Meeting the Behavioral Health Needs of Children in Foster Care
A Plan for Denver County

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EXECUTIVE SUMMARY

Nationally, about 500,000 children are in foster care on any given day. Most of these children are placed in foster care because of abuse or neglect. Often this abuse or neglect occurs within the context of parental substance abuse, extreme poverty, mental illness, or homelessness (National Commission on Family Foster Care, 1991). These children are at an elevated risk for experiencing developmental delays and physical or behavioral health needs.

To address the unique needs of children in foster care, Denver Health, the “safety net” hospital for the Denver metropolitan area, developed a new clinic that uses the medical home model to meet the medical and oral health needs of children in foster care. This clinic is called the Connections for Kids Clinic (CFKC) and strives to provide coordinated health care in a stable environment for this vulnerable population. While the clinic has always provided referrals for children with behavioral health needs, for a variety of reasons behavioral health was never fully integrated into the clinic. In 2009, the CFKC convened a panel of experts to develop a plan for integrating behavioral health care into the clinic. The panel recommended that the following four activities be implemented:

- Conduct a behavioral health screening of all children in foster care
- Develop a network of community based behavioral health providers
- Hire staff to coordinate care for children in foster care
- Develop a database for facilitating care coordination

While these activities will require grant funding in the initial phases, it is anticipated that these changes will ultimately be sustained through billing for services and cost savings to the system.
INTRODUCTION

Providing truly integrated health care is a challenge in community based pediatric practices. These challenges only increase when the practice serves children in foster care. Denver Health has created a clinic that strives to do just that. As this clinic has grown, it has become clear that it cannot adequately serve the needs of children in foster care without integrating behavioral health care. Given the complexity of integrating behavioral and physical health for children in foster care, the clinic brought together a panel of experts to develop a plan to do this. This report outlines the findings of this Expert Panel.

CHILDREN IN FOSTER CARE

In the United States between 12% and 16% of children experience some kind of developmental problems. Unfortunately, only one-third of those children, usually those with the most obvious conditions, are identified before they begin school. This under-identification represents a missed opportunity because waiting until children enter school to identify problems can compromise future educational success and well being (Halfon et al., 2005). A growing body of research also links early childhood experiences with later cognitive, social, emotional, and physical health development. By intervening early, health care providers can influence children's health and development. Early intervention can also improve their readiness to learn at school and decreasing the risk for many adult diseases.

Early identification is especially important for children in foster care. Nationally, about 500,000 children are in foster care on any given day and this number has been increasing over the last several years (Szilagyi, 1998). Most of these children are placed in foster care because of abuse or neglect. Often this abuse or neglect occurs within the context of parental substance abuse, extreme poverty, mental illness, or homelessness (National Commission on Family Foster Care, 1991). Several studies have shown that because of these challenges, children living in foster homes are at increased risk for physical health concerns, behavioral health problems, or developmental delays. In a study of 6177 children in foster care in Utah, Steele and Buchi (2008) found that over half of the children had more than one acute or chronic condition that required a medical referral. The most common conditions were overweight or obesity and dental problems. When examining behavioral health issues, 44% of the children had at least one condition and
26% had more than one. The most common diagnoses were reactive attachment, adjustment disorders, oppositional defiant disorder and conduct disorder. In addition, more than a third of children over the age of 12 had some type of mood disorders (Steele and Buchi 2008). According to the Child Welfare League of America, 40 to 85 percent of children in foster care experience behavioral health disorders. Equally concerning is the rate of developmental delays found in children in foster care. In a study of 2419 children assessed shortly after placement in foster care, 23% of the younger children screened positive for developmental issues and 22% of older children were already receiving special education services prior to placement (Chernoff et al., 1994). While it is clear that a large number of children in foster care are in need of physical and behavioral health services, it is estimated that less than one-third of these children receive the care that they need (Halfon et al., 2005).

