Charlie and Nadine H. v. Corzine

Supplemental Monitoring Report: An Assessment of Provision of Health Care Services for Children in DYFS Custody

Center for the Study of Social Policy
1575 Eye Street, NW, Suite 500
Washington, DC 20005

December 22, 2009

ACKNOWLEDGEMENTS

The Center for the Study of Social Policy (CSSP), the Federal Court Monitor for *Charlie and Nadine H. v. Corzine*, would like to thank those organizations and individuals who assisted us in conducting this review. We would like to thank the Department of Children and Families (DCF), for its assistance in finalizing the Review instrument, coordinating the receipt of case records, supplying reviewers, and otherwise supporting the Review process. The Office of the Child Advocate also contributed by reviewing and commenting on drafts of the Review instrument and by supplying case reviewers. The Monitor would especially like to thank the members of the on-site Review Team from New Jersey's DCF, New Jersey's Office of the Child Advocate, and nurses employed by the Francois Xavier Bagnoud Center located within the University of Medicine and Dentistry of New Jersey who are contracted to work in DYFS Child Health Units. Their assistance was invaluable.

Supplemental Monitoring Report: An Assessment of Provision of Health Care Services for Children in DYFS Custody

TABLE OF CONTENTS

LIST OF TABLES

Table

LIST OF FIGURES

Figure

Supplemental Monitoring Report: An Assessment of Provision of Health Care Services for Children in DYFS Custody

I. INTRODUCTION AND SUMMARY

Purpose of this Report

In July 2006, the Center for the Study of Social Policy (CSSP) was appointed by the Honorable Stanley R. Chesler of the United States District Court for the District of New Jersey as Federal Monitor of the class action lawsuit *Charlie and Nadine H. v. Corzine*.[1] As Monitor, CSSP is charged with independently assessing the State's progress in meeting the requirements and outcomes established in the Modified Settlement Agreement, approved by the Court in July 2006, and directed to correcting longstanding problems in the performance of the State's child welfare system.

CSSP has issued, to date, five comprehensive monitoring reports[2] assessing the State's progress on all of the Phase I requirements in the Modified Settlement Agreement (MSA). As the State moves forward with its reform, now the Monitor is charged with reporting on a larger range of Phase II performance benchmarks related to the provision of services to children and families and the results (outcomes) of the State's interventions to protect children and ensure their permanent placement with families and their overall well-being. This supplemental monitoring report is focused on the provision of health care services to children entering foster care. The case record review also examined the Department of Children and Families' Division of Youth and Family Services' (DCF/DYFS) performance on a range of the MSA's visitation requirements (e.g., social work visits with children and their parents), results of which are included in an upcoming Monitoring Report.

In examining the health care experience of children entering out-of-home placement, the Monitor examined performance on pre-placement medical assessments for children entering out-of-home care; full medical examinations for children within 60 days of placement; mental health assessments for those children with a suspected mental health need; the immunization status of children in out-of-home placement; the provision of medical information to a child's caregiver

[1] *Charlie and Nadine H. et al. v. Corzine*, Modified Settlement Agreement, United States District Court for the District of New Jersey, Civ. Action No. 99-3678 (SRC), July 18, 2006.

[2] See respectively, *Progress of the New Jersey Department of Children and Families: Period I Monitoring Report for Charlie and Nadine H. v. Corzine—June 2006 through December 31, 2006*. Washington, DC: Center for the Study of Social Policy. February 26, 2007; *Progress of the New Jersey Department of Children and Families: Period II Monitoring Report for Charlie and Nadine H. v. Corzine—January 1, 2007 through June 30, 2007*. Washington, DC: Center for the Study of Social Policy. October 26, 2007; *Progress of the New Jersey Department of Children and Families: Period III Monitoring Report for Charlie and Nadine H. v. Corzine—July 1, 2007 through December 31, 2007*. Washington, DC: Center for the Study of Social Policy. April 16, 2008; *Progress of the New Jersey Department of Children and Families: Period IV Monitoring Report for Charlie and Nadine H. v. Corzine—January 1, 2008 through June 30, 2008*. Washington, DC: Center for the Study of Social Policy. October 30, 2008; and *Progress of the New Jersey Department of Children and Families: Period V Monitoring Report for Charlie and Nadine H. v. Corzine—July 1 through December 31, 2008*. Washington, DC: Center for the Study of Social Policy. April 27, 2009.

within five days of placement; and the receipt of follow up care and treatment to meet health and mental health needs. To understand visitation patterns, the Monitor examined the number of visits by caseworkers with children in state custody; visits by caseworkers with parents; visits between children and parents; and visits among separated siblings.

A decision was made to assess performance in these areas through an independent case record review of a statistically valid sample of cases, as the State concurrently pursues work to accurately report on these requirements through NJ SPIRIT, their management information system. This report provides both baseline information on some requirements not previously available through NJ SPIRIT and provides independent analysis of some information reported through NJ SPIRIT. Appendix A provides a summary of the relevant MSA requirements that were assessed during this review and presents the findings in comparison to established benchmarks for performance (some of which are not scheduled to be achieved until later in Phase II of the MSA). In these instances, the information is provided to understand baseline performance in relation to what is expected of the agency.

The case record review was designed to provide information on important elements of children's experiences when they are first removed from their homes due to child abuse and/or child neglect and placed by the State in out-of home care. The Review focused on those children who entered out-of-home care between July 1 and December 31, 2008 and who remained in care at least 60 days. The Review examined the provision of timely health and mental health care and the visitation patterns among children and their families and caseworkers as described above. The Review did not examine the health care experiences of children in care longer than six months. As a result, this Review did not look at medical examinations in compliance with Early and Periodic Screening, Diagnosis, and Treatment guidelines or semi-annual dental visits.

Staff and consultants of the Federal Court Monitor were joined in conducting the Review by representatives of the New Jersey Office of the Child Advocate (OCA), staff of the Division of Youth and Family Services (DYFS), and nurses from DYFS Child Health Units. The data analysis and preparation of findings and recommendations are the product of the Federal Court Monitor.

Summary of Findings

As is discussed more in the body of the report, DCF has embarked on an ambitious agenda to improve the delivery of health care services for children in foster care. Its plan to create Child Health Units staffed by nurses in every DYFS local office holds promise of ensuring that each child's medical and mental health needs are thoroughly assessed and promptly and appropriately treated. As of February 2009,[3] DCF had hired and put into position 50 percent of the targeted number of nurses (health care case managers) and 93 percent of staff assistants. The Monitor's findings, analysis of reasons behind them, and recommendations on health care delivery are intended to be useful to the State as it fully develops and implements its health care plan throughout Phase II of the MSA.

In the course of the Review, the Monitor also was able to collect data on several other important issues, including where children are placed when they first enter out-of-home care, how often

[3] As of June 30, 2009, the percentage of filled health care case managers was 79% and staff assistants was 98%.

children change placements during the Review time period and what is documented in case records about the timely provision of information to foster parents about the children placed in their homes.

Placement Type and Stability

- For the Review sample of children entering care between July 1 and December 31, 2008 and remaining in care for at least 60 days, 58 percent (58%) of children experienced one placement. Twenty-five percent (25%) of children experienced two placements, 9 percent had three placements, 5 percent had four placements, and 2 percent of children had five or more placements.

- By March 6, 2009, the end of the Review period, 37 (3%) children had exited care, with 92 percent of those 37 children being reunified with a parent, one child entering detention, one youth exiting to independent living, and one child exiting into the care of a maternal grandmother.

- Eighty-one percent (81%) of children were initially placed in a family-like setting when they came into foster care, with 35 percent of children placed with a relative or family friend and 46 percent placed in a resource family home.

Health Care Assessment and Service Delivery in the First Six Months in Care

- Ninety-one percent (91%) of children entering out of home care received a pre-placement medical assessment in a non-emergency room setting.

- Seventy-four percent (74%) of children received a comprehensive medical examination within 60 days of out-of-home placement.

- Forty-six percent (46%) of children entering out of home care received a mental health screen to determine if they had a mental health need.

- All of the children (100%) who were screened and determined to have a suspected mental health need received a full mental health assessment.

- Eighty-three percent (83%) of children were up-to-date on their immunizations after their comprehensive medical examination.[4]

- Forty-one percent (41%) of children received follow up care for at least one identified health or mental health need. Dental care, mental health services, and eye appointments were the services for which children were most likely to be waiting.

- Ninety-nine percent (99%) of children who experienced an acute or episodic health need during the Review period received treatment.

[4] Immunization status was only measured for those children in the sample who had a CME.

- Fifty-one percent (51%) of children who experienced an acute or episodic mental health need during the Review period received treatment.

- Eighty-three percent (83%) in the sample had an identified medical home (usually a primary care physician) and 71 percent of children were connected to the Child Health Units for review and management of their health care needs.

Sharing Information about Health History and Health Needs

- Reviewers found documentation that Health Passports (containing medical information about a child) were conveyed to caregivers within five days of a child's placement in 13 percent of cases. Another 47 percent of caregivers eventually received the Health Passport. There was no evidence of a Health Passport provided to a child's caregiver in 40 percent of cases.

- There is minimal documented evidence that medical information from the comprehensive medical examination is shared beyond DCF/DYFS staff (that is, reviewers found little documentation that the results of medical exams were provided to birth parents, relative caregivers and resource parents).

Recommendations related are included in Sections IV of this report.

The report is organized as follows:

Section II. **Methodology** provides an overview of the Review Team, information collected, and how the information was analyzed.

Section III. **Demographic data** of the sample, including information about the number of placements children experienced during the Review time period.

Section IV. **Health and Mental Health Care** Findings and Recommendations

Appendix A contains Select Indicators from *The Child and Family Outcome and Case Practice Performance Benchmarks* that relate to the findings and recommendations of this assessment

Appendix B contains a copy of the data collection instrument.

II. METHODOLOGY

The case record review was conducted from May 26 – June 5, 2009. The Review Team consisted of staff of the *Charlie and Nadine H. v. Corzine* Federal Court Monitor (The Center for the Study of Social Policy), consultants hired by the Monitor, nurses employed by the Francois Xavier Bagnoud Center (FXB) located within the University of Medicine and Dentistry of New Jersey (UMDNJ) who are contracted to work in DYFS Child Health Units, employees from New Jersey's Department of Children and Families, and staff from New Jersey's Office of the Child Advocate (OCA). The total pool of available reviewers was 18, although approximately 10-12 individuals reviewed cases each day during the two week review period.

The CSSP case Review Team designed a sampling plan, developed a structured data collection instrument, trained the Review Team, employed a quality assurance approach to ensure inter-rater reliability, and utilized SPSS for data analysis. These activities were accomplished as follows:

1. Sample Plan and Implementation

The universe of children for the case record review was every child who entered New Jersey's state custody between July 1 and December 30, 2008 and remained in custody for at least 60 days. From this group, a random, statistically valid sample of cases were chosen, designed to produce a $\pm$ 5 percent margin of error with 95 percent confidence in its results.

Three hundred (300) cases were randomly selected from the total universe of 2020 children meeting the aforementioned criteria. Eight cases were dropped from the sample because upon review of the case file they failed to meet the criteria (the cases dropped involved children who were not in DYFS custody at all or not in care for the full 60 days). The total number of cases included in the analysis was 292 children; the reduction from 300 to 292 did not affect the statistical margin of error.

The Review Team used a structured instrument (see Appendix B) for data collection. Each team member had access to NJ SPIRIT (New Jersey's computer based child welfare information management system), the auxiliary paper files from DYFS workers, and health care records compiled by Child Health Unit staff, when available, to confirm and gather data needed to complete each case record review.

2. Data Collection

The structured data collection instrument used to review the case records was produced using Survey Monkey, an online software tool used for creating surveys and questionnaires. This instrument was designed in collaboration with Troy Blanchard, Ph.D. of Louisiana State University. Drafts of the instrument were reviewed by DYFS staff and staff of the Office of Child Advocate. Three CSSP staff pilot tested the instrument in early May and made adjustments as necessary. On-site data collection took place May 26 – June 5, 2009 in a central location in Trenton, New Jersey.

3. Reviewer Training

Each reviewer participated in a four hour training facilitated by a senior staff member of the Federal Court Monitor (the Center for the Study of Social Policy). The training included: reviewing the tool, learning to navigate NJ SPIRIT, and reviewing an example case record. The results of the test case record were discussed in-depth to ensure uniformity in decision making.

4. Quality Control and Assurance

All auxiliary DYFS paper and health case record files were brought to a central review site in Trenton, NJ. Child Health Unit representatives and DCF staff assisted reviewers in understanding medical records and DYFS case notations. During the two week review, three Monitor staff checked data collection instruments for completeness and internal consistency prior to data entry and analysis. For the first two days of the Review, each record received a full second review by Monitor staff to ensure consistency and inter-rater reliability among the reviewers. Subsequently and throughout the data collection period, Monitor staff conducted random second reviews of cases for consistency and completeness.

5. Data Analysis

The data collection instruments were coded into a format that allowed statistical analysis using the SPSS (Statistical Package for the Social Sciences) computer program. Review Team comments were also captured and reviewed to gain a greater understanding of each case reviewed.

6. Limitations of Case Record Review

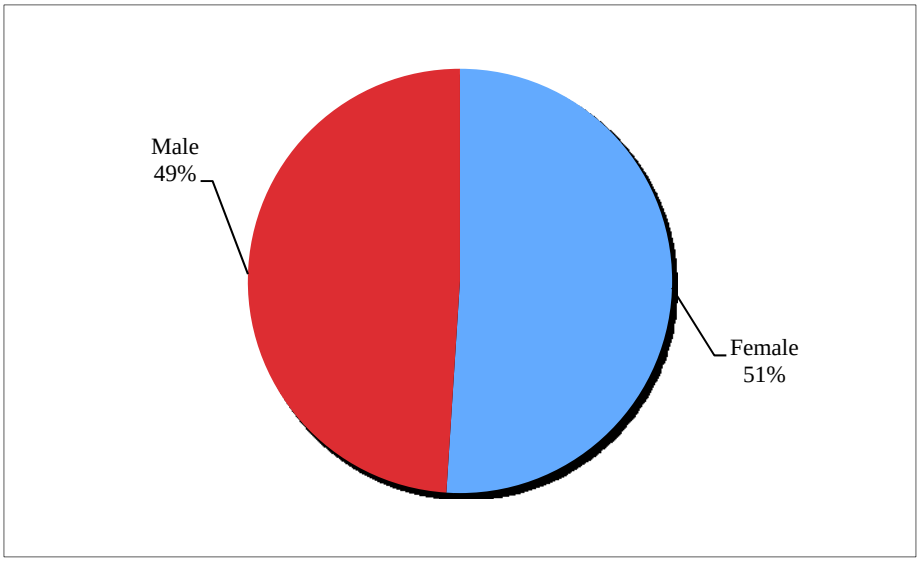
The Review only assesses practice based on the documentation in the case record. The Review relied exclusively on documentation in NJ SPIRIT, the DYFS paper case file, and if available the Child Health Unit case file. There were many instances of incomplete documentation, so it is possible that there were additional efforts to secure health care and conduct visitations for children in out-of-home care that were not documented and therefore not credited in the Review. Additionally, case record reviews have limitations in assessing the comprehensiveness and quality of service delivery. Some questions, such as understanding the full nature of follow up care children receive for health needs, are more completely understood by a qualitative review in which caregivers and providers are interviewed.

