseling	Interpersonal relationship between the nurses and client(s) intended to increase or enhance capacity for self-care and coping
11. Consultation	Interactive problem-solving between nurse and client in which optional solutions are jointly generated
12. Collaboration	Commitment of two or more persons in organizations to enhance capacity and achieve a mutual goal
13. Coalition Building	Promotion and development of alliances among organizations or constituencies for a common purpose
14. Community Organizing	Process by which community groups are helped to identify common problems/goals, mobilize resources, and develop/implement strategies to reach goals
15. Advocacy	Plead someone's cause or act on someone's behalf with the focus on developing capacity to be own advocate
16. Social Marketing	Adaptation of commercial marketing principles and technologies to influence and improve health of populations
17. Policy Development and Enforcement	Process through which a health issue achieves a place on decision-makers' agenda, acquires a plan of resolution, and is assigned needed resources

Health Intervention guide. Two independent coders also reviewed the list of activities and the coding decisions based on the definitions and examples in the Minnesota Manual (Minnesota Department of Health, 2000). The three coders conferred and agreed on coding decisions.

The types of interventions practiced most frequently were dependent on the team. The interventions most frequently observed were health teaching, referral and follow-up, surveillance, case management, and collaboration. All but surveillance are interdependent interventions and need other members of the team to be effective. These interventions were observed in conjunction with child social workers, health care providers, and foster parents. The written PHN job descriptions specifically detailed the interventions of collaboration, referral and follow-up, and case management, and these interventions were observed frequently.

The nurses were not observed practicing counseling and infrequently observed practicing advocacy and consultation. Advocacy requires acting on someone's behalf with a focus on developing that person to become their own advocate. Consultation is interactive problem solving with a client so the client can select the best solution. Counseling is having an interpersonal relationship that increases the client's capacity for self-care and coping. All these interventions require interaction with a client that increases the client's ability to make healthy choices, advocate for themselves, or perform self-care. These interventions require the nurse to let go of the process and let the client do for him- or herself. The process is in educating, exploring solutions, and allowing freedom for the client to use the information to make choices. Most of the observations reflected the nurse intervening on behalf of the client and not involving the client in the process or choices. This may be appropriate for nurses working in protective services with minors, because the Child Welfare agency has the ultimate responsibility for the safety of the child. However, involving foster caregivers will increase their ability to care for these medically fragile children, and will likely make the nurses' interventions more long-lasting.

Public health interventions can be practiced at three levels, and should be implemented at multiple-practice levels, either simultaneously or

Source: Adapted from Minnesota Department of Health, 2000.

sometimes sequentially (Minnesota Department of Health, 2000). The three levels are individual and family, community, and systems. To successfully practice at the system-focused level, the interventions need to be multidisciplinary. These types of interventions are generally longer lasting and a way to impact more clients. System interventions include changing organizations, policies, and laws. The child welfare nurses were not observed practicing the interventions of policy development and enforcement or community organizing. Because the foster care nurses were adept at working within a multidisciplinary team, they might be able to use these skills for working at the system level also.

Future of the Foster Care Nursing Role

As an example of intervening at a system level, foster care nurses were major participants in a multidisciplinary foster care health care policy summit in Los Angeles in May, 2005, funded by the California Endowment and sponsored by The Alliance for Children's Rights and The Children's Law Center of Los Angeles. The nurses' in-depth knowledge of the difficulties that are faced within the foster care system in obtaining, coordinating, planning, and communicating about health care needs and services was voiced in each of the six breakout sessions. Policy recommendations from the conference included a more integrated approach between the health care community and the child welfare system, with the PHN integral to optimum coordination.

Research on this new nursing role is needed to explore how nurses are used in different child welfare agencies; whether nurses can affect the integration and communication between services for foster children; and the relationship between teamwork, client involvement, and effective interventions. The Health and Education Passport can be significant tool in evaluating the nurses' impact on health. The Minnesota Intervention Model provided a useful framework for the informal observations and can be used in more formal research activities.

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