**FAMILIES OF CHILDREN IN FOSTER CARE**

While the medical field has a role to play in caring for the needs of children in foster care, families also play a vital role. Many existing programs that provide physical and behavioral health care to foster children focus only on including foster parents, but not biological parents or relatives. In fact, it is common for these programs to overlook or completely dismiss the significance of family participation. In a national survey of health care providers that serve children in foster care, McCarthy (2002) found that birth parents are seldom involved in their child’s health care, have little contact with their child’s health care workers, and are not directly invited to attend meetings or appointments. There are numerous reasons for this lack of involvement. In some cases, there is a safety issue and the child welfare system needs to focus on protecting a child from his or her parents. Other times, medical clinics will perceive it as a conflict of interest to allow birth parents to attend initial evaluations or seek treatment at the same clinic as their child in foster care (McCarthy, 2002).

A number of researchers have criticized the exclusion of biological parents as counterintuitive since almost 70% of children in foster care ultimately reunite with their biological family (McCarthy, 2002). In fact, some studies indicate that family involvement is absolutely crucial to the success of any medical home providing services to foster children, especially since the biological family can provide vital details about a child’s medical history, behavioral health, or current needs (McCarthy, 2002). The biological family often has the best information about the
child’s health situation and they need to be able to provide this information to treatment providers (Grayson, 2009). If reunification occurs, as is the goal in many cases, the child should continue to receive health care from the same providers to ensure continuity of care. This continuity of care is of particular concern for children in foster care if biological parents have not been informed of the health care their children received while in a foster home. Ultimately, biological parents should: know their children’s providers, have an active role in the child’s care, and be kept in the loop throughout the entire process. Additionally, children feel more at ease and cooperate more often with health care providers when they have a supportive involved family. When a family is provided with enough support and information prior to and during reunification, it is less likely the child will ever need to reenter the foster care system (Grayson, 2009). As a result, a child’s biological family needs to be included whenever possible; their needs, beliefs, and culture should be considered and they should be provided with appropriate support (McCarthy, 2002).

BEHAVIORAL AND PHYSICAL HEALTH CARE OF CHILDREN IN FOSTER CARE

Physical Health

Almost by definition, children who enter foster care have a variety of physical, developmental and behavioral health needs that have not been adequately addressed. Compared with children from the same socioeconomic background, foster children have much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays, and poor school achievement (Frank, 1980; Steele & Buchi, 2008). While some children enter the foster care system with chronic illnesses, sexually transmitted diseases, or HIV, often these children do not receive the health care they need (Simms et al., 2000). It could be anticipated that once a child enters the foster care system, these medical issues will be addressed. However, some studies indicate that the health care that children receive while in the foster care system is just as poor as the health care they received prior to entering the system. Studies conducted by the United States General Accounting Office (1995) indicate that children in foster care do not receive adequate preventative health care while they are in the system. This may be indicative of many children’s health concerns not being adequately treated or even worse not identified (Schor, 1988; US General Accounting Office, 1995).
In part, this inadequate health care is the result of the many transitions children in foster care experience. A quarter of children in foster care will be placed in at least three different homes while in care and some children experience many more moves. Furthermore, up to 35% of children reenter the foster care system after being returned to their families. These changes in placement are likely to be accompanied by changes in physicians (AAP, 2001). With each of these changes there is the potential for important information about a child’s medical history to be lost. As a result, available health information about these children is incomplete, dispersed over multiple locations and their care is fragmented. This may mean that health conditions that require ongoing care are not addressed, necessary medications may be discontinued, or even worse, providers may not even know about issues that require immediate attention. It is for this reason that the AAP Committee on Early Childhood, Adoption, and Dependent Care asserts that all children in foster care need to receive initial health screenings and comprehensive assessments of their medical, behavioral, dental health, and developmental status. Results of these assessments must be linked to the provision of individualized comprehensive care that is continuous and part of a Medical Home (AAP, 2001). Despite this clear recommendation, the health care that children receive while in the foster care system is often compromised by insufficient funding, poor planning, lack of access to providers, lack of coordination of services, poor communication among the health care providers and child welfare professional, as well as prolonged wait periods for community-based health services.