III. DEMOGRAPHIC INFORMATION ON REVIEW SAMPLE

Gender

As shown in Figure 1, of the 292 children, in the sample 149 (51%) were female, and 142 (49%) were male. This is comparable to DCF's reports that on December 31, 2008, of all of the 8,846 children in out-of-home placement, 48 percent were female and 52 percent were male.[5]

Figure 1: Gender of Children in Case Record Review Sample of Children Entering Care between July 1 and December 31, 2008 (n=292)



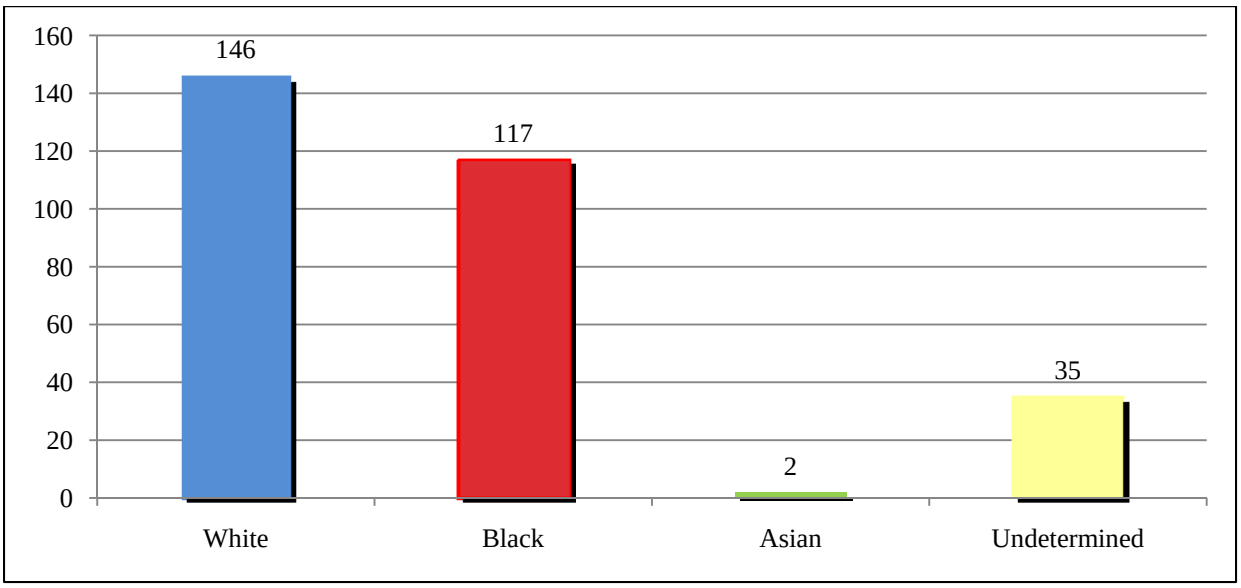
Source: CSSP case record review, June 2009

Race/Ethnicity

One hundred forty-six (146) children in the sample were identified as white; 117 as Black or African American; 2 were Asian; and in 35 cases the child's race was undocumented or unable to be determined. In many cases, the child was of more than one race.

[5] This data is not a true comparison since DCF's data represent the children in care on December 31, 2008 and data collected for the review examine a cohort of children entering care within a six month time period and staying in care for at least 60 days.

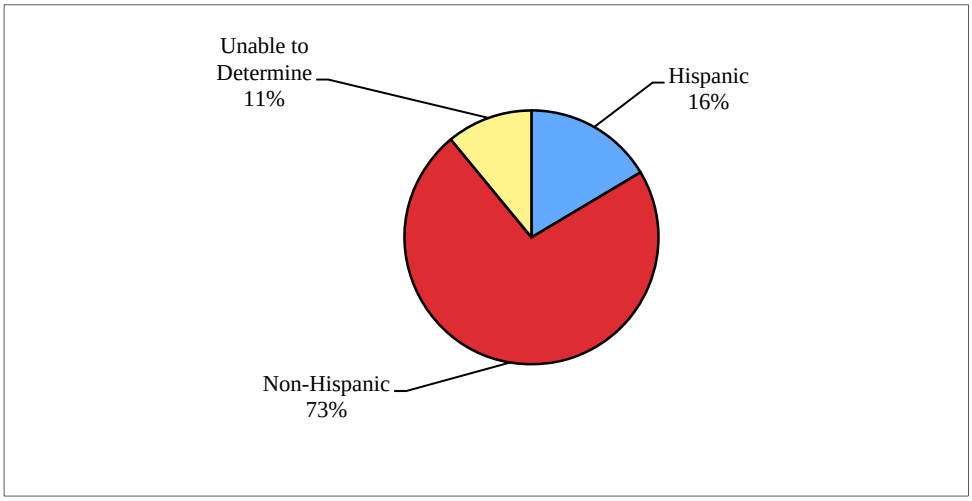
Figure 2: Race of Children in Case Record Review Sample of Children Entering Care between July 1 and December 31, 2008



Source: CSSP case record review, June 2009

Hispanic ethnicity was the only ethnicity regularly recorded by DCF. Forty-eight (48) children were determined to be Hispanic, 212 were non-Hispanic, and the ethnicity for 32 children was not determined. Overall, there is not consistent documentation of children's race and ethnicity.

Figure 3: Ethnicity of Children in Case Record Review Sample of Children Entering Care between July 1 and December 31, 2008 (n=292)



Source: CSSP case record review, June 2009

Age

Children entering care ranged in age from newborn to 18 years old. The following table lists the number of children by age. Fifty-four percent (54%) of children who entered care were age five or younger, with the largest percentage (26%) under the age of one. DCF reported that on December 31, 2008, 50 percent of all children in out-of-home placement were age five or younger, with 25 percent under the age of two.

Table 1: Age of Children in Case Record Review Sample (n=292)

Age	Number	Percent
Age 0	75	26
Age 1	21	7
Age 2	16	6
Age 3	22	7
Age 4	14	5
Age 5	10	3
Age 6	10	3
Age 7	10	3
Age 8	12	4
Age 9	16	6
Age 10	7	2
Age 11	5	2
Age 12	12	4
Age 13	4	5
Age 14	11	4
Age 15	16	6
Age 16	13	5
Age 17	17	6
Age 18	1	0

Source: CSSP case record review, June 2009

A small, but significant, number of children entering foster care have major medical needs.

As is the case nationally, a meaningful number of children entering foster care had a myriad of significant physical and mental health problems. Twenty-three (8%) of the children in the Review sample were considered by DYFS to be "medically fragile." These children faced a variety of medical complications, examples include:

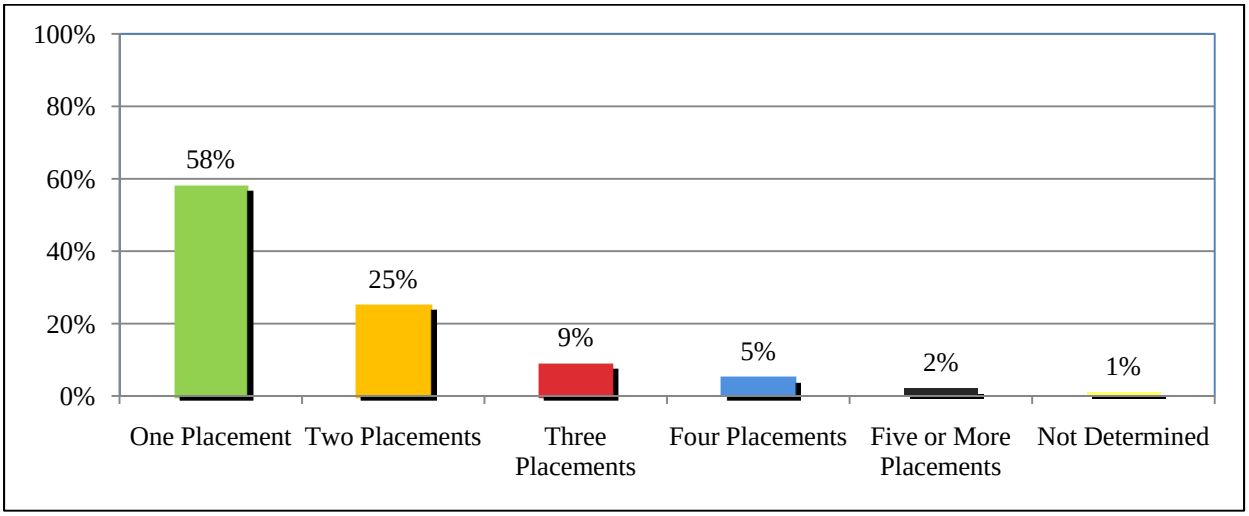
- infants born premature and with significant complications due to prenatal drug and alcohol exposure
- complications from HIV positive status
- lung disease
- severe developmental delays

- complications from Shaken Baby Syndrome
- need for feeding tubes ("g-tube")
- heart abnormalities

Placement experience when entering out of home care

Children in the sample were in out-of-home placement anywhere from 60 days to six months at the time of the Review.[6] During this time period, the majority (169 children/58%) experienced one placement, 73 children (25%) had two placements, 26 children (9%) had three placements, 15 children (5%) had four placements, and five children (2%) children had five or more placements. Reviewers were unable to determine the total number of placements for four children (1%).[7]

Figure 4: Number of Placements for Children Entering Care between July 1 and December 31, 2008 and remaining in care 60 days or more (n=292)



Source: CSSP case record review, June 2009

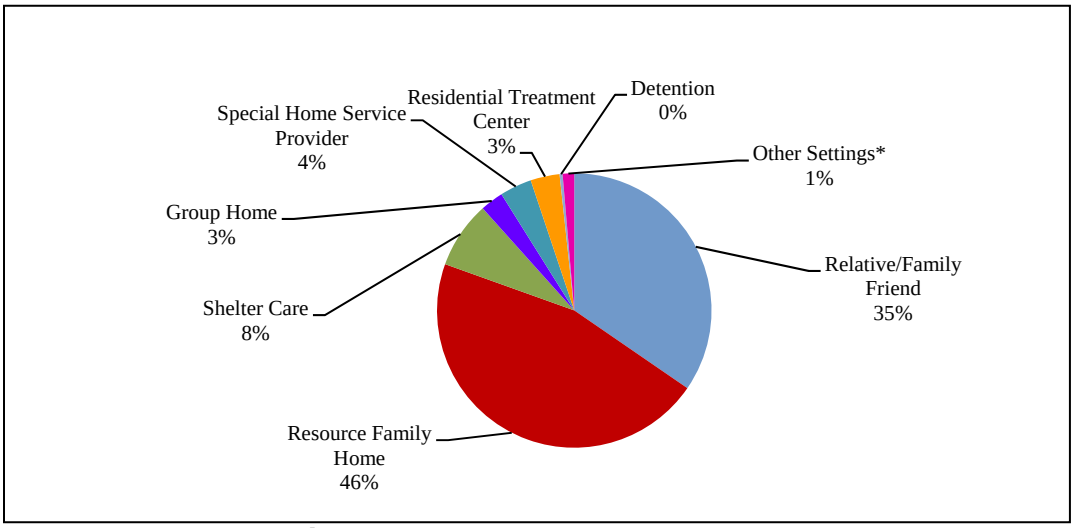
Type of placements

The initial out-of-home placement for 81 percent (81%) of children was in a family-like setting – 101 (35%) children were placed with a relative/family friend and 134 (46%) were placed in a resource family home. Other settings included shelter care, (23 children—8%); group home, (8 children—3%); special home service provider; (11 children—4%); residential treatment center, (10—3%); detention, (less than 1%); and four children (1%) were in other settings (teen mother baby program; substance abuse treatment; unable to determine). Figure 5 below shows placement settings of the children in the sample at initial placement.

[6] The time in care for children in this sample ranged from just over 60 days to the entire review period and beyond. Thirty-four children (12%) went home during the review period, and 3 others exited through reunification with a grandparent, commitment to detention, or independent living.

[7] From the documentation in the record, the total number of placements was not clear. In all 4 of these cases, children experienced more than one placement.

Figure 5: Type of Initial Out-of-Home Placement for Children Entering Care between July 1 and December 31, 2008 and Remaining in Care for 60 days or more (n=292)



Source: CSSP case record review, June 2009

As noted above, 123 children experienced multiple placements during the Review period. Seventeen of those children (17) exited care by March 6, 2009, [8] the last date of the Review period. For the 106 children who remained in care, 76 percent were living in a family-like setting. Table 2 below captures the placement of children who moved from their initial placement and remained in care.

Table 2: Placement Settings for Children Experiencing Multiple Out-of-Home Placements and still in care as of March 6, 2009 (n=106)[9]

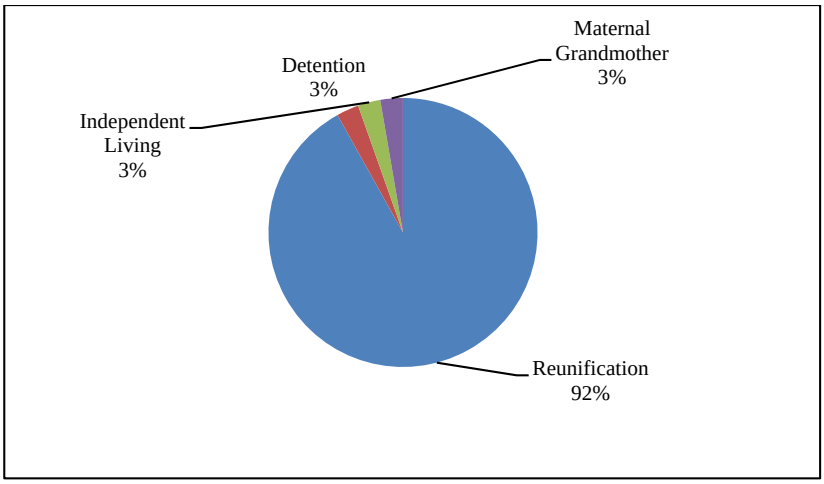
Type of placement	Number of children(percentage)
Relative/Family Friend	38 (36%)
Resource family	42 (40%)
Residential treatment	8(8%)
SHSP	4(4%)
Group home	4(4%)
Shelter	4 (4%)
Other	6 (6%)

Source: CSSP case record review, June 2009

[8] An additional 19 children in the Sample who had only one placement and 1 child who reviewers could not determine number of placements also exited care by March 6, 2009.
[9] Due to rounding of percentages to nearest whole number, the total does not equal 100 percent.

By March 6, 2009, a total of 37 children (13% of the sample) entering care between July 1 and December 31, 2008 had exited care. Thirty-four of these children (92%) were reunified with a parent, one child entered detention, one child exited to independent living, and one child exited into the care of a maternal grandmother. (See Figure 6 below).

Figure 6: Type of Exit for Children in Case Record Review Sample Exiting Care by March 6, 2009
(n=37)



Source: CSSP case record review, June 2009

IV. HEALTH AND MENTAL HEALTH CARE

Between 2007 and 2009, DCF redesigned the health care delivery system for children and youth in out-of-home care in accordance with the Modified Settlement Agreement (MSA). The case record review was designed in part to provide an independent verification of many of the health care services DCF is required to provide under the MSA and as specified under DCF's *Coordinated Health Care Plan for Children in Out-of-home Placement.* Specifically, the Review measured:

- Provision of pre-placement medical assessments to all children entering out of home care and the timing and location of these assessments (MSA, II.F.2.i & 3)
- Provision of information regarding a child's health status and needs (Health Passport) to a child's caregivers within five days of that child's placement (II.F.8)[10]
- Provision of a Comprehensive Medical Examination (CME) to all children in out of home care for 60 days or more (MSA, II.F.2.ii)
- Provision, as part of the CME, of a mental health screen and, for those children with suspected mental health needs, provision of a full mental health assessment (MSA, II.F.2.v)
- Immunization status of children in out-of-home placement
- Follow up medical and mental health care for children in out-of-home placement (MSA, II.F.2.vi)

Some of the health indicators required under the MSA are not addressed in this report and cannot be measured using the sample of children newly entering out-of-home care. Specifically, the Review does not look at medical examinations in compliance with EPSDT guidelines for children in care one year or more and semi-annual dental examinations for children ages three and older in care for six months or more. Assessing performance on these measures requires that children be in care for a period of time longer than the parameters of the Review sample. These requirements will be measured through other methods and/or in subsequent case record reviews.

