Ensuring the Health and Well-Being of Children in Foster and Kinship Care During a Pandemic: Lessons Learned and Recommendations

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This white paper was developed by the Rees-Jones Center for Foster Care Excellence at Children's Health and the Committee on Foster Care of the Texas Pediatric Society. It is endorsed by the Texas Pediatric Society, the Texas Chapter of the American Academy of Pediatrics.

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Introduction

As Texas re-opens amid rising hospitalization rates and ongoing concerns related to COVID-19, much about the future remains uncertain. Preventive measures, such as physical distancing and limiting large gatherings, are effective ways to limit the spread of coronavirus, and this new reality requires that our systems and institutions are prepared to operate within these circumstances. Included among these systems and institutions are those serving children in the child welfare system. Although it appears thus far that children are much less likely than adults to be physically harmed by COVID-19, the virus has threatened the safety and wellbeing of children in numerous ways.

Not all individuals are equally impacted by COVID-19. Among those disproportionately affected are the nearly 30,000 Texas children involved with the child welfare system. Efforts to slow the spread of the virus, although necessary, have reduced availability of in-person visits with caseworkers and biological family members, delayed court hearings related to reunification, reduced in-person visits with medical providers and delayed well child care, hampered efforts to recruit new foster homes, and made it more difficult to find placements for children leaving institutional settings.

This white paper focuses on the challenges faced by children and families involved in the child welfare system that have been intensified during the COVID-19 pandemic. Reflecting on our experiences as pediatric primary care medical homes for children in the child welfare system and the feedback we have received from caregivers and community partners, we draw attention to positive changes made in response to the COVID-19 pandemic and provide recommendations for addressing the challenges going forward. Recommendations are grouped into four overarching categories: telehealth, communication, safety, and placement stability and support.

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Telehealth

Fear of exposure to coronavirus, coupled with concerns about effective safety measures, created challenges for engaging patients in essential healthcare. To ensure patients received needed care, many medical homes turned to telehealth. Expanded use of telehealth was possible because state and federal leaders worked with hospitals and physicians to waive certain regulatory requirements so that medical providers can prioritize safety and access to care during the declared disaster. This included waiving certain requirements for billing for services provided by telephone, online prescribing and written consent, enabling health care providers to meet patients' needs. Telehealth has not, however, advanced without challenges for service providers and families. This section highlights positive aspects of the adoption of telehealth, the challenges related to providing pediatric care via telehealth, and recommendations for promoting access and quality of care moving forward.

POSITIVE OUTCOMES

- Increased access to medical care and mental health services, especially in rural and underserved communities
- Helped mitigate the need for personal protective equipment
- Reduced the potential for exposure, particularly for service providers and caregivers of multiple children and/or immunocompromised children
- Decreased transportation-related challenges and associated costs
- Allowed for increased capability of adults engaged in the patient's care (e.g., biological parent; case worker; court-appointed special advocate) to participate in health visits
- Allowed the medical provider a view into the child's home living environment
- Decreased no-show rates, allowing children to receive care in a timely manner

CHALLENGES/LIMITATIONS

- Confusion regarding which services were reimbursable and for what length of time
- Internet access, sufficient bandwidth and expertise to troubleshoot technical problems
- Education on the use of various platforms, for both providers and patients.
- Upfront costs for health care providers associated with developing or accessing telehealth platforms
- Lack of an evidence base on the utility and effectiveness of telehealth across health care services (e.g., play therapy, occupational therapy)
- Concerns about ethical and appropriate provision of therapeutic services (e.g., children and clinicians are alone in their own space during therapy to ensure privacy; clinician knows how to contact the caregiver if safety-related behaviors arise that would involve the need for emergency intervention)
- Not all visit types are conducive to a virtual modality (e.g., well checks requiring vaccines; initial evaluations, developmental assessments)
- Difficulty developing therapeutic relationship for some patients via virtual modalities

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Telehealth (cont.)

RECOMMENDATIONS

1. Legislation should be enacted to codify telehealth payment parity and audio-only reimbursement. A statewide task force that includes medical, mental health, and other service providers could help in determining what visits are most appropriate for virtual modalities, identifying barriers to care, and developing additional recommendations for legislative changes and best practices for providers.
2. Continue to reimburse for audio-only services to ensure patients whose caregivers do not have access to other technology still have access to care.
3. Efforts to improve availability of telehealth should include increasing access to HIPAA-compliant platforms and IT personnel to help with troubleshooting, providing direct funding for health systems and smaller practices to implement telehealth, and/or incentivizing providers to use telehealth.
4. Expand the research base on effective delivery of various therapies, such as occupational therapy, and administering developmental screeners, such as the Ages and Stages Questionnaire, via telehealth.
5. Mental health providers should ensure that they and the children to whom they are providing therapy are in appropriate, safe environments and that children's cognitive and emotional states are conducive to telehealth therapy sessions. For example, providers should confirm that the child has a private place to participate in therapy, that the child has the cognitive capacity to meaningfully engage with the provider, they have caregiver emergency contact information.
6. Ensure instructions provided to caregivers on accessing the virtual platform are straightforward, easily understood, and available in a patient and caregiver's primary language.
7. Identify and develop best practices in providing trauma-informed care in virtual environments.
8. Develop training for caregivers on best practices in communication during virtual visits, with a focus on developmentally appropriate strategies for young children.