While the health care that children in foster care receive is often inadequate, for some children it is the first time in their lives that they have received health care. For those children who have never received routine health care, entering the foster care system is a chance to improve their emotional and physical health.

**Behavioral Health**

If the provision of physical health care is fragmented, the provision of behavioral health care is often inconsistent and unreliable. Although a broad range of supportive and therapeutic services is needed, most children do not undergo a comprehensive developmental or psychological assessment at any time during their placement (AAP, 2001). In part this is because children in foster care experience many barriers to receiving coordinated behavioral health care that are not experienced by other children.
While most children are brought to appointments by their parents, children in foster care are brought by their foster parents. In some cases foster parents are not legally empowered to make treatment decisions for the children in their care, particularly regarding mental health needs. This function is provided by the human services agency acting as the child’s guardian. As a result, the department must approve all referrals for services and provide signatures for all forms, such as the consent for treatment. This significantly delays the referral process. Also, community behavioral health providers may not fully understand this process and therefore may be reluctant to accept consent for treatment from someone other than the child’s biological parent. Foster children may also have a number of special treatment needs related to the experiences that led to their entry into the foster care system, such as exposure to violence or trauma. Addressing these treatment needs may require special training on the part of behavioral health providers. Even when behavioral health providers clearly understand the needs of children in foster care, a change in behavioral health providers can have negative consequences for the child. Often successful psychotherapy is dependent upon the establishment of a therapeutic relationship between the provider and client. If disruption of these relationships occurs, as often happens when children move from one placement to another, it can severely limit the effectiveness of treatment.

Continuity of care may be particularly important for certain groups of children. For example, it is suspected that children with Reactive Attachment Disorder and children who experience frequent hospitalizations, regardless of diagnosis, may move from one placement to another at higher rates than children with other diagnoses. Therefore, it may be necessary to craft a system of care that “moves with” certain groups of children. By developing a system of care that maintains the therapeutic relationship for such groups of children, there may be an increased possibility of stabilizing these children in placement settings. Children moving from one placement to another is a major concern for child welfare agencies. This is because frequent unplanned moves have such a detrimental effect on children. Moves often result in loss of attachments for children in many ways because all of their significant relationships change: caretakers, therapists, school settings, and medical providers. Internal studies conducted by the Denver Department of Human Services over the last 2 years, have concluded that more than 16% of moves in care can be attributed to the child’s behavior (Mitchell, 2009). These types of
placement changes often lead to disruptions in the therapeutic relationship and may allow for information about referrals for behavioral health treatment to be lost. This makes it hard for the child welfare system to adequately meet these children’s needs. Therefore, it is imperative that a coordinated plan be developed to ensure that the behavioral health needs of children in the foster care system are identified and referrals are made to behavioral health providers who understand the unique needs of children in foster care

**ASSESSING THE BEHAVIORAL HEALTH NEEDS OF CHILDREN IN FOSTER CARE**

The majority of children who enter foster care have experienced abuse and neglect in environments that often do not promote normal growth and development (AAP, 2006). This means that for many children behavioral health care can be as important as physical health care. However, children in foster care still receive insufficient services, mostly as a result of under-identification of children with behavioral health issues (Romanelli et al., 2009). While appropriate early intervention has proven effective for treating developmental and behavioral disorders, early intervention requires early identification of developmental and behavioral health issues (Bruhn, 2008; Perry, 1999). Therefore, it is crucial to implement comprehensive developmental and behavioral health assessments for children in foster care in order to design an appropriate developmental and behavioral health treatment plan. In the absence of this, it is unlikely that children will successfully achieve placement permanency (AAP, 2006). In addition, failure to address the needs of these children early on can allow their problems to grow exponentially over time (Bruhn, 2008). In contrast, Garwood (2001) suggested that early identification of problems will allow referrals to occur in a timely fashion, prepare foster parents for the specific care that children need and provide baseline information in case a child experiences multiple placements.