DCF's *Coordinated Health Care Plan for Children in Out-of-home Placement* (May 2007) outlines the current obstacles to accessing quality health care services for children in out-of-home placement and the State's plan to deliver services to them. This plan described new Child Health Units to be built in each DYFS local office. These units consist of a clinical nurse coordinator, health care case managers (nurses), and staff assistants. A regional nurse administrator supervises local units for a particular region (aligning with the division of DCF Area Offices). DCF worked with University of Medicine and Dentistry of New Jersey's

[10] MSA section II.F.8 requires the State to develop a medical passport for children in out-of-home care. Subsequent negotiations with the State resulted in the requirement that these passports are conveyed to the caregiver within 5 days of placement. DCF policy currently requires the Health Passport to be conveyed within 72 hours of placement.

Francois-Xavier Bagnound Center (FXB) and DYFS local offices to build these units. At the time of the Review, as of February 28, 2009, DCF reported that 121 of the 243 health care case manager positions were filled and 115 of the 123 staff assistant positions had been filled, with ongoing recruitment and hiring of additional nurses and staff assistants.

DCF's *Coordinated Health Care Plan* also required that children receive pre-placement assessments within 24 hours of entering out-of-home care and that most of these assessments be provided in non-emergency room settings. Health care case manager nurses in the Child Health Units were to be available to conduct some of these assessments with others occurring in the community. Further, the plan modified the manner in which Comprehensive Medical Examinations (CMEs) are delivered. CMEs are now provided through a varied of community-based medical providers including children's own pediatricians. Whereas previously a small number of contracted providers conducted a specialized medical, neurological and psychological examination known as the Comprehensive Health Evaluation of Children (CHEC), a larger pool of providers now conduct an examination of a child's health systems, developmental history, and a screening examination for a child for mental health needs. If a mental health need is suspected based on the screening, the child is then expected to receive a full mental health assessment from the CME provider that conducted the examination or another qualified provider.

FINDINGS

1. Documentation in case files showed that in 98 percent of cases pre-placement assessments occur for children entering out-of-home care, and most assessments are provided in a non-emergency room setting.

The MSA requires that all children entering out-of-home care receive a pre-placement assessment (PPA) within 24 hours of placement and the vast majority of assessments should be in a non-emergency room setting. According to DYFS policy, the purpose of a pre-placement assessment is "to evaluate and document whether a child entering care appears free of

- Acute health issues
- Contagion
- Injuries and/or bruising requiring immediate medical attention

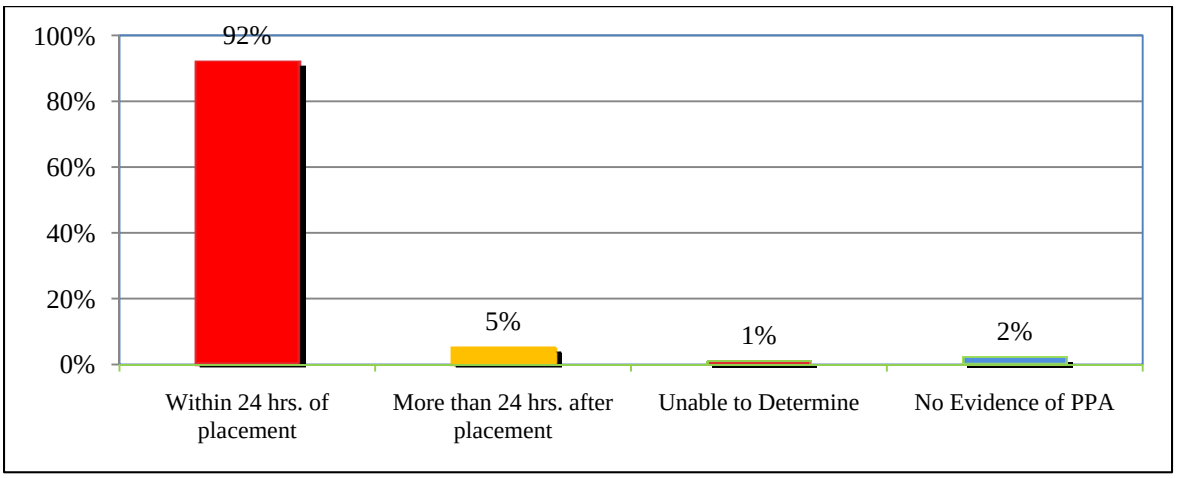
The assessment also provides information about the child's health care needs that is to be shared with the child's substitute caregiver, Worker, and primary care doctor."[11]

Almost all (285/98%) of the children in the sample had evidence in the case file and/or NJ SPIRIT of receiving a pre-placement assessment (PPA) associated with their first out-of-home placement. The vast majority (268/92%) received their pre-placement assessment within 24 hours of placement. Fourteen children (5%) had a pre-placement assessment more than 24 hours after placement, reviewers were unable to determine timing of pre-placement assessments for three children (1%), and reviewers found no evidence of a PPA for seven children.[12] (See Figure 7 below).

[11] DYFS Policy Manual IIK, 1201.2.

[12] For one of the seven children there was documentation that a PPA occurred 16 days after initial placement. For purposes of this review, an assessment at that point is not considered a PPA.

Figure 7: Pre-Placement Assessments to Children Entering Out-of-Home Care (n=292)

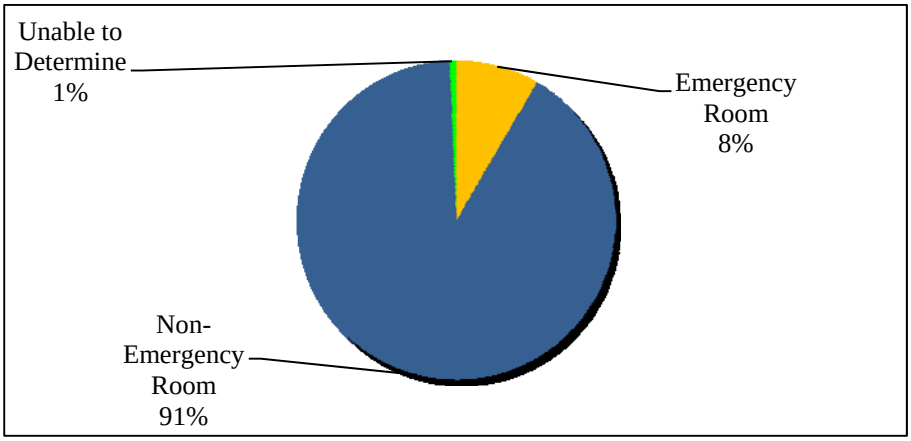


Source: CSSP case record review, June 2009

Ninety-one percent (91%) of children receiving a PPA had this assessment in a non-emergency room setting. Twenty-four children (8%) received the PPA in an emergency room setting, and for two children (1%), reviewers were unable to determine based on the evidence in the record where the PPA occurred. (See Figure 8 below).

Based on the documentation, DYFS is utilizing a variety of practitioners to provide PPAs to children in a non-emergency room setting. In 64 cases, DYFS Child Health Unit nurses provided the PPA and 12 children saw their primary care provider for the PPA. For many of the infants entering care, the PPA was conducted at the hospital where they were born before they were directly released into DYFS custody (21 cases). Other providers of PPAs included residential treatment centers, shelters, and after-hours nurses contracted by DYFS.

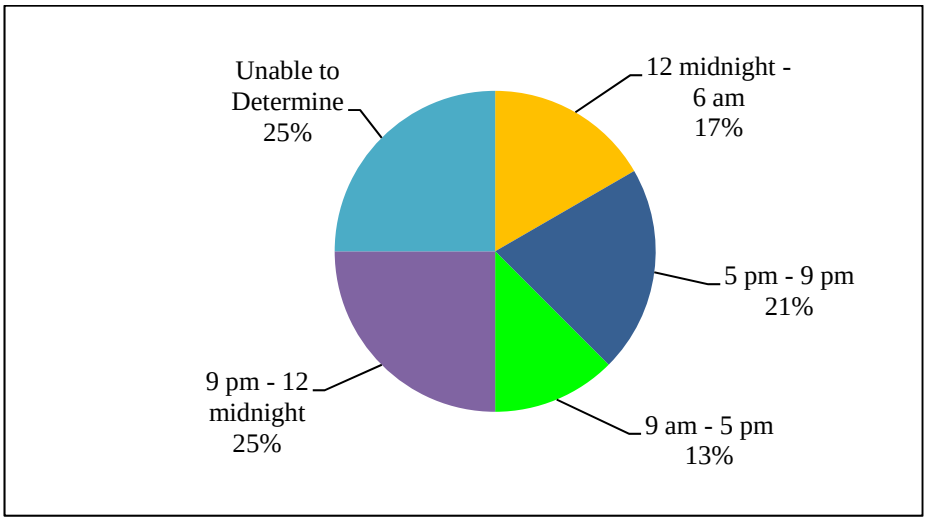
Figure 8: Location of Pre-Placement Assessment (n=285)



Source: CSSP case record review, June 2009

Of the PPAs that occurred in an emergency room setting, the majority occurred during non-office hours. Only three of the 20 PPAs in emergency rooms occurred during office hours. Reviewers noted that for several of the PPAs that occurred in an emergency room, the child or the parent had been brought to this location for medical treatment prior to a DYFS decision to place the child.

Figure 9: Timing of Pre-Placement Assessments in Hospital Emergency Rooms (n=24)



Source: case record review, June 2009

2. ***Subsequent pre-placement assessments, also known as replacement assessments are occurring but not for all children.***

Neither DCF/DYFS policy or the MSA require a pre-placement assessment before each subsequent foster care placement if a child changes placement while in DYFS custody. According to DCF policy, the DYFS worker, nurse, and if needed supervisor determine on a case-by-case basis if a pre-placement assessment is needed for a subsequent placement. As children change placements, the likelihood of them receiving a pre-placement assessment decreases. One hundred twenty-three (123) children in the sample experienced a second out-of-home placement during the Review time period.[13] Of those children, 81 (66%) received a replacement assessment. Seventy-six (94%) of these assessments occurred in a non-emergency room setting, one (1%) in an emergency room, and the location of 4 (5%) assessments could not determined. Of the 81 children receiving replacement assessments, 73 (90%) occurred within 24 hours of placement, two (3%) occurred more than 24 hours later, and the timing of six (7%) were not able to be determined based on the evidence in the record. The number of children who experienced three or more placements during the Review period was 46; the Monitor could not draw a statistically valid conclusion about assessments from this number.

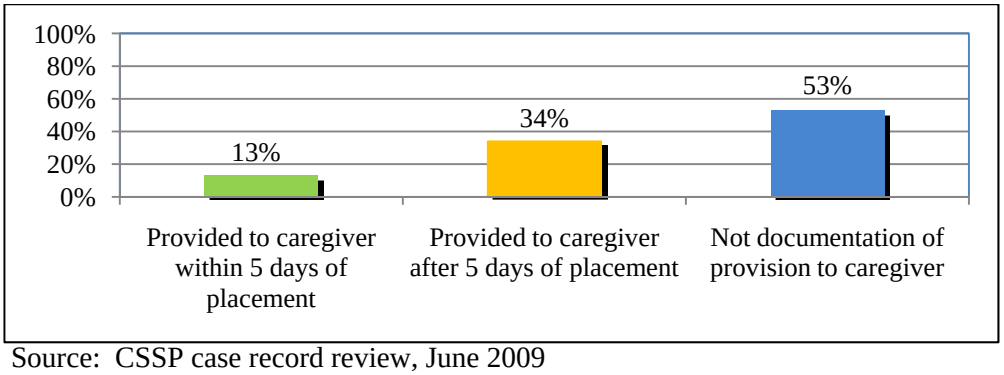
[13] Margin of error for this subsample is ± 9 percent.

3. ***Documentation showed that DYFS provided caregivers with medical information, Health Passports, for the children placed in their care in 34 percent of cases.***

Within five days of a child entering out-of-home placement, the caregiver is supposed to receive information regarding the known health care status and needs of the child in his or her care through a document that is known as a Health Passport. Currently, DYFS uses a form, known as the 11-2A, to collect health information from parents and other sources and to record and report the findings of the PPA. This form is then supposed to be given to the caregiver. DCF policy requires that the CHU nurse complete the 11-2A form, which is maintained by the local office Child Health Unit, and it is supposed to be provided to the caregiver within 72 hours of the child's placement. This policy is relatively new and Child Health Units are yet not fully staffed across the State. Not surprisingly, the Review found minimal documentation that 11-2A Health Passports were provided to caregivers within the first five days of having a child placed with them.

Of the 285 children receiving an initial PPA[14], there was no evidence in over half (54%) of cases of a Health Passport being conveyed to the caregiver regarding the child's health status. In 36 cases (13%), reviewers found documentation that the 11-2A Health Passport was given to the child's caregiver within five days of placement. For another 96 cases (34%[15]), reviewers found evidence that the Health Passport was provided to the caregiver at some point during the child's placement, but not within the first five days. In fact, many of the 11-2A cover letters to caregivers were undated so it was not possible to determine when the documents were provided. In other cases, the Child Health Units had been more recently staffed with nurses who had reviewed a child's file and in that process, sent an introduction letter with an 11-2A on the child to the caregiver. This strongly suggests that as the Child Health Units become fully staffed, the consistent sharing of the medical information through the 11-2A should improve.

Figure 10: Health Passport for Children Entering Out-of-Home Care (n=285 children)



Source: CSSP case record review, June 2009

[14] This MSA outcome was measured from the total number of children receiving a PPA in order to understand what information from the PPA or other known health information was or was not conveyed to the caregiver. Results based on the sample of 285 still have a ±5 percent margin of error.

[15] For this and all other analysis, percentages were rounded to a whole number. Thus, some measures add up to more than 100 percent.

Of the 132 cases where information was provided to the caregiver (either within the five days or later), reviewers consistently noted that the information appeared limited. Information most likely to be included on the 11-2A included immunization history (43 cases) and medical findings from the pre-placement assessment (42 cases). Other types of information shared include: current medical concerns (28 cases); medications the child is currently taking (22 cases); needed medical appointments (16 cases); and the child's Medicaid card (4 cases).[16]

4. Documentation in case files showed that 74 percent of children receive Comprehensive Medical Examinations within the first 60 days of placement; an additional 19 percent of children received the CME, but after 60 days.

Under the MSA, children entering out-of-home placement are expected to receive a Comprehensive Medical Examination (CME) within 60 days of entering placement (MSA II.F.2.ii). CMEs are provided through a varied of community-based medical providers including children's own pediatricians. CMEs require a review of the child's medical history, developmental history, and a current review of the child's physical systems (including skin, vision, hearing, ears, nose, throat, cardiac, respiratory, gastrointestinal, etc...). In addition, a mental health *screen* should be conducted of children[17], and if the screen indicates a suspected need, a full mental health *assessment* must be conducted. The Comprehensive Health Evaluation of Children (CHEC) is a specialized type of service that fulfills the requirements of a CME. CHECs require a three part examination—medical, neurodevelopmental, and mental health for every child.

Of the 292 children in the sample, reviewers found documentation that 273 (93%) received a CME. There was no documentation to support that 19 (7%) children had received a CME.[18] Of the 273 children who received a CME, 59 (22%) children received a CHEC.

Almost three-quarters (74%) of children had the CME within the required 60 days of placement. 139 children (48%) had a CME exam within 30 days of placement[19]and another 77 children (26%) received this exam between 31 and 60 days. An additional 56 children (19%) received the CME, but after 60 days. (See Figures 11, 12 and 13 below).

[16] Margin of error for this subsample is ±8 percent.

[17] For the purposes of this Review, we looked at mental health screenings and assessments for children older than three years of age as mental health assessments are more likely to be used with older, verbal children. The Monitor also did not look for mental health assessments for children who are already receiving services from the behavioral or mental health system.