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Communication

COVID-19 required agencies and organizations to adopt new protocols and procedures designed to keep children and staff safe. As we learned more about COVID-19, including exposure risks and outcomes, policies and guidance informing the protocols were constantly changing. Some of these changes helped to ensure lines of communication stayed open, but the lack of a central location for housing the most current guidance resulted in confusion among caseworkers, providers, and caregivers on what was being recommended and required of them. This section highlights the positive outcomes of adopting and/or expanding communication modalities as well as the challenges related to communication between CPS, caregivers, and healthcare providers followed by recommendations for improving communication in the future.

POSITIVE OUTCOMES

- Increased frequency in contact between caregivers and child protective services (CPS) caseworkers and child-placing agency (CPA) case managers led to greater opportunity to offer support and build relationships.
- Use of virtual technology to promote cross-system communication and collaboration among caregivers, CPS, healthcare providers, education system, legal system, and other community support systems (e.g., virtual case conferences).
- Greater frequency of communication between biological parents and their children and between foster parents and biological parents, using virtual modalities. This was especially helpful for biological families who were living long distances from their children (e.g. transportation barriers).

CHALLENGES/LIMITATIONS

- Changing guidance and a lack of a central place for posting guidance (e.g., website) from CPS caused confusion about what was required regarding health-related visits (e.g., 3-in-30).
- Lack of an evidence base on communicating with patients and their caregivers in a trauma-informed manner in the virtual context.
- Access to and understanding of how to use various technologies that enable communication during social distancing and shelter-in-place orders.
- An overwhelming amount of information coming from a variety of trusted sources made it difficult to discern what was most relevant.
- Inconsistent and often unrealistic expectations of biological families and caregivers regarding length and frequency of virtual visitation and developmentally appropriate behavior during these visits. For example, because young children typically have short attention spans and rely on physical touch to communicate affection, the quality of virtual meetings between biological parents and their young children was variable.
- Cancelled and delayed legal proceedings, along with limited access to virtual hearings, led to stalled permanency for children (e.g., delayed reunifications, kinship placements, adoptions).

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Communication (cont.)

RECOMMENDATIONS

1. Form a cross-sector emergency preparedness task force consisting of organizations and individuals that work with children involved in the child welfare system, such as CPS, health care providers, child-placing agencies, foster and kinship caregivers, court-appointed special advocates, and judges, to provide guidance and recommendations for ensuring effective communication during pandemics or other states of emergency.
2. Centralize official communications on a single website (e.g., DFPS website) to ensure all parties have access to the current guidance (e.g., 3-in-30 and well-child check requirements, visitation guidelines). Avoid sharing information through email, except to provide hyperlinks to the official website, when possible, to ensure the most current information is shared.
3. This website should include easy-to-follow instructions on how to access and operate commonly used virtual platforms.
4. Incorporate positions within child-serving organizations that foster collaboration across systems and enhance trauma-informed care, such as embedding CPS liaisons within health care settings.
5. Continue to promote virtual options for participation in meetings and to encourage cross-sector communication and collaboration.
6. Comply with requirements for legal proceedings statewide and expand efforts to allow courts to use virtual platforms.

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Safety

A primary goal in both health care and child welfare is ensuring the safety of children and families. COVID-19 related policies have been put in place by the state of Texas, as well as local government officials, to help protect the well-being of children, families, and local communities. These new policies have limited the exposure of children and caregivers to COVID-19; however, some of these safety policies have also placed limitations on the ability of agencies and health care workers to be able to fully assess the child's current situation for safety. This section outlines the implications of these policies and address ways in which we can balance the needs to reduce potential COVID-19 exposure with the need for health care and child welfare workers to ensure that children are safe from abuse and neglect in their homes.

CHALLENGES/LIMITATIONS

- Typical reporters of abuse and neglect (e.g., family, neighbors, teachers, health care providers) have had decreased in-person contact with children due to social distancing measures and lack of personal protective equipment.
- Because of the nature of institutional settings, children and staff in psychiatric hospitals, residential treatment centers, and juvenile detention centers are at higher risk of exposure and potential infection with COVID-19.
- Caregivers with pre-existing health conditions and/or over the age of 65, who were deemed to be high risk, may have to determine whether to shelter-in-place for their own safety or leave the house to care for the children in their home (e.g., required in-person appointments, picking up prescriptions, etc.). Similarly, the need for social distancing may make it difficult for these caregivers to provide adequate care and limit the abilities of CPS and other agencies to provide support.
- Fear of COVID-19 exposure led some families to suspend accepting new children into their homes. Recruiting new foster parents also became more difficult. Limited availability of placements in some places led to children once again sleeping in CPS offices.
- Messages about when and how to seek testing and treatment, what activities are okay to pursue, and the level of risk involved in various activities have been disjointed, and at times, contradictory. The result has been confusion about such important matters as whether it is safe to go the emergency room, to attend well-child visits, to visit an urgent care, or to continue ongoing health treatments (e.g., therapy).
- Access to data, such as collateral interviews and external medical records, may have been limited due to physical distancing, reduced staffing, and sometimes closures of facilities. The decreased access to essential data may have resulted in delayed decision-making and redundant evaluations or interventions.