Several individuals and organizations have provided recommendations for which elements should be included in a comprehensive assessment program (AAP, 2006; AACAP, 2003; Romanelli et al., 2009; Silver, 2007; Leslie, 2003; Perry, 1999; Milburn, 2008; AAP, 2001; AAP, 2006).
The AAP (2006) suggested that one of the functions of an assessment program is to identify any and all developmental and behavioral health issues. Garwood and others suggested that children should be assessed without anyone else in the room if possible, so that any concerns can be freely expressed (AACAP, 2003; Garwood, 2001). It is important not only to assess problems, but also a child’s strength and coping styles (Romanelli et al., 2009). In addition, the assessment should be family-centered, in which family is defined as people who have primary responsibility for the children in care (AACAP, 2003; AAP, 2006). Assessments should be culturally and linguistically appropriate. It is also important to evaluate the child in the context of their current and past placements. This will help foster parents better understand the needs of the child and assist in promoting an environment that helps the child thrive (AACAP, 2003; AAP, 2006; Milburn, 2008; Silver, 2007). Finally, a comprehensive assessment program should have the capacity to evaluate all children, including infants, where a dynamic, developmental perspective is essential due to their rapid development (Perry, 1999; Silver, 2007). In order to ensure this type of comprehensive assessment, several authors have recommended that the assessment take place through a centralized location such as a specialized foster care clinic (Leslie, 2003; Bruhn, 2008). These assessments should be conducted by specially trained professionals hired specifically for this purpose (Leslie, 2003; Bruhn, 2008). Any system designed to provide comprehensive assessments of the behavioral health needs of children in foster care must contain four steps. Each of these steps is distinct, but should follow each other as part of a sequential process. The steps are:

1) Initial screening for behavioral health needs that obtains a baseline and gathers background information (Perry, 1999)
2) In-depth behavioral health assessment of children identified by the initial screening as having behavioral health needs (Romanelli et al., 2009)
3) Linking children to appropriate behavioral health treatment based on any needs identified through the in-depth assessment
4) Routine screening for behavioral health needs during well child visits and following any major life events such as hospitalization, placement changes, or transition out of the foster care system (AAP, 2006).

It is important that a protocol be developed to ensure that children in foster care move smoothly from one step to another. Without such a protocol, there is a risk that children in foster care will fall through the cracks and fail to receive the services they need (Bruhn, 2008). As children in
foster care move through this sequence, information gathered at each step should be shared with caregivers and foster care workers. This information should include the strengths, needs, and recommendations for treatment (Perry, 1999).

**Initial Screening for Behavioral Health Needs**

Initial behavioral health screening, including a screening for alcohol and drug use, is should take place within 24 hours of a child entering the foster care system (AACAP, 2003). Those infants who enter the foster care system at birth should be screened for in utero substance exposure. The initial screening process for children should first assess the levels of distress the child experiences from being removed from the home (AACAP, 2003). Children should then be screened for acute risks such as suicidal ideation, homicidal potential, psychotic or substance abuse symptoms, and any other concerning behaviors which indicate the need for an immediate assessment and intervention (Romanelli et al., 2009). For children without urgent risks, the screening should serve as a “snapshot” of the child’s strengths and needs in the following domains: life history, developmental, educational, emotional, behavioral and family dynamics for both the birth and foster family (AAP, 2006; AACAP, 2003; AAP 2001; Garwood, 2001; Perry, 1999). Children with identified needs in any of these areas should be immediately referred for an in-depth assessment. This is particularly important for children under the age of three that show signs of developmental problems (AAP 2006).

While primary care providers conduct the majority of behavioral health development assessments, the use of specific instrument for behavioral health identification is not common nor is the use of the Diagnostic and Statistical Manual of Mental Disorder (Leslie, 2003; Gardner, 2004). Clinical judgment alone has been shown to lead to under-identification of developmental impairment (Rydz, 2006). Therefore, formal evaluation measures should be used to ensure accurate diagnoses (Leslie, 2003). In choosing the instruments best suited for children in foster care, several factors should be taken into consideration (Drotar et al., 2008):

- The purpose of the assessment
- The characteristics of the child
- Family background and risk factors
• Base rates of problems such as risk levels
• Resources for implementing assessment procedures such as staff availability
• Available technical assistance such as on-site trained professionals
• Community resources.