[18] Of the 19 children who reviewers were unable to document a CME, there was notation in the NJ SPIRIT Medical Profile in 12 of those cases that the child had received a CME. For two of those cases, the CME was delivered outside of the review period. For the other 10 CMEs, reviewers found no documentation in the hard-copy of the case file or other NJ SPIRIT notes supporting that the examination had occurred. In two cases, the reviewer noted that the workers notes stated that the child did not appear at the appointment identified in NJ SPIRIT and that the CME needed to be rescheduled.

[19] This 30 day standard is the model standard set by the Child Welfare League of America and the American Academy of Pediatrics.

Figure 11: Number of Children Receiving CME (n=292)

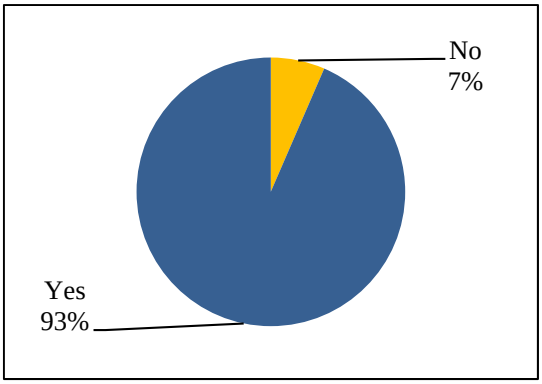
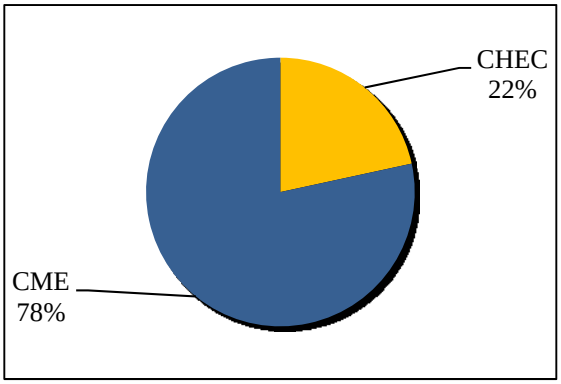
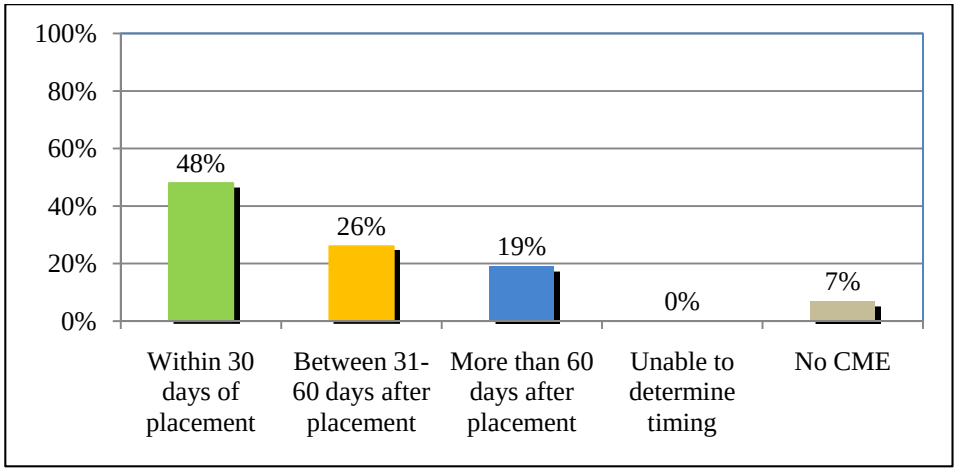


Figure 12: Children Receiving a CME or CHEC (n=273)



Source: CSSP case record review, June 2009

Figure 13: Provision of CME Within 60 days of Placement (n=292)



Source: CSSP case record review, June 2009

In general, children who received CME from a community-based provider were examined more quickly than those who received the CHEC exam. Of the 214 children receiving a CME, 116 (54%) had a CME within 30 days of entering placement, another 57 (27%) had a CME within 60 days of entering placement. Forty (19%) children had a CME more than 60 days after placement, and reviewers were unable to determine the date of the CME for one (.5%) child. As previously described, CHEC exams are specialized examinations offered by four specialized providers in the state.[20] Of the 59 children who had a CHEC, 23 (39%) had a CHEC within 30

[20] Notably, reviewers found several instances of children who received a CME from a community-based provider who then went on to receive a CHEC.

days of entering placement, and another 20 (34%) had a CHEC within 60 days of entering placement. Sixteen (27%) children waited more than 60 days for the CHEC exam.

Information about comprehensiveness of examination

One of the limitations of the study is the difficulty of assessing the comprehensiveness of a medical examination through a review of physician, nurse and social worker notes; however, in the vast majority of cases, reviewers found that the medical provider documented his or her review of each of the child's physical systems.

Developmental assessments

The Review also looked for documentation that the CME provider assessed the child's development, that is examined the child's intellectual, language, emotional and social development (behavioral assessments or educational assessments are considered developmental assessments for this purpose). Of the 273 children who received a CME, reviewers found documentation that 173 (63%) children received a developmental assessment; for 98 (36%) their was no documentation of a developmental assessment. Two of the 273 children were removed from the sample due to reviewer error.

The Review found strong evidence that children under the age of six received a developmental assessment. Specifically, of the 154 children under age six who received a CME, 124 children (81%) received a developmental assessment; there was no documentation that 30 children (19%) had received this assessment. For children ages six and older, there was not consistent evidence of a developmental assessment. The Review found documentation that 49 children (42%) age six years and older receiving a CME had a developmental assessment as part of their exam; there was no documentation that 68 children (58%) had received a developmental assessment.[21]

5. For 54 percent of eligible children receiving a CME, there was insufficient evidence that they received the required mental health screen. However, all children with a suspected mental health need detected in a CME screen received a mental health assessment.

Reviewers looked for documentation that eligible children received a mental health screen as part of their CME. For children for whom the screen indicated a suspected mental health need, the Review also measured how many children received a full mental health assessment.[22] Of the 273 children who received a CME, 139 children were either under the age of three or had already been identified with behavioral/mental health needs and thus were judged not to need a mental health screen/assessment.

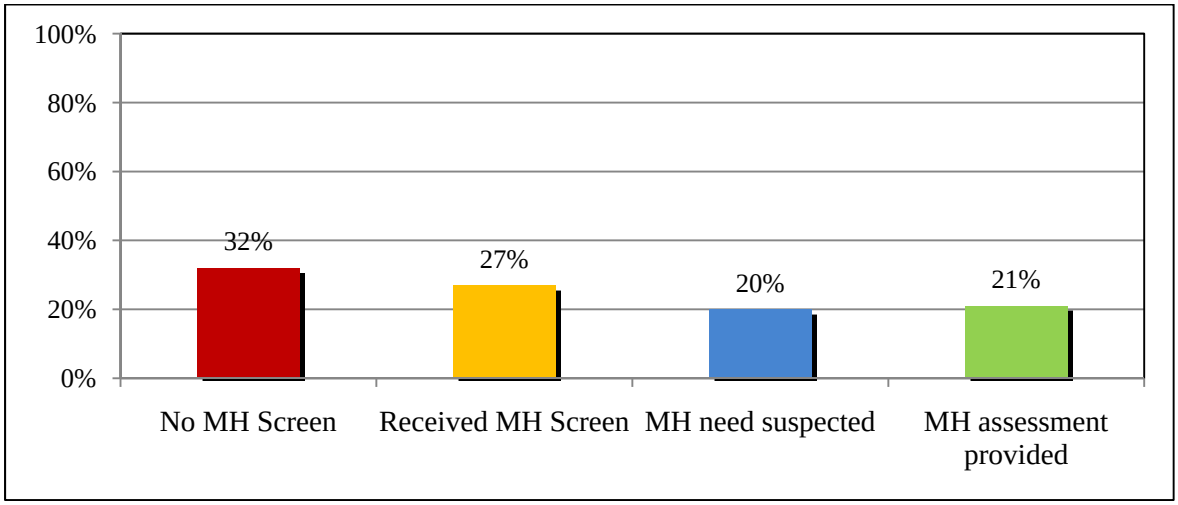
Based on the documentation in the case files, more than half of the 134 eligible children did not receive the required mental health screen.[23] Specifically, 62 (46%) children received a mental health screen and for 72 children (54%) children, there was no evidence of a mental health

[21] There were 119 children age six or older who received a CME. Due to reviewer error, two children age six had to be excluded from the denominator, thus 117 children was the denominator used.
[22] In this study, children eligible for a mental health screen/assessment are older than three and are not already receiving services from the mental or behavioral health systems.
[23] Margin of error for this subsample is ±8 percent.

screen in the records. All of the 72 children without mental health screens received a CME.[24] Of the 62 children who received a mental health screen, 32 children received a CHEC and 30 received a CME by a community provider. The lack of documented mental health screening is of great concern, especially given the significant psychological stresses for youth coming into out-of-home care from their experiences of abuse or neglect, and separation from their caregivers.

In the majority of cases in which a mental health screen was administered, the mental health screen indicated a need for a full mental health assessment – 46 (74%) children had a suspected mental health need, 16 (26%) did not. All of the 46 children received a full mental health assessment[25] with a suspected mental health need.

Figure 14: Mental Health Assessment for Eligible Children (n=134)



Source: CSSP case record review, June 2009

6. Eighty-three percent of children are up-to-date on their immunizations after their CME.

The Review examined the immunization status of children at the time of their CME. Thus, the sample size for this measure was the 273 children who received a CME, rather than the 292 total sample.[26] In this way, reviewers had the opportunity to review the CME report, NJ SPIRIT, and case file for evidence of the child's immunization status. Of these children, 157 (58%) did not require immunizations at the time of the CME and 116 (43%) required immunizations to become current. Of the 116 children, 22 did not receive any immunizations, 24 received some, and 70 received sufficient immunizations to be considered up-to-date. Thus a total of 227 (83%) of children were up-to-date on immunizations after their CMEs. In a few cases, reviewers found

[24] Because a core component of the CHEC is a psychological evaluation, this finding is not surprising.
[25] An additional child without a suspected mental health need received a full mental health assessment.
[26] Because this case record review was based solely on the documentation in DCF's files, it was determined that the best way to examine the immunization status of children was to look at all of the records for children who received a CME as opposed to the entire sample.

documentation that immunizations were not provided due to the child's current poor health status (e.g., a child had leukemia, bronchitis, or other illness) or that the CME provider did not have sufficient information regarding the child's immunization history.[27]

7. Based on the documentation in the case records, there is minimal evidence of pertinent health history being made available to the CME provider prior to the comprehensive medical exam.

The CME provider considers medical and family history when determining the needs of a child and providing a plan of care. Based on documentation in the case files, it was difficult to determine what if any medical history CME providers had received in advance of their exam of the child. CME providers were most likely to receive information on the child's immunization records (immunization history was available in 83% of the CMEs). In many cases, providers appeared to have obtained some health history about the child such as birth history or neonatal care and current health issues such as growth and nutrition, allergies, significant injuries, etc. The information least likely to be available was dental care history for children ages three and above. In several cases, reviewers noted that the CME provider had necessary health information as they were already the child's medical home. In a small number of the cases[28], reviewers determined that there was some health history or concerns that were known by DYFS, but no documentation that this information was shared with the CME or CHEC provider. For example, reviewers found:

- documented in case file that the child had a history of sexual abuse but no evidence that the information was conveyed to the CME provider and provider did not identify any mental health needs;
- CME provider noted missing immunization records, however, documentation in the file shows DYFS had immunization history before date of CME exam; and
- DYFS was in receipt of the child's dental information but no evidence this was shared with the CME doctor.

[27] In these cases, the review counted these children as not current with immunizations.
[28] In seven cases it appears that DYFS had relevant medical information that should have been shared with the CME provider.

Table 3: Documentation Shared With CME Provider

Documentation that Provider received information at or prior to CME	Number of Cases/(Percent)*
Immunization records	196 out of 273 (83%)
Birth history for children 6 or younger	51 out of 168 (30%)
Neonatal care for children 6 or younger	64 out of 168 (38%)
Current health issues including growth, nutrition, allergies, significant injuries, hospitalizations/ surgeries	143 out of 273 (52%)
Dental care for children 3+ above	60 out of 180 (33%)
Family history	126 out of 273 (41%)
Already in possession of health history because CME provider was medical home	14 out of 292 (5%)

Source: CSSP case record review, June 2009
*The denominator is different for each item because some documentation requirements are linked to the child's age.

8. There is documented evidence that a caseworker, DYFS staff person, birth parent, resource parent and/or other adult accompanied the child to the CME in 65 percent of cases.

The Review examined who accompanied the child to the CME appointment. This was deemed important because of the relative lack of information sent to providers in advance of examinations and the fact that those accompanying a child to the exam may typically be able to provide pertinent medical and family history. For example, one reviewer noted "CHEC provider interviewed resource parents (paternal great grandmother and paternal grandmother)" to gather some history. Additionally, the DYFS Case Practice Model encourages caregiver and parent participation in the process as this is a time for information sharing and planning for the care of a child. Finally, as medical appointments can be stressful to children, the Review looked to see what personal or professional support was available to the child. In at least 10 cases, the child's birth parent came to the CME, in 53 cases the relative placement provider attended, in 53 cases the resource parent attended, in 96 cases the caseworker attended, and in two cases the child was accompanied by a DYFS transportation aide. In 96 cases the reviewer was unable to determine who, if any one, accompanied the child to the exam.

Table 4: Other Adults Attending CME
(n=273 CME examinations; 177 cases where there is documentation that at least one person accompanied the child)

Who Attended CME	Number of Cases*
Birth Parent	10
Relative Placement Provider	53
Resource Parent	53
DYFS Caseworker	96
DYFS Transportation Aide	2
Other adult	10
Unable to determine if any one came	96

*In 42 cases, more than one of the adults listed above accompanied the child to the exam.
Source: CSSP case record review, June 2009

The Review also attempted to assess whether there were any language barriers for children receiving a CME. In six of the cases reviewed, it appeared that there was a need for a language interpreter. However, reviewers were unable to determine if a translator/interpreter was provided in four of the cases, in one case an interpreter was provided and in another an interpreter was not provided.

9. Reports from the CME, when generated, are not consistently shared with critical participants in the case.

Initial Reports

In addition to looking at information provided to the medical provider, the Review sought to determine how information about the CME is communicated back to DYFS, caregivers and parents. To do this, reviewers looked for documentation of reports obtained from the CME and who received these reports.[29] Initial reports are generated at the end of the exam. Many community-based CME providers only generate an initial report. DYFS has an initial report form, but several providers use their own form. For 58 percent of the CMEs, reviewers found initial reports of the CME in the case records. Most of these reports were provided to the DYFS case worker (129) and the Child Health Unit (127). There was little evidence that the child's identified primary care provider (17) or resource or relative caregiver (17) received the report or the information contained within it. There was no documentation that birth parents had received

[29] For the period under review, DCF reports that DYFS had not instructed workers to document the sharing of CME reports with other case participants.

the report. In a few instances, reviewers found evidence in the case file that resource parents were verbally told about findings in the CME.

Final Reports

For 107 CMEs, both a final and initial report were documented; there was no documentation of an initial or final report in 22 cases. Final reports are more comprehensive reports which are intended to summarize the medical history and the current examination of the child and use the findings to design a plan of care. For 200 CMEs (73%) there was a final report generated. Most CHEC providers used a slightly different format to accommodate their more lengthy reports. The DYFS caseworker (171) and CHU (155) were most likely to receive the report. There was evidence that in some instances the child's primary care provider (44), resource parent (7), and birth parent (2) received the final report. In general, based on the case file documentation, it was hard to determine who received what information.