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Safety (cont.)

RECOMMENDATIONS

1. Form a cross-sector emergency preparedness task force consisting of organizations and individuals that work with children involved in the child welfare system, such as CPS, health care providers, child-placing agencies, foster and kinship caregivers, court-appointed special advocates, and judges, to provide guidance and recommendations for ensuring children's safety during pandemics or other states of emergency. (This could be the same task force as the one recommended under recommendations for improving communication.)
2. Increase community awareness about the increased risk of child maltreatment during times of extreme stress, including how to identify and report suspected child maltreatment.
3. Increase capacity and capability for on-site/mobile medical care and screenings to institutions with high risk capacities (e.g. residential treatment centers, emergency shelters, juvenile detention centers) during states of emergency.
4. Increase access to personal protective equipment for caseworkers, high-risk caregivers, and essential workers in institutions where children are placed.
5. Continue efforts to expand partnerships with community agencies (e.g., faith-based initiatives, CPAs) to help fill gaps in services and provide increased support to caregivers, particularly kinship caregivers. Support services can include respite care, counseling, and access to essential supplies (e.g., contactless grocery delivery).
6. Centralize communications, such as on a single website, to ensure accurate and consistent information (e.g., protocols, exposure risk) is available to caregivers and entities serving children in foster and kinship care.
7. Allow for shared data systems, which will assist with access to data from different entities that interact with the same population.

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Placement Stability and Support

COVID-19 policies have required most children to continue their day-to-day activities from their homes, placing a greater burden on caregivers in areas such as required supervision and assistance with schoolwork. These additional requirements and unplanned adjustments may increase stress among children and their caregivers, leading to potential placement breakdowns. Typical support systems for caregivers, such as school/day care, therapies, and respite services may not be available or have become limited to virtual interactions. This section will outline the advantages of time spent at home with the child as well as the difficulties that have impacted placements followed by recommendations to promote placement stability and access to support services.

POSITIVE OUTCOMES

- Increased convenience and accessibility to trainings and other resources via virtual platforms
- Increased frequency of contact between caseworkers/case managers and caregivers via virtual platforms
- Increased caregiver involvement in placement and permanency discussions due to access via virtual platforms (i.e., court hearings, family team meetings).

CHALLENGES/LIMITATIONS

- Increased demands on caregivers
- Fewer in-person supports, specifically from providers and caseworkers
- Limited access to crisis management for behaviors
- Limited support and/or resources for kinship families
- Limited options for respite care
- Inability to access resources typically provided in the school setting or through community organizations

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Placement Stability and Support (cont.)

RECOMMENDATIONS

1. Build capacity for mental health services for caregivers via virtual platforms (e.g., telehealth services for counseling/therapy).
2. Evaluate access to crisis management resources during states of emergency, particularly for caregivers, child welfare workers, and CPAs.
3. Increase access to training and education for caregivers regarding problematic behaviors when limited resources are available.
4. Continue funding for existing programs that enable caregivers to provide safe environments for their children. Specifically:
   a. Emergency Paid Sick Leave Act – The Act is scheduled to expire in December 2020. It should be extended until a vaccine is readily available in order for caregivers to care for themselves and their family members who become ill from COVID-19.
   b. Respite care –Allocate funding specifically for increased respite resources to both CPS and CPAs. Allow CPAs to provide respite to non-licensed kinship families involved with CPS during emergency circumstances.
   c. Youth Empowerment Services (YES) Waiver – Allocate additional funding and/or incentives to encourage expanded crisis response resources, such as adding mobile crisis units and expanding emergency funding.
5. Continue utilization of virtual platforms to allow caseworkers, case managers, educators, and other community organizations to maintain frequent contact with families and provide additional support when in-person contact is not available.

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Conclusion

The COVID-19 pandemic brought additional challenges to a child welfare system tasked with providing care to the nearly 30,000 Texas children entrusted to its care. This white paper comes at a critical time, as we evaluate our collective actions to address the health disparities apparent for children in foster and kinship care. We highlight both the positive outcomes and evident challenges in the areas of telehealth, communication, safety, and placement stability and support. The recommendations provided center around increasing access to essential services for children and their caregivers, ensuring that standards of care are met, and innovative solutions to build capacity for services to support children in foster or kinship care and their caregivers. These efforts will require cross-sector collaboration, policy changes, and continued funding to promote the health, safety, and well-being of children in foster and kinship care.

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