When selecting a screening instrument, the amount of time needed to complete the screening should be considered, particularly for clinics with busy schedules.

There are many assessment tools available for professionals to choose from. Instruments should have good psychometric properties such as validity, reliability, and maximum sensitivity and specificity. Sensitivity and specificity levels of 70% to 80%, respectively, are usually acceptable (AAP 2001; Glascoe, 2000; Rydz, 2005). However, most instruments are not developed for individuals who have gone through major life disruptions, such as entering foster care. Therefore screening results must be interpreted with care. Results of screens may be more reflective of a child’s reaction to a recent placement change rather than an actual behavioral health disorder (Garwood, 2001). Input from parents is also important since they are often the best source of accurate information about their children (AAP 2001; Glascoe, 2003).

**In-depth Assessment of Children**

Some groups have advocated that all children receive a comprehensive evaluation within 30 days of entering the foster care system, irrespective of the results of the screening (Silver, 2007; AAP, 2006). There is reason to believe that the chaos created by entering the foster care system makes it difficult to get an adequate assessment of a child’s needs. Therefore, by providing a more in-depth evaluation of psychosocial risk factors, developmental delays, maltreatment, and traumatic events experienced by the child once they have had an opportunity to adjust to their new placement, a clearer picture of the child’s true needs may emerge (AAP, 2006, Romanelli et al., 2009; Silver, 2007). For infants who enter the foster care system at birth, it is recommended that assessments are conducted only after they have been in a placement for at least six months so the infant and his or her caregiver can establish a relationship, since it is essential to assess infants with familiar caregivers (Perry, 1999; Silver, 2007). These in-depth assessments should only be
conducted by qualified behavioral health providers who have experience working with maltreated children (Perry, 1999, Romanelli et al., 2009).

**Linking Children to Appropriate Treatment**

Once behavioral health conditions are identified, treatment plans should be formulated, and children should be referred to treatment professionals (AAP, 2006). Romanelli and her colleagues (2009) recommend that children only be referred to treatment providers that have a collaborative partnership with the foster care system. Research has shown that when coordination increases between mental health providers and the foster care system, children’s access to care improves and children with the most need receive more services (Romanelli et al., 2009). These treatment providers should also agree to comply with regulations around the sharing of information, the use of evidence based practices, and be included in the permanency planning process.

It is important for treatment providers to be trained and experienced in providing evidence based practices which are proven to be effective in improving the lives of children in foster care (Romanelli et al., 2009). A list of such evidence based practice can be found in Romaelli et al. (2009). These evidence based practices should be individualized, strength based, and include caregivers to the greatest extent possible. If the permanency plan includes reunification, the child’s birth parents must also be included. Including caregivers in the treatment process is a proven method for improving outcomes for children in foster care (Romanelli et al., 2009)

**Routine Screening**

Periodic reevaluations of the child will help to determine the effectiveness of treatment and allow providers to make necessary changes in the treatment plan in order to reflect improvements or deterioration the child experiences while in placement (AAP, 2006; Romanelli et al., 2009; AACAP, 2003). Rescreening is also suggested for children about to leave the system (AACAP, 2003), for children experiencing significant environmental changes (Romanelli et al., 2009), and for young children age 0 to 3 due to their rapid developmental growth (Silver, 2007; Rydz, 2006; AAP, 2001). Since initial screening and evaluation results may vary depending on a child’s conditions (i.e. compliance, tiredness or disorientation by a new placement), ongoing multiple
screenings and evaluations may provide a more accurate assessment of the child’s needs (Rydz, 2005).