Table 5: Individuals with Whom CME Reports Are Shared

Sharing of Reports	Initial n=158	Final n=200
DYFS Caseworker	129	171
Child Health Unit	127	155
Primary Care Provider	17	44
Resource/Relative Caregiver	17	7
Birth Parent	0	2

Source: CSSP case record review, June 2009

Plan of Care

A total of 298 CME reports were found for 249 cases. One hundred and seven (107) cases had both an initial and final report, 144 cases had either an initial or a final report. Of the 298 total CME reports, 201 included a plan of care for the child. In 48 cases there was either no plan of care (10 cases) or the plan of care did not address the ongoing needs of the child (38 cases). Plans of care for children included identifying ongoing immunization needs, further EPSDT exams, directions to care for chronic or acute health conditions, and referrals for specialized services. However, reviewers also noted cases in which it appeared that not all the health care needs of the child had been picked up in the plan of care. Examples include:

- No specific information about how the child is to use medication to treat asthma;
- Birth mother had history of alcohol and drug use, but the infant was not evaluated for prenatal exposure, nor were any referrals made for such an evaluation; and
- Child had speech delays that were not addressed in the plan of care.

While these findings point to areas for further review and consideration, there are serious limitations from a case file review for all issues regarding comprehensiveness of medical care. Additional qualitative review is necessary in order to truly understand and evaluate the quality of

sharing information, teaming, and case planning to ensure that children receive the health and mental health care services they need.

10. Documentation in the case records showed that 41 percent of children receive some type of follow up care after their CME.

The Review examined documentation in the record regarding the follow up care of children for mental health services, dental care, educational services, and with specialists such as cardiologists, pulmonologists, dermatologists, and allergists. The difficulties of measuring this quantitatively are a limitation of this Review. Given these caveats, the Review found that 112 (41%) of the 273 children who had a CME received follow up care for at least one need identified in the CME during the time period of the Review. Many children received follow up care with their primary care physician (medical home) for immunizations and well-child checkups.[30]

The Review found that needs most likely to be unaddressed were dental care and mental health services, followed by eye appointments. The State has previously identified the lack of dental care and mental health providers available to children in out-of-home placement. Documentation in this review found several instances of diligent efforts by DYFS caseworkers to find providers that accepted Medicaid.

11. Eighty-three percent of children in out-of-home placement have an identified Medical Home.

There was evidence of an identified medical home, that is, a primary care physician, for 243 of the 292 children in the sample (83%); 49 children (17%) did not have an identified medical home. As previously described, in several cases DYFS was able to arrange to have the child's existing medical home provide a child with a PPA, CME, and/or follow up care.

12. In 99 percent of cases where children had an acute medical need, documentation verified treatment for that need. In 78 percent of cases where children had an acute mental health needs, documentation verified treatment for that need.

The Review also looked at the treatment of acute or episodic health and mental health needs of children. Of the 292 children in the sample, 102 had an acute or episodic health need requiring medical attention during the Review period. The types of needs included treatment for bronchitis, a fractured tooth, ear infections, etc. Of those 102 children, there was evidence that 101 (99%) children received treatment.

Of the 292 children, fifty-one (51) children had an acute or episodic mental health need that required attention. Examples include suicidal ideation, problematic behavior at school resulting in suspensions, need for grief counseling, need for monitoring psychotropic medication. Of these 51 children, there was documentation that 40 (78%) had received treatment.

[30] A specific number cannot be provided as this information was primarily conveyed through reviewer notes.

13. <u>The full implementation of fully staffed Child Health Units in each DYFS office holds promise of continuing improvement in health care delivery and outcomes</u>.

The beneficial impact of the Child Health Units was immediately noticeable in the Review. Children who received Health Care Management from CHUs have a blue folder dedicated to keeping medical information in one place. In the sample, there was evidence that 207 children (71%) were assigned to a CHU nurse or otherwise attached to the Child Health Units, and 85 children were not. Documentation of health care delivery was improved for the children attached to health care case managers. There were many examples of nurses working with families to understand the needs of children. For example, a nurse went to visit a parent in prison, nurses made home visits to see children and check on their medical needs, and the documentation in these files indicated that nurses appeared to be monitoring and tracking follow up care.

RECOMMENDATIONS

- ***DCF should continue its work to fully implement its HealthCare Plan, and fill all of the outstanding vacancies for Health Care Case Managers and quickly fill any vacancies created by turnover.***

- ***DCF should take steps to ensure that all eligible children receive the required mental health screen; one option to explore is charging Health Care Case Managers with specific responsibility to ensure this occurs for all eligible children.*** Health Care Case Managers are obviously playing a large role in providing, coordinating, and documenting the health care of children in out-of-home placement. DCF should explore using these nurses to review CME reports to see if a mental health screen has been conducted for all children over the age of three who have not already been evaluated for mental or behavioral health services. In addition, DCF should use the health care case managers to conduct routine mental health screening of children in out-of-home placements to ensure that children with a suspected mental health need are identified and receive appropriate follow up evaluation. Once a screen has been conducted, DCF and CME providers have demonstrated that full mental health assessments are provided to children with a suspected mental health need. Future evaluation work should be done to assess the effectiveness of the current screen used, who is administering the screen, and the use of screens to assess children and youth at other times beyond the initial removal from their families.

- ***DCF should improve documentation of all health related information.*** For children whose health care is being managed by Child Health Units, reviewers found that records are clearly kept in blue files. However, many of these blue files failed to date medical information (the Health Passport) which was conveyed to the child's caregiver. This information should be delivered to caregivers within five days (as required by the MSA) or 72 hours (as required by DCF policy). When cases were not managed by Child Health Units, Reviewers found medical information difficult to locate and track in the case files

and in NJ SPIRIT. A lack of documentation regarding children's health care needs can result in a failure to address all relevant needs in case planning.

- ***DCF should improve the sharing of health information with all relevant providers and caregivers.*** Specifically, DCF should ensure that caregivers receive required medical information within five days of a child's placement. Further, DCF should continue efforts to ensure that CME and other health care providers receive relevant health information in advance of their medical examinations. Immunization records, most of which are available through a statewide electronic database, were the information most likely to be shared with the CME provider before an examination. Additional effort is required to obtain and share medical information with providers. Reviewers found several examples of DYFS workers having pertinent medical information and CME providers describing such information as missing.

- ***DCF should take steps to ensure that all medical concerns are followed up with appointments with necessary providers, particularly for dental, mental health and eye care***. As part of these efforts, DCF should continue to support efforts that recruit and retain specialists who accept Medicaid. DCF has made attempts to recruit a larger pool of dentists and other specialists to treat children in out-of-home placement. The Review found that many workers make diligent efforts to locate providers willing to accept Medicaid, but that these providers were hard to find. Further, DCF should continue to work with Health Care Case Managers with specific responsibility to make sure that follow up occurs for all eligible children.

- ***DCF should encourage parents and other family members, when appropriate, to bring children to CME appointments and otherwise assist in ensuring medical providers have important health histories***. Consistent with the Case Practice Model, DYFS case workers should partner with parents to ensure that medical providers have the most up-to-date information about their children's medical history in advance of their examinations. Part of efforts at engagement and teaming should include encouraging parents and other close family members to attend CMEs and to participate in children's ongoing health care plans.

Appendix A:
Select Indicators from *Charlie and Nadine H. v. Corzine* Child and Family Outcome and Case Practice Performance Benchmarks

Reference	Indicator	Performance from Case Record Review	Dec 2008 Performance (Reported by DCF)	Benchmark	MSA Final Target
MSA III.A.3c	Placement of Children in family settings (Family Resource Home/Kinship Home)	81%	Phase II measure, not reported	83% as of July 2008	Beginning July 2009 and thereafter, at least 85%.
MSA II.F.5	Pre-placement medical assessments completed in a non-emergency room setting	98% received PPA, 94% within 24 hours of placement. 92% of children receiving a PPA, had the service in a non-emergency room setting.	92%	By June 30, 2008, 95% of children will receive a pre-placement assessment in a non-emergency room setting.	By December 31, 2009, 98% of children will receive a pre-placement assessment in a non-emergency room setting.
MSA II.F.8	Children's caregivers receive an up-to-date health passport within 5 days of placement	13% (36 of 285 children who had an initial PPA).	Not available	By June 30, 2010, 75% of caregivers will receive a current Health Passport within 5 days of a child's placement	By June 30, 2011, 95% of caregivers will receive a current Health Passport within 5 days of a child's placement.
MSA III.B.11	Children receiving Comprehensive Medical Exams completed within 60 days of child's entry into care	74% received a CME within 60 days of placement (48% received a CME within 30 days of placement).	80% received a CME within 60 days of placement	By June 2008, 80% of children shall receive full medical examinations within 30 days of entering out-of-home care and at least 85% within 60 days.	By January 1, 2009 and thereafter, at least 85% of children shall receive full medical examinations within 30 days of entering out-of-home care and at least 98% within 60 days.

Appendix A:
Select Indicators from *Charlie and Nadine H. v. Corzine* Child and Family Outcome and Case Practice Performance Benchmarks

Reference	Indicator	Performance from Case Record Review	Dec 2008 Performance (Reported by DCF)	Benchmark	MSA Final Target
MSA II.F.2	Mental health assessments for children with a suspected mental health need.	Of 134 eligible children, 46% received a mental health screen. Of those, 46 indicated a suspected mental health need and 100% received a full mental health assessment.	59% of all children (11,801) in out-of-home care during the monitoring period received a mental health assessment. Unable to determine if children with suspected mental health need received assessment without qualitative review, which is pending.	By December 2008, 80% of children with suspected mental health need should receive assessments.	By December 31, 2011, 90% of children with a suspected mental health need will receive a mental health assessment.
MSA II.F.2	Receipt of timely accessible and appropriate follow up care and treatment to meet health care and mental health needs	Review found that at least 112 children received at least one follow up care service after their CME (41%).	70% (statewide sample*)	By December 2008, 65% of children will receive follow up care and treatment to meet health care and mental health needs.	By December 31, 2011, 90% of children will receive timely accessible and appropriate follow up care and treatment to meet health care and mental health needs.
	Children are current with immunizations	Of the 273 children who received a CME, 227 (83%) were considered up to date with immunizations upon completion of exam.	81% (statewide sample*) 87% of 2,116 children receiving health care case management for at least one quarter	By December 2009, 90% of children in custody will be current with immunizations.	By December 31, 2011, 98% of children in custody will be current with immunizations.

* Two separate statewide samples were conducted by DCF to evaluate the delivery of health care services to children in out-of-home placement. Sample One was a representative, random sample of 358 children in placement for at least one day between July 1 – December 31, 2008 who were at least three years old and had been in placement for at least one year. The full cohort was 5,033. The results have a margin of error of ±5 percent. This sample was used to determine EPSDT visits, semi-annual dental examinations, and immunizations. Sample Two was a representative sample of 306 children who entered care between July 1- December 31, 2008, received a Comprehensive Medical Examination, and required follow up care. The full cohort was 1,504 children. The results have a margin of error of ±5 percent. This sample was used only to examine follow up care.

Appendix B
Data Collection Instrument

Case Record Review

*** 1. Review Case #:**

*** 2. Case Record/SPIRIT #:**

*** 3. NJ SPIRIT Person ID#:**

*** 4. DYFS Local Office:**

*** 5. REVIEWER:**

6. Case could not be reviewed because:

- ◯ Not Applicable
- ◯ Children in care less than 60 days
- ◯ Records not found/produced
- ◯ Child adopted and record sealed
- ◯ Other (please specify)

Appendix B
Data Collection Instrument

DEMOGRAPHIC and PLACEMENT INFORMATION ON CHILD

7. Gender:

- ◯ Male:
- ◯ Female:

8. Date of Birth

MM DD YYYY

Month/Date/Year ☐☐ / ☐☐ / ☐☐☐☐

9. Race – Check All that Apply

- ☐ White
- ☐ Black or African American
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Undetermined
- ☐ Other (please specify)

10. Ethnicity

- ◯ Non-Hispanic
- ◯ Hispanic
- ◯ Unable to Determine

11. Date of child's first out of home placement between July 1, 2008 and December 31, 2008:

MM DD YYYY

Month/Day/Year ☐☐ / ☐☐ / ☐☐☐☐

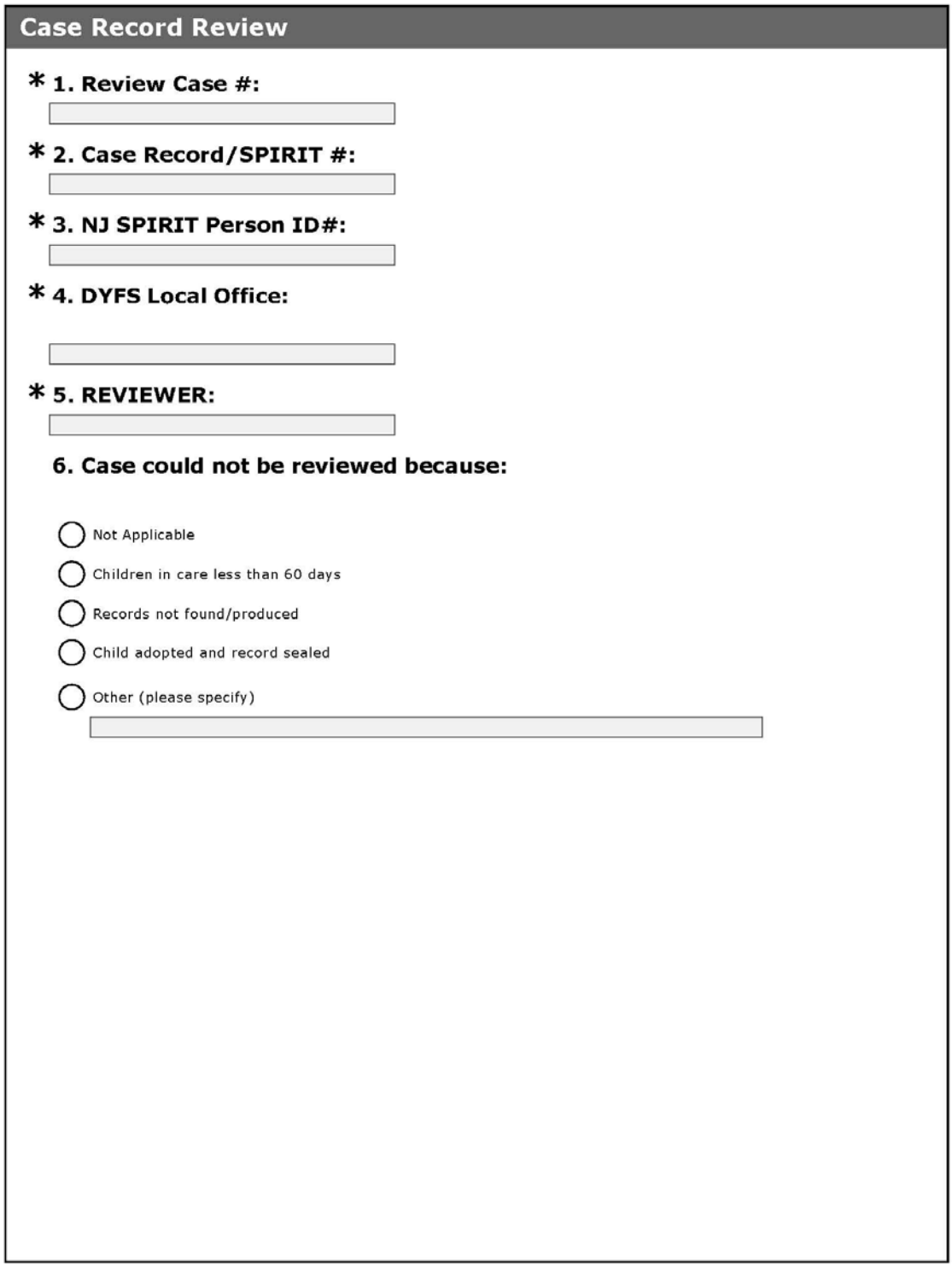
12. Age when entered this placement episode

Years Months

Years/Months ☐☐ ☐☐

13. Location of this placement (county)

Appendix B
Data Collection Instrument



Case Record Review

*** 1. Review Case #:**

*** 2. Case Record/SPIRIT #:**

*** 3. NJ SPIRIT Person ID#:**

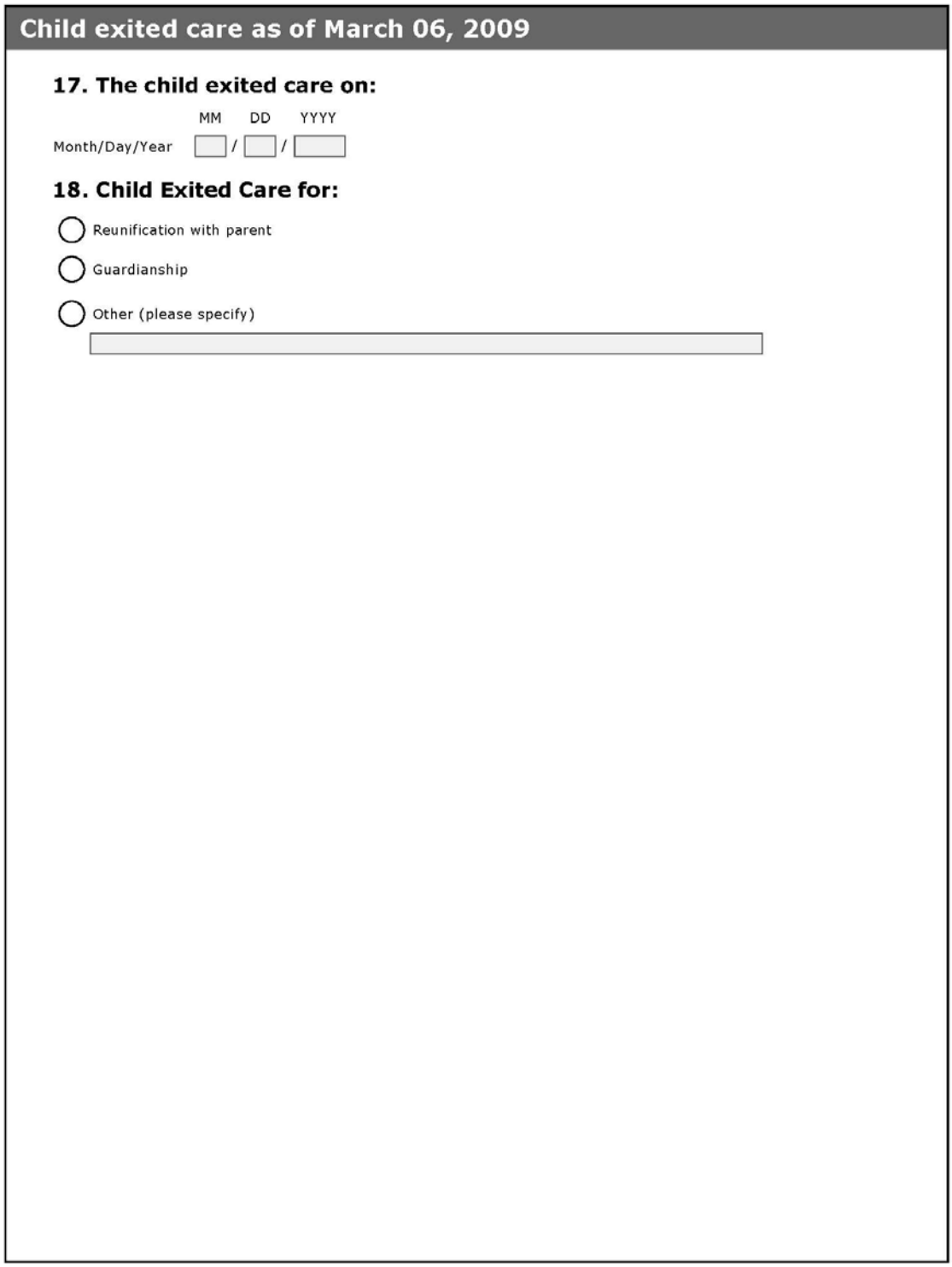
*** 4. DYFS Local Office:**

*** 5. REVIEWER:**

6. Case could not be reviewed because:

- ◯ Not Applicable
- ◯ Children in care less than 60 days
- ◯ Records not found/produced
- ◯ Child adopted and record sealed
- ◯ Other (please specify)

Appendix B
Data Collection Instrument



Child exited care as of March 06, 2009

17. The child exited care on:

MM DD YYYY

Month/Day/Year ☐ / ☐ / ☐

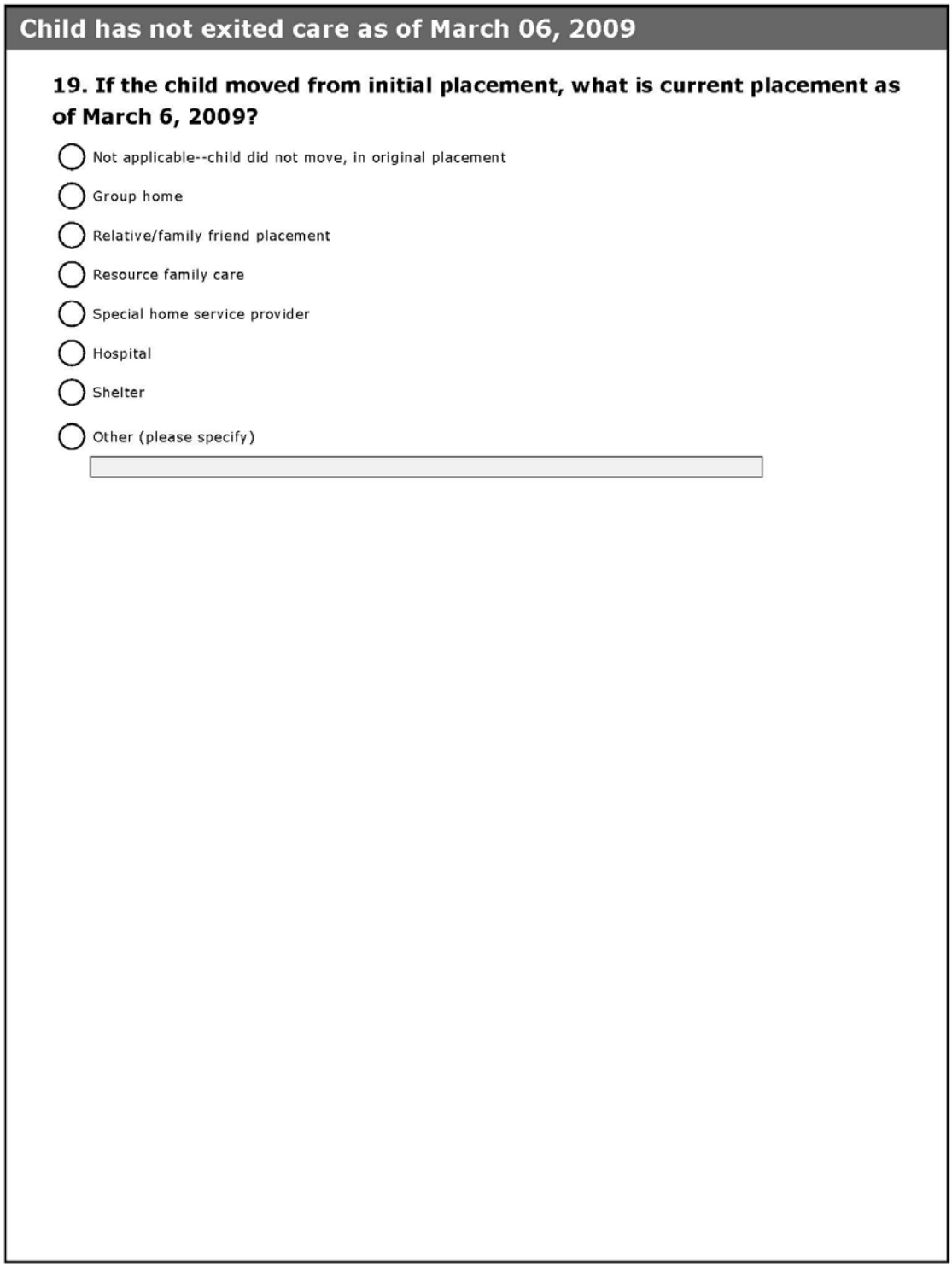
18. Child Exited Care for:

◯ Reunification with parent

◯ Guardianship

◯ Other (please specify)

Appendix B
Data Collection Instrument



Child has not exited care as of March 06, 2009

19. If the child moved from initial placement, what is current placement as of March 6, 2009?

- ◯ Not applicable--child did not move, in original placement
- ◯ Group home
- ◯ Relative/family friend placement
- ◯ Resource family care
- ◯ Special home service provider
- ◯ Hospital
- ◯ Shelter
- ◯ Other (please specify)

Appendix B
Data Collection Instrument

Health Care Pre-placement Assessment

20. Is there evidence in the record that the child received a pre-placement medical assessment?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Health Care Pre-placement Assessment cont.

21. Date of pre-placement assessment:

☐ Unable to Determine

☐ Month/Day/Year (Enter as MM/DD/YYYY)

22. Timing of pre-placement assessment

◯ Prior to placement

◯ Within 24 hours after placement

◯ More than 24 hours after placement

◯ Unable to determine

23. Location of pre-placement assessment:

☐

◯ Emergency Room

◯ Non-Emergency Room

◯ Unable to determine

Appendix B
Data Collection Instrument

If pre-placement assesment took place in the emergency room please indicate...

24. Day of week pre-placement assessment was completed:

25. Time of day the assessment was conducted

- ◯ 6am - 9am
- ◯ 9am - 5pm
- ◯ 5pm - 9pm
- ◯ 9pm - 12midnight
- ◯ 12 midnight - 6am
- ◯ Unable to determine

Appendix B
Data Collection Instrument

If pre-placement assesment did not take place in the emergency room:

26. Indicate where the assessment occurred

- ◯ Primary Care Provider
- ◯ Federally Qualified Health Center
- ◯ Other community provider
- ◯ CHU nurse
- ◯ Unable to determine
- ◯ Other (please specify)

Appendix B
Data Collection Instrument

Child's medical status/ information provided to resource provider

27. Is there evidence in the record(s) that the DYFS form 11-2A (the child's medical information) was either physically handed or mailed to the resource provider within the first 5 days of placement?

- ◯ Yes
- ◯ No, but after 5 days
- ◯ No, no evidence of any information conveyed

Appendix B
Data Collection Instrument

Child's medical status/ information provided to resource provider cont.

28. Based on the evidence in the record, medical information given to resource provider within the child's first five days of placement included: (check all that apply)

- ☐ Unable to determine
- ☐ Immunization history
- ☐ Information from pre-placement assessment
- ☐ Current medications
- ☐ Medical concerns
- ☐ Needed medical appointments
- ☐ Other (please specify)

Appendix B
Data Collection Instrument

29. Is there evidence that this child has been assigned to a CHU nurse's caseload?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

2nd out of home placement?

30. Did the child experience a 2nd out of home placement?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Addendum A-Pre-placement assessment for Placement #2

31. Is there evidence in the record that the child received a pre-placement medical assessment?

☐

◯ Yes

◯ No

Appendix B
Data Collection Instrument

Addendum A-Placement #2

32. Date of pre-placement assessment:

- ◯ Unable to determine
- ◯ Month/Day/Year

33. Timing of pre-placement assessment

- ◯ Prior to placement
- ◯ Within 24 hours after placement
- ◯ More than 24 hours after placement
- ◯ Unable to determine

34. Location of pre-placement assessment:

- ◯ Emergency Room
- ◯ Non-Emergency Room
- ◯ Unable to determine

Appendix B
Data Collection Instrument

Addendum A-Placement #2

35. If Emergency Room, indicate:

	Day of week pre-placement assessment was completed	Time of day the assessment was conducted
Pre-placement occurred:		

Appendix B
Data Collection Instrument

Addendum A-Placement #2

36. If non-emergency room, indicate where the assessment occurred:

- ◯ Primary Care Provider
- ◯ Federally Qualified Health Center
- ◯ Other community provider
- ◯ CHU nurse
- ◯ Unable to determine
- ◯ Other (please specify)

Appendix B
Data Collection Instrument

Addendum A-Placement #2

37. Is there evidence in the record(s) that the child's medical information was conveyed within the first 5 days of placement to the resource provider through DYFS form 11-2A (this form was either physically handed to the resource provider or mailed)?

- ◯ Yes
- ◯ No, but after 5 days
- ◯ No, no evidence of any information conveyed

Appendix B
Data Collection Instrument

Addendum A-Placement #2

38. Based on the evidence in the record, medical information provided to resource provider within the child's first five days of placement included: (check all that apply)

- ☐ Unable to determine
- ☐ Immunization history
- ☐ Information from pre-placement assessment
- ☐ Current medications
- ☐ Medical concerns
- ☐ Needed medical appointments
- ☐ Other (please specify)

Appendix B
Data Collection Instrument

Addendum A-Placement #2

39. Is there evidence that this child has been assigned to a CHU nurse's caseload?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

3rd out of home placement?

40. Has the child had a subsequent placement?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Addendum A-Pre-placement assessment for Placement #3

41. Is there evidence in the record that the child received a pre-placement medical assessment?

☐

◯ Yes

◯ No

Appendix B
Data Collection Instrument

Addendum A-Placement #3

42. Date of pre-placement assessment:

- ◯ Unable to determine
- ◯ Month/Day/Year (Enter MM/DD/YYYY)

43. Timing of pre-placement assessment

- ◯ Prior to placement
- ◯ Within 24 hours after placement
- ◯ More than 24 hours after placement
- ◯ Unable to determine

44. Location of pre-placement assessment:

- ◯ Emergency Room
- ◯ Non-Emergency Room
- ◯ Unable to determine

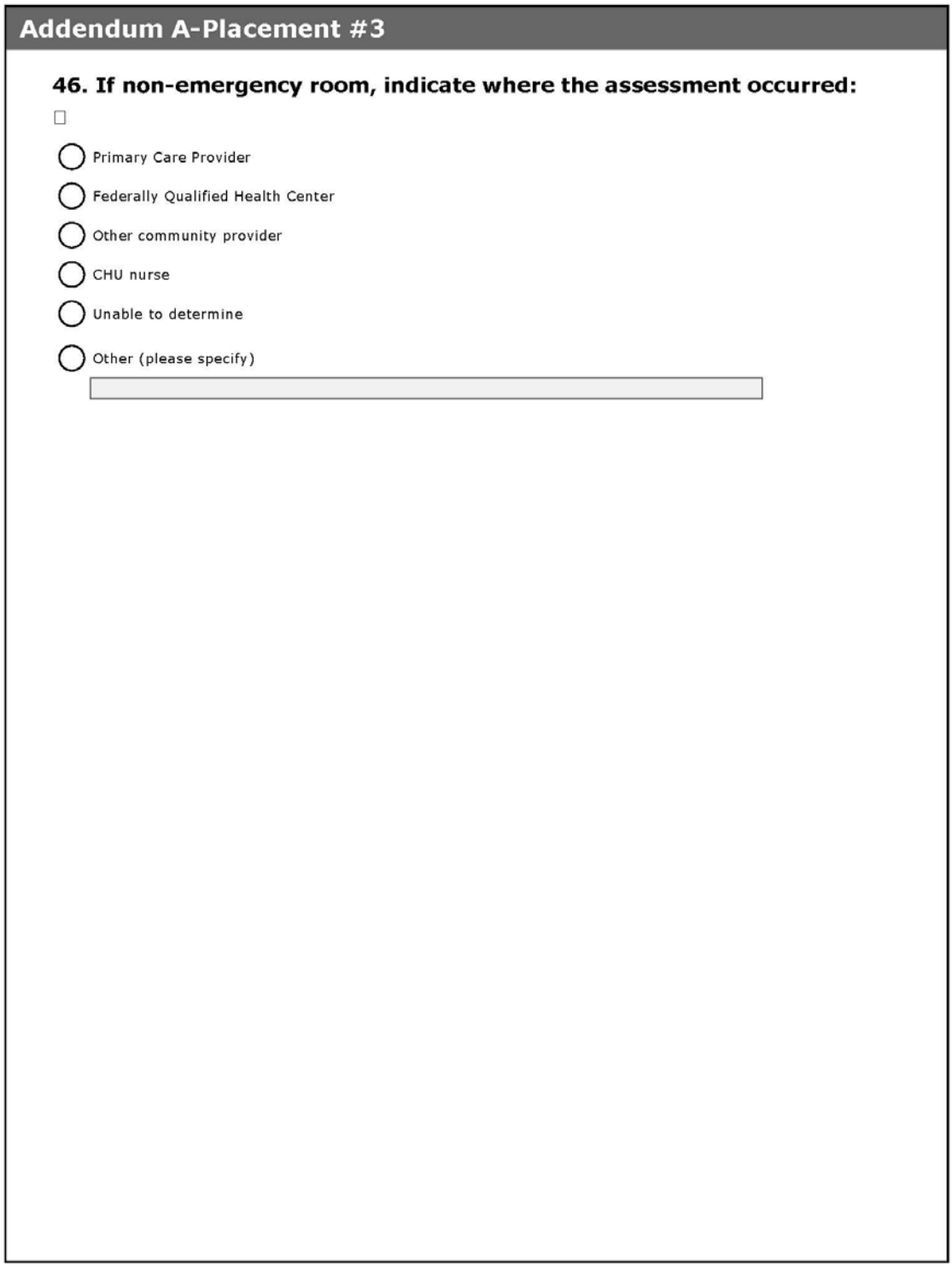
Appendix B
Data Collection Instrument

Addendum A-Placement #3

45. If Emergency Room, indicate:

	Day of week pre-placement assessment was completed	Time of day the assessment was conducted
Pre-placement occurred:		

Appendix B
Data Collection Instrument



Addendum A-Placement #3

46. If non-emergency room, indicate where the assessment occurred:

- ◯ Primary Care Provider
- ◯ Federally Qualified Health Center
- ◯ Other community provider
- ◯ CHU nurse
- ◯ Unable to determine
- ◯ Other (please specify)

Appendix B
Data Collection Instrument

Addendum A-Placement #3

47. Is there evidence in the record(s) that the DYFS form 11-2A (the child's medical information) was either physically handed or mailed to the resource provider within the first 5 days of placement?