MEDICAL HOME

As mentioned above, children in foster care are at risk for developing a number of complex physical and behavioral health issues. Therefore, the American Academy of Pediatrics (AAP) has recommended that children in foster care receive all of their health care services from a single health care provider. This provider should be familiar with the child’s health care needs and provide a consistent safe environment where the child can discuss their concerns (AAP, 2001). One way to create such a health care environment is through the development of a medical home. A medical home is not a building, house or hospital; rather it is an approach to providing health care that coordinates all aspects of health including physical, oral, and behavioral health. A medical home creates a multi-disciplinary team of providers that work closely together in a health care setting to provide compassionate culturally effective child and family centered services. The medical home evolves from a partnership formed between the child and the health care provider. The medical home should remain the same despite changes in foster placement to ensure continuity of care and treatment of priority health concerns. Not only does the medical home create a supportive and consistent environment for the child, it also assures the development of a centralized comprehensive record that includes all behavioral, oral and physical health services that have been delivered.

The treatment providers caring for children in a medical home setting also need to provide ongoing education about pertinent health care issues to foster care agency staff, legal staff, educators, foster parents and birth parents. Treatment providers may also function as monitors to ensure further abuse or neglect does not occur while the children are in the foster care system.

CONNECTIONS FOR KIDS CLINIC (CFKC)

In 2006, Denver Health, the “safety net” hospital for the Denver metropolitan area, developed a new clinic located within Denver Health’s Eastside Family Health Center. The clinic utilizes the medical home model to meet the medical and oral health needs of children in foster care in Denver County. This unique clinic, called the Connections for Kids Clinic (CFKC), strives to provide both coordinated health care and a stable environment for these children. To support the
efforts of this clinic Denver Health has entered into an agreement with Denver Human Services to provide health care through the CFKC for all children in foster care living in Denver. This agreement was designed to ensure that the medical provider for children in the custody of Denver Human Services does not change as children move through the foster care system. In some cases this mandate has been waived, for children who have been placed in care settings that are substantially outside the Denver metropolitan area or for children that will continue to be seen by their previous primary care provider. Even with these waivers, it is estimated that more than 80% of children in foster care in Denver are seen by the CFKC. For these children, the CFKC provides one of the only stable and constant environments these children have.

Over the last three years, the clinic has grown from serving just a handful of children during one half-day session to serving more than hundreds of children in five half-day sessions a week. In 2009 the CFKC clinic had more than 2232 medical visits. The clinic growth has not only been demonstrated by the number of children served, but numerous additional elements have been added to support the clinic. In 2007, the CFKC developed a system to more comprehensively gather and track children’s medical histories by using Child Health Passports. These passports track a child’s immunizations, illnesses and treatments through a database that is integrated with the existing Colorado Statewide Automated Child Welfare Information System. The grant also set up a Passport Team to collect the medical history of every child that enters the foster care system. One of the members of the team, a registered nurse, calls the person who is most informed about the child’s medical history to collect as much information as possible and enter it into the Passport database. In addition to the development of the Passport, the Passport Team is responsible for monitoring the health care needs and services provided to children in foster care who live outside the Denver metropolitan area.

Several other steps have been taken to build the infrastructure of the clinic. The clinic has sought out and received private grant funding to hire a nurse case manager. The nurse case manager has been a vital part of the CFKC because she provides prompt, family-centered care that greatly enhances services to foster families. The nurse case manager coordinates specialty referrals, facilitates provision of medical equipment and services in the home, and ensures that foster children follow-up with needed medical evaluations. She is a valuable support to foster families, listening to their concerns and offering psychosocial support as needed to the families of these
high risk children. The nurse case manager maintains close communication with case workers and foster care placement agencies so that she can provide information regarding patient needs and the concerns of specific foster families. She is also responsible for ensuring critical paperwork gets completed including documentation for the Denver Department of Human Services (DDHS), foster placement agencies, residential treatment centers, and group homes. The CFKC has also received grant funding to support a Child Abuse and Neglect Fellow. This not only enables a Pediatrician to be trained in the specialized area of the unique needs of children in foster care, but also provides some needed support for the Family Crisis Center and the CFKC.