- ◯ Yes
- ◯ No, but after 5 days
- ◯ No, no evidence of any information conveyed

Appendix B
Data Collection Instrument

Addendum A-Placement #3

48. Based on the evidence in the record, medical information provided to resource provider within the child's first five days of placement included: (check all that apply)

- ☐ Immunization history
- ☐ Information from pre-placement assessment
- ☐ Current medications
- ☐ Medical concerns
- ☐ Needed medical appointments
- ☐ Other (please specify)

Appendix B
Data Collection Instrument

Addendum A-Placement #3

49. Is there evidence that this child has been assigned to a CHU nurse's caseload?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

4th out of home placement?

50. Has the child had a subsequent placement?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Addendum A-Pre-placement assessment for Placement #4

51. Is there evidence in the record that the child received a pre-placement medical assessment?

☐

◯ Yes

◯ No

Appendix B
Data Collection Instrument

Addendum A-Placement #4

52. Date of pre-placement assessment:

- ◯ Unable to determine
- ◯ Month/Day/Year (Enter MM/DD/YYYY)

53. Timing of pre-placement assessment

- ◯ Prior to placement
- ◯ Within 24 hours after placement
- ◯ More than 24 hours after placement
- ◯ Unable to determine

54. Location of pre-placement assessment:

- ◯ Emergency Room
- ◯ Non-Emergency Room
- ◯ Unable to determine

Appendix B
Data Collection Instrument

Addendum A-Placement #4

55. If Emergency Room, indicate:

	Day of week pre-placement assessment was completed	Time of day the assessment was conducted
Pre-placement occurred:		

Appendix B
Data Collection Instrument

Addendum A-Placement #4

56. If non-emergency room, indicate where the assessment occurred:

- ◯ Primary Care Provider
- ◯ Federally Qualified Health Center
- ◯ Other community provider
- ◯ CHU nurse
- ◯ Unable to determine
- ◯ Other (please specify)

Appendix B
Data Collection Instrument

Addendum A-Placement #4

57. Is there evidence in the record(s) that the DYFS form 11-2A (the child's medical information) was either physically handed or mailed to the resource provider within the first 5 days of placement?

- ◯ Yes
- ◯ No, but after 5 days
- ◯ No, no evidence of any information conveyed

Appendix B
Data Collection Instrument

Addendum A-Placement #4

58. Based on the evidence in the record, medical information provided to resource provider within the child's first five days of placement included: (check all that apply)

- ☐ Immunization history
- ☐ Information from pre-placement assessment
- ☐ Current medications
- ☐ Medical concerns
- ☐ Needed medical appointments
- ☐ Other (please specify)

Appendix B
Data Collection Instrument

Addendum A-Placement #4

59. Is there evidence that this child has been assigned to a CHU nurse's caseload?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

5th out of home placement?

60. Has the child had a subsequent placement?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Addendum A-Placement #5

61. Is there evidence in the record that the child received a pre-placement medical assessment?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Addendum A-Placement #5

62. Date of pre-placement assessment:

- ◯ Unable to determine
- ◯ Month/Day/Year (Enter MM/DD/YYYY)

63. Timing of pre-placement assessment

- ◯ Prior to placement
- ◯ Within 24 hours after placement
- ◯ More than 24 hours after placement
- ◯ Unable to determine

64. Location of pre-placement assessment:

- ◯ Emergency Room
- ◯ Non-Emergency Room
- ◯ Unable to determine

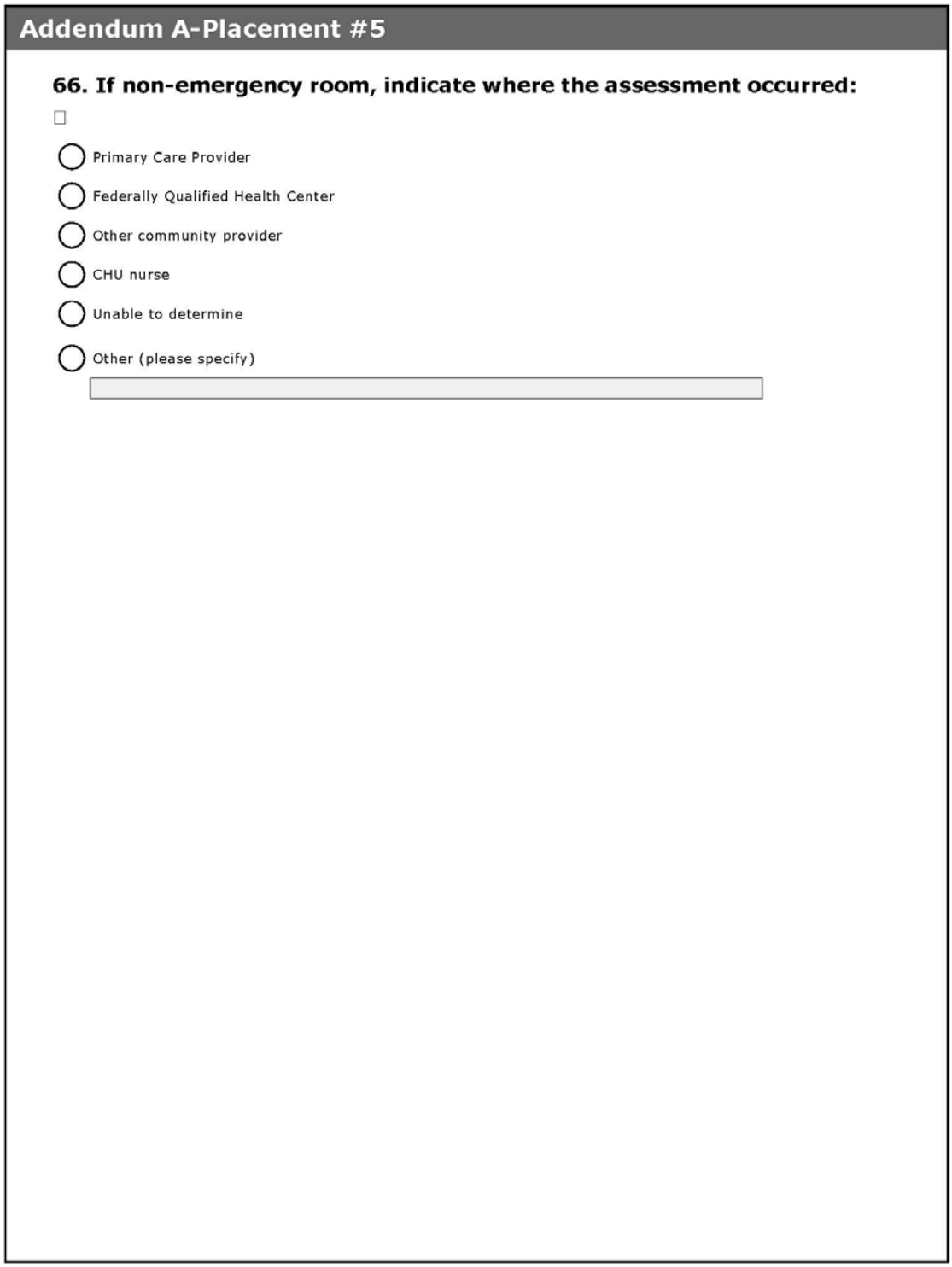
Appendix B
Data Collection Instrument

Addendum A-Placement #5

65. If Emergency Room, indicate:

	Day of week pre-placement assessment was completed	Time of day the assessment was conducted
Pre-placement occurred:		

Appendix B
Data Collection Instrument



Addendum A-Placement #5

66. If non-emergency room, indicate where the assessment occurred:

- ◯ Primary Care Provider
- ◯ Federally Qualified Health Center
- ◯ Other community provider
- ◯ CHU nurse
- ◯ Unable to determine
- ◯ Other (please specify)

Appendix B
Data Collection Instrument

Addendum A-Placement #5

Child's medical status/ information provided to resource provider

67. Is there evidence in the record(s) that the DYFS form 11-2A (the child's medical information) was either physically handed or mailed to the resource provider within the first 5 days of placement?

- ◯ Yes
- ◯ No, but after 5 days
- ◯ No, no evidence of any information conveyed

Appendix B
Data Collection Instrument

Addendum A-Placement #5

68. Based on the evidence in the record, medical information provided to resource provider within the child's first five days of placement included: (check all that apply)

- ☐ Immunization history
- ☐ Information from pre-placement assessment
- ☐ Current medications
- ☐ Medical concerns
- ☐ Needed medical appointments
- ☐ Other (please specify)

Appendix B
Data Collection Instrument

Addendum A-Placement #5

69. Is there evidence that this child has been assigned to a CHU nurse's caseload?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Child's medical status/ information provided to resource provider cont.

70. Is there evidence in the record that a primary care provider or other medical provider acts as the child's medical home?

- ◯ No
- ◯ Yes (indicate medical home)

71. Is there evidence in the record that this child is considered by DYFS to be medically fragile?

- ◯ No
- ◯ Yes (describe medical issue(s))

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations

72. Is there evidence in the record that the child received a Comprehensive Medical Examination (CME)?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

73. Who provided the CME?:

- ◯ Contracted Comprehensive Medical Examination provider
- ◯ Comprehensive Health Evaluation for Children (CHEC) provider
- ◯ Other community provider

74. Based on the evidence in the record, the CME provided was:

☐

- ◯ A general CME
- ◯ A Comprehensive Health Evaluation for Children (CHEC)
- ◯ Unable to determine

75. Indicate exam date

☐

- ◯ Unable to determine
- ◯ Month/Day/Year (Enter as MM/DD/YYYY)

76. The date of the CME is:

- ◯ Within 30 days of placement
- ◯ Between 31-60 days of placement
- ◯ More than 60 days after placement
- ◯ No evidence that child received either CME or CHEC
- ◯ Unable to Determine

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

77. Based on the evidence in the record, who accompanied child to CME? (check all that apply)

- ☐ Birth parent
- ☐ Relative placement provider
- ☐ Resource parent
- ☐ Caseworker
- ☐ Transportation aide
- ☐ Other
- ☐ Unable to determine

78. Was there an indication of a need for a language interpreter for the child during the exam?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

79. Was interpretation provided?

- ◯ Yes
- ◯ No
- ◯ Unable to determine

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

*** 80. Is there evidence in the record that available medical history was shared with the medical provider conducting the CME?**

	Yes	No, no evidence of sharing	No, no history available to share	Not applicable
Birth History-Prenatal Care (ONLY ANSWER FOR CHILDREN 6 OR YOUNGER)	○	○	○	○
Birth History-Neonatal Care and Testing (ONLY ANSWER FOR CHILDREN 6 OR YOUNGER)	○	○	○	○
Immunization	○	○	○	○
Other Health Information (Hospitalizations/surgeries, Behavior and Development, Significant injuries ER visits, growth and nutrition, allergies, special services)	○	○	○	○
Dental Care (ONLY ANSWER FOR CHILDREN 3 AND ABOVE)	○	○	○	○
Family History	○	○	○	○

Comments

81. Is there evidence in the record that the medical provider assessed the child's health systems? (Head, eyes, ears, nose, mouth/throat, neck, nodes, chest/lungs, heart, abdomen, extremities, back, genitalia, neuro, skin).

☐ Yes, all that apply to child

☐ No

☐ Some (specify systems not reviewed)/COMMENTS: (anything noteworthy/exceptional about the exam)

Appendix B
Data Collection Instrument

82. Is there evidence in the record that the child needed immunizations at the time of the CME?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

The child needed immunizations at the time of the CME

83. When were the vaccinations given?

- ◯ Vaccines given at exam and brought up to date
- ◯ Some vaccines given
- ◯ No vaccines given

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

84. Is there evidence in the record that a mental health screen was conducted for the child as part of the CME?

- ◯ Yes
- ◯ No
- ◯ Not applicable – child already identified with behavioral/mental health needs; child too young (under age 3)

Appendix B
Data Collection Instrument

85. If a mental health screen was conducted, is there evidence in the record that the screening indicated a suspected mental health need?

- ◯ Yes
- ◯ No

86. If a mental health screen was conducted, is there evidence in the record that a mental health assessment was provided to the child?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

87. The mental health assessment was provided to the child...

- ◯ During CME
- ◯ During CHEC
- ◯ At a subsequent CME or CHEC appointment

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

88. Is there evidence in the mental health record that a mental health assessment was scheduled?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

89. For children age 6 or younger, is there evidence in the record that the child's developmental needs were assessed as part of the CME?

- ◯ Yes
- ◯ No
- ◯ Not applicable, Child over the age of 6

Appendix B
Data Collection Instrument

90. Indicate developmental needs were identified? (Check all that apply)

- ☐ None
- ☐ Developmental delays
- ☐ Behavioral concerns
- ☐ Speech therapy
- ☐ Learning disability
- ☐ Further examination needed now or in the future
- ☐ Other (please specify)

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

91. For children older than 6 years, is there evidence in the record that the child's educational needs were assessed as part of the CME?

- ◯ Yes
- ◯ No
- ◯ Not applicable, Child under the age of 6

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

92. Indicate educational needs identified? (check all that apply)

- ☐ None
- ☐ Developmental delays
- ☐ Behavioral concerns
- ☐ Speech therapy
- ☐ Learning disability
- ☐ Further examination needed now or in the future
- ☐ Other (please specify)

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

93. Was an initial report generated at the end of the medical exam?

- ◯ Yes
- ◯ No
- ◯ Unable to determine

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

94. Based on the evidence in the record, to whom was the initial report provided? check all that apply

- ☐ DYFS caseworker
- ☐ CHU nurse
- ☐ Identified primary care provider
- ☐ Identified specialist
- ☐ Resource parent
- ☐ Relative/family friend caregiver
- ☐ Birth parent
- ☐ No evidence of distribution
- ☐ Other (please specify)

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

95. Is there evidence in the record that a final report that contained medical findings and recommendations was generated?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

96. Is there evidence in the record that the report was sent to DYFS?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

97. How soon after the examination was the report provided to DYFS?

- ◯ Within 2-3 weeks of date of examination
- ◯ Within 3-6 weeks of examination
- ◯ Over 6 weeks after examination
- ◯ Unable to determine

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

98. Based on the evidence in the record, to whom was the final exam report sent (check all that apply):

- [ ] DYFS caseworker
- [ ] CHU nurse
- [ ] Identified primary care provider
- [ ] Identified specialist
- [ ] Medicaid HMO care manager
- [ ] Law Guardian
- [ ] Birth parent
- [ ] No evidence of distribution
- [ ] Other (please specify)

Appendix B
Data Collection Instrument

99. Based on the evidence in the record, did the report include a plan to address the child's ongoing health needs, if any?

- ◯ Yes
- ◯ No

Appendix B
Data Collection Instrument

Comprehensive Medical Examinations cont.

100. Based on the evidence in the record, were there any identified needs that were not picked up in the plan of care?

- ◯ No, all identified needs appear to be picked up in the plan of care
- ◯ Yes (explain)

Appendix B
Data Collection Instrument

Follow Up

Were required referrals made?

101. Based on the evidence in the record, did the child receive the specified follow up actions identified in the CME, if applicable?

	Were required referrals made?	Was required follow-up care scheduled?	Was required follow-up care received?
Mental health assessment, includes psychological and psychiatric evaluations			

102. Based on the evidence in the record, did the child receive the specified follow up actions identified in the CME, if applicable?

Dental

	Were required referrals made?	Was required follow-up care scheduled?	Was required follow-up care received?
General			
Orthodontia			

Other (please indicate if referrals were made, follow up care was scheduled and if follow up care was received)

103. Based on the evidence in the record, did the child receive the specified follow up actions identified in the CME, if applicable?

Specialist

	Were required referrals made?	Was required follow-up care scheduled?	Was required follow-up care received?
Pulmonologist			
Allergist			
ENT			
Cardiologist			
Neurologist			
Dermatologist			

Other (please indicate if referrals were made, follow up care was scheduled and if follow up care was received)

Appendix B
Data Collection Instrument

Follow Up Cont.

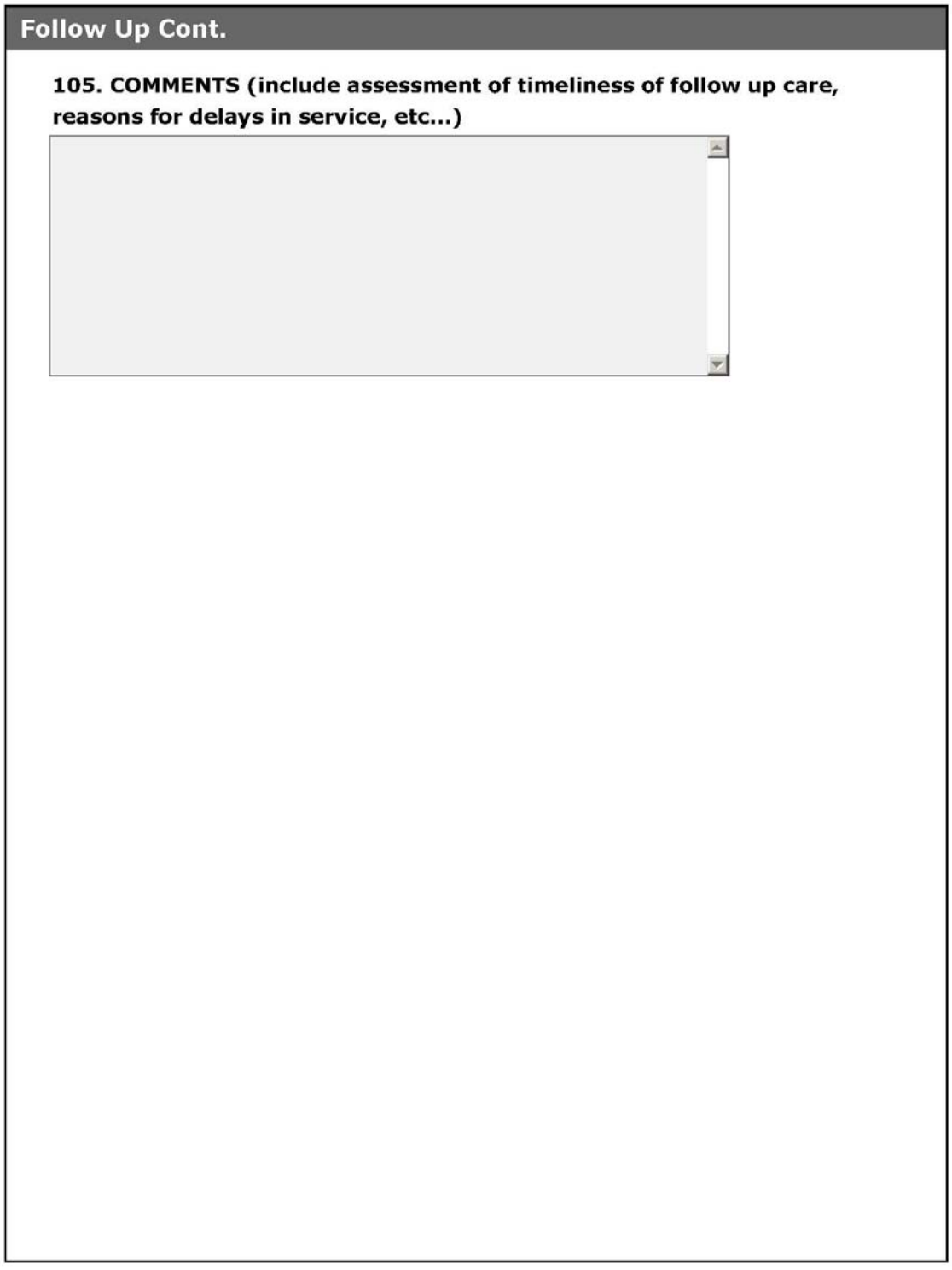
104. Based on the evidence in the record, did the child receive the specified follow up actions identified in the CME, if applicable?

Developmental/Educational

	Were required referrals made?	Was required follow-up care scheduled?	Was required follow-up care received?
Special Education			
Tutoring			
Speech therapist			

Other (please indicate if referrals were made, follow up care was scheduled and if follow up care was received)

Appendix B
Data Collection Instrument



Appendix B
Data Collection Instrument

Follow Up Cont.

106. Were all episodic or acute physical and dental health care needs that occurred from July 1, 2008 through March 6, 2009 met? (example, a serious virus, broken leg, lost glasses, the flu, chipped tooth, mouth injury)

- ◯ Yes, all
- ◯ Yes, some, indicate ones not met below
- ◯ No, specify below
- ◯ Not applicable, no acute needs

Other (please specify)

107. Were all episodic or acute MENTAL health care needs that occurred from July 1, 2008 through March 6, 2009 met?

- ◯ Yes, all
- ◯ Yes, some, indicate ones not met below
- ◯ No, specify below
- ◯ Not applicable, no acute needs

Other (please specify)

Appendix B
Data Collection Instrument

Visitation

Visitation with Parents/other designated reunification resource

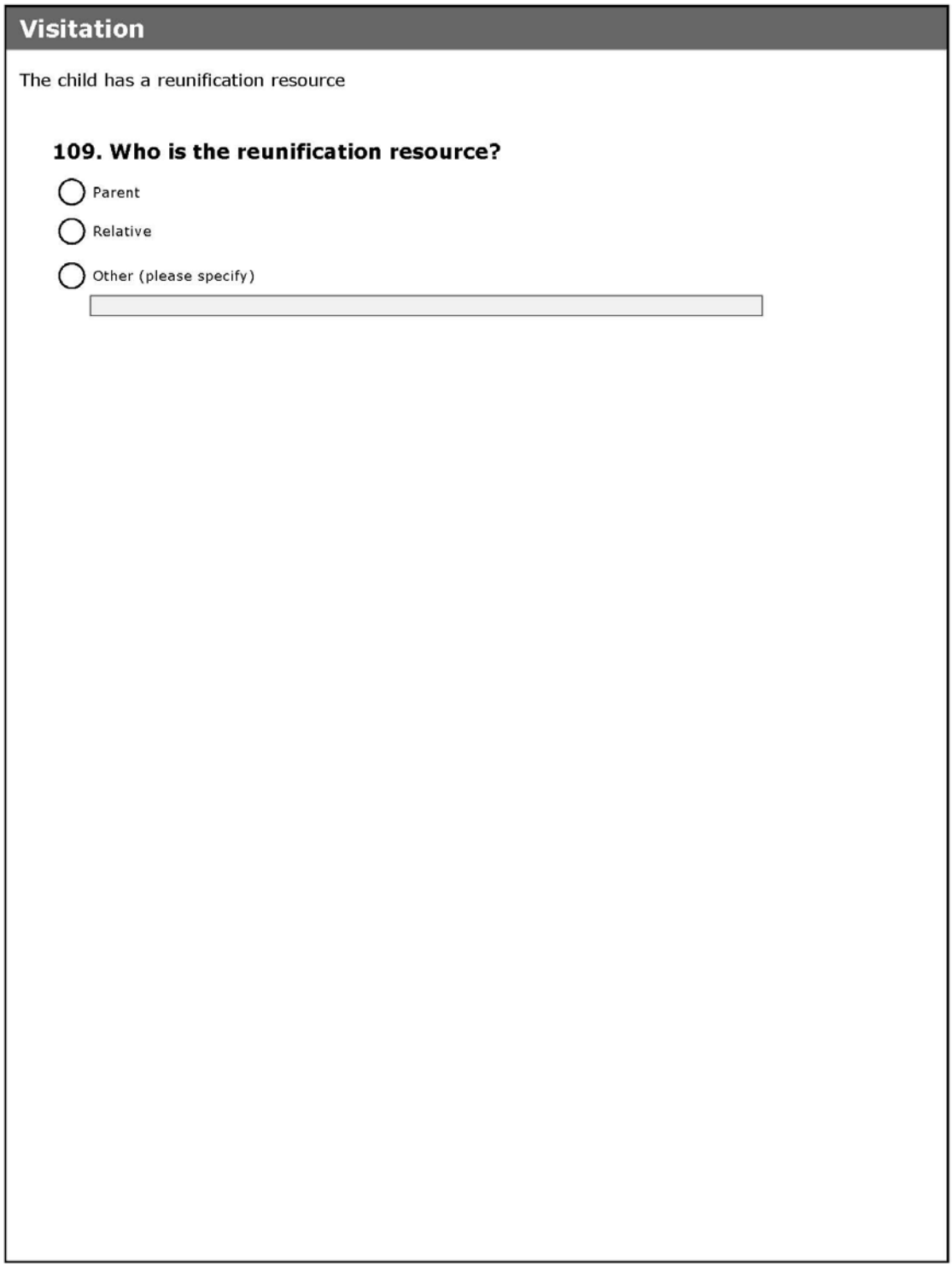
108. Does the child have a permanency goal of reunification?

☐

◯ Yes

◯ No

Appendix B
Data Collection Instrument



Visitation

The child has a reunification resource

109. Who is the reunification resource?

- ◯ Parent
- ◯ Relative
- ◯ Other (please specify)

Appendix B
Data Collection Instrument

Child-Parent Visits

110. For each month, in column 1, identify whether visits are applicable. In column 2, record the number of visits the child had with the person or persons with whom they are to reunify. (If the child visited at the same time with 2 people with whom they will reunify—for example, both their mother and father—count as 1 visit).

If visits are not applicable (such as parent is living outside of state more than 50 miles or country or parental rights have been terminated or child was not in placement that month) record 'NO' in Column 1.

	Column 1	Column 2
July 2008		
August 2008		
September 2008		
October 2008		
November 2008		
December 2008		
January 2009		
February 2009		

Appendix B
Data Collection Instrument

Weekly visits with their parents

Standard: children shall have WEEKLY VISITS WITH THEIR PARENTS when their permanency goal is reunification unless clinically inappropriate and approved by the Family Court

111. Does this visitation pattern meet the STANDARD above?

- ◯ Yes
- ◯ No □
- ◯ Unable to determine, explain

112. COMMENTS (about visitation—e.g.: Documented barriers to visitation, etc.)

Appendix B
Data Collection Instrument

Visitation with Siblings

Visitation with Siblings

113. At any time during the review period, did the child have minor siblings in DYFS custody with whom the child was not placed?

- ◯ Unable to determine
- ◯ No
- ◯ Yes. Indicate number of siblings

Appendix B
Data Collection Instrument

Visitation with Siblings

Visitation with Siblings

114. Describe siblings visiting pattern. If visits are not feasible with all siblings (sibling placed out-of-state more than 50 miles, AWOL from placement, or contact determined to be detrimental to child's best interest) or child was not in placement that month record as 'N/A'.

	Visits With all siblings	Visits With some siblings	Visits With no siblings	n/a
July 2008	◯	◯	◯	◯
August 2008	◯	◯	◯	◯
September 2008	◯	◯	◯	◯
October 2008	◯	◯	◯	◯
November 2008	◯	◯	◯	◯
December 2008	◯	◯	◯	◯
January 2009	◯	◯	◯	◯
February 2009	◯	◯	◯	◯

Appendix B
Data Collection Instrument

Visitation with Siblings

Standard: Children in DYFS custody who have minor siblings also in DYFS custody with whom they are not residing shall visit with those siblings as appropriate.

115. Does this visitation pattern meet the STANDARD above?

- ◯ Yes
- ◯ No □
- ◯ Unable to determine, explain

116. COMMENTS (about visitation—e.g.: Documented barriers to visitation, etc.)

Appendix B
Data Collection Instrument

Caseworker VISITATION with child

Caseworker VISITATION with child

117. Child--For each month, record the number of face-to-face visits the child had with a DYFS caseworker. If the child was not in placement that month, record as n/a.

	Number of face-to-face visits with worker in placement	Number of face-to-face visits with worker in other setting
July 2008		
August 2008		
September 2008		
October 2008		
November 2008		
December 2008		
January 2009		
February 2009		

118. STANDARD--Caseworker visits:
o At least two visits per month (one of which is in the placement) during the first two months of an initial placement (or subsequent placement for children in state custody).
o At least one caseworker visit per month in the child's placement

Does this visitation pattern meet the STANDARD above?

- ◯ Yes
- ◯ No □
- ◯ Unable to determine, explain

Appendix B
Data Collection Instrument

119. COMMENTS (about visitation—e.g.: Documented barriers to visitation, etc.)

Appendix B
Data Collection Instrument

Caseworker VISITATION with parent/reunification resource

Caseworker VISITATION with parent/reunification resource

120. For each month, record the number of face-to-face visits the parent or other reunification resource had with a DYFS caseworker. If the child was not in placement that month or parental rights had been terminated, record as n/a.

	Number of face to face visits with caseworker or private provider.
July 2008	
August 2008	
September 2008	
October 2008	
November 2008	
December 2008	
January 2009	
February 2009	

121. STANDARD--Caseworker visits:
o At least two face-to-face visits per month with the parents or other legally responsible family member of children in custody with the goal of reunification.
o At least one face-to-face visits per month with the parents or other legally responsible family member of children in custody with goals other than reunification unless parental rights have been terminated.

Does this visitation pattern met the STANDARD?

◯ □Yes

◯ □No, specify

◯ □Unable to determine, explain

if No or Unable to Determine, please explain

Appendix B
Data Collection Instrument

122. COMMENTS (about visitation e.g.: Documented barriers to visitation, etc.)

Appendix B
Data Collection Instrument