Not only has the clinic increased the number of providers, it has also begun to provide other services in addition to physical health care. The CFKC has begun to enroll children under the age of three in the “Cavity Free at Three Dental Program.” The Cavity Free at Three Dental Program is designed to reduce dental caries in the children by providing a dental risk factor assessment, fluoride treatment, as well as education and goal setting regarding childhood caries prevention. The CFKC has also begun to provide routine developmental screening for children under age four. This program has already begun to benefit the children served by the clinic. In 2009, only 30% of children of the children seen at the CFKC clinic were linked to developmental services prior to being screened. However, after screening the number of children already receiving or referred for services jumped to 64%. While the integration of these two programs has been a success, there is one area of health care that providers have long recognized as a gap in the services provided through the CFKC. There is an urgent need to provide not only physical and oral health care, but also behavioral health care. Certainly, when a child has identified behavioral health needs they are referred to a behavioral health provider in the community, but behavioral health has never been integrated in the way it needs to be in order to create a true medical home.

**CFKC AND BEHAVIORAL HEALTH CARE**

Although referrals for behavioral health assessments have always been made by providers at the CFKC, it was not always clear that the children were actually getting the services they needed. The reasons for this are complex, but fall into a three broad categories: issues related to consent
and confidentiality, issues around reimbursement for services, and a mismatch between the service areas of the foster care system and behavioral health providers.

During the normal course of their work individual providers in both the foster care system and behavioral health care system are privy to very personal information that, if disclosed, could have serious negative consequences for the individuals served. Therefore, each of these systems is governed by a strict set of legal standards and professional ethics that dictate how and when information may be shared. There is nothing in the standards that prohibits providers in either system from disclosing whether an individual who was referred for services was actually seen, even without a signed release of information. However, professionals in these fields tend to be very conservative in sharing information and often are unwilling to even release information about whether an individual attended their initial appointment. This “rather safe than sorry” mentality frequently leads to a situation in which there is no way to ensure that an individual is receiving the services they need.

Even when a referral has been successfully completed, the systems that reimburse providers for behavioral health services often keep children from getting the care they need. Behavioral health services for children in foster care may be reimbursed by Medicaid, private insurance, victim’s assistance money provided through the District Attorney’s office, various grants obtained by behavioral health providers and DDHS, or Core Services Dollars which are administered through DDHS and designed to fund services that are not covered by another funding source. Unfortunately, each of these funding sources comes with its own set of rules governing which providers can access the money and how the money can be used. This means that not every behavioral health provider can be reimbursed for services, even if the services they provide are needed by the child.

The difficulty in coordinating funding is further complicated by the way the foster care system and the behavioral health care system determine which agency is responsible for providing services to a child. Foster care services are provided based on where the child is living when they enter the system and behavioral health services are provided based on where the child currently lives. This means that a child might enter foster care in Denver County, but will receive behavioral health services in another county because they are living in a foster home outside of Denver. The complexity of addressing these issues initially stymied efforts to
coordinate behavioral health care within the CFCK. Therefore, in 2008 the CFKC sought out and received funding to develop a coordinated plan that would allow behavioral health care for children in foster care to be provided through the clinic.

**PLANNING FOR BEHAVIORAL HEALTH INTEGRATION**

With funding in hand, the CFKC set out to develop a plan to integrate behavioral health care into the clinic by engaged in four activities:

- Review the literature in order to identify best practices for providing behavioral health services to children in foster care
- Map out behavioral health services available to children in foster care in Denver in order to identify any gaps in services
- Convene a panel of experts to use the literature review and mapping to develop a plan for integrating behavioral health into the CFKC
- Finally, present this plan to individuals served by the CFKC to determine whether this plan would meet their needs.

**Literature Review**

A review of the literature was conducted to better understand the best practices for serving children in the foster care system. In particular the literature review focused on the developmental and behavioral health needs of children in foster care, administrative barriers to integrating high quality behavioral health care for children in foster care, identifying effective screening and assessment measures, the funding of behavioral health services, increasing the stability of placements for children in foster care, and the integration of behavioral health services into medical clinics. The literature review is summarized in many of the sections above.

In addition to the literature review, other programs around the country that provide behavioral health services to children in foster care were identified. The STAR Health program in Texas, Fostering Hope in Oklahoma, Starlight Pediatrics in New York, Utah’s system of public health nurse case managers, and Illinois’ HealthWorks program were reviewed to identify best practices in existing programs. The Star Health program is a statewide system that uses a managed care model to coordinate services for children in foster care. This system also coordinates the medical
records of children in foster care, ensures care meets the standards set for children in foster care, and trains medical providers. Fostering Hope was started in 2006 and is the program that most closely resembles the CFKC. It is a single site clinic that provides health care services, physician advocacy, preventive education and behavioral health programs. This clinic is based on an agreement between the Department of Human Services and Medicaid, because of this agreement Fostering Hope is able to use Medicaid records to provide historical information about the medical history of the children they serve. Like Fostering Home, Starlight Pediatrics is also designed around a single clinic that is housed within the Monroe County Health Department. This clinic provides physical health care, behavioral health care and case management. Similar to the CFKC, children in foster care in Monroe County are required to attend this clinic and as a result this clinic serves approximately 90% of the children in foster care. Utah’s system is also based out of Public Health. After a 1993 lawsuit, a statewide system was developed in Utah which included a statewide database to track the medical histories of children in foster care. This system is used to supply every child in foster care with a hard copy of their medical record that travels with them from placement to placement. While these children receive medical care from local clinics and providers, each child has a public health nurse who is responsible for ensuring that they receive all needed health care. The Illinois HealthWorks program was developed by the Department of Child and Family Services (DCFS) and was designed to serve all 31,000 children in foster care, except those in a detention facility or a psychiatric hospital. This program provides comprehensive in home psychological assessments performed by a behavioral health professional and the DCFS caseworker. Initially this program was not well received by the caseworkers. However the program quickly gained their support once caseworks saw the value of these assessments. Despite the differences in the way these programs provide services, all these models rely on a centralized computerized database that integrates medical information with data from the State Automated Child Welfare Information System (SACWIS). While the federal government has mandated that every state have a SACWIS, not every SACWIS system does a good job managing health care data. The programs that are most effective at meeting the health care needs of children in foster care are the ones that have developed a system to efficiently manage data.
Behavioral Health Services Mapping

Much of the mapping of the behavioral health services available in the Denver metropolitan area was conducted by the Expert Panel as described below. The Expert Panel included Dr. Robert Bremer who is the Executive director of Access Behavioral Health Care. Access Behavioral Health Care is a nonprofit health plan that is responsible for managing Medicaid contracts for behavioral health services in the Denver metropolitan area. Because of the unique role of Access Behavioral Health Care, Dr. Bremer was able to share information about the services available and the wait time individuals’ experience. As of the quarter ending in October 2009, Access Behavioral Care had 1132 behavioral health providers in its network, including 197 providers able to prescribe medications. Of those providers, only 37 (4.1%) were not accepting new referrals. In addition newly referred individuals were able to access services in a timely way, only one of the 466 referrals in that quarter had to wait more than 7 days for an appointment. Based on this data, it was quickly determined that there is more than enough capacity within the provider network to serve the foster care population. The gaps that were identified were not in the quantity or type of providers, instead these gaps resulted from the disconnect in the coordination of behavioral health services due to the unique needs of children in foster care. One major gap is that few behavioral health providers are trained in the special needs of children in foster care. Also, the communication systems between the foster care system and community behavioral health providers do not appear to adequately support the kind of coordinated care that is necessary to address the needs of the children served through the CFKC. It was these gaps that the Expert Panel set out to address.

Expert Panel

The project convened a panel of experts that included representatives from the child welfare system, health care providers, behavioral health care providers, funders and foster parents. The Expert Panel met monthly for eight months to develop a model for integrating behavioral health care into the clinic. The Expert Panel took into consideration the literature on behavioral health treatment for children in foster care and examined models of integrated health care for children in the foster care system. While the panel experienced some initial difficulty in recruiting members, the panel eventually reached 21 individuals (see Appendix A). While the size of the Expert Panel is a testament to the interest in the community for this project, it is difficult for such
a large group to efficiently develop this kind of a plan. Therefore, the Expert Panel broke into
four workgroups. The individuals on the Expert Panel joined these groups based on their areas
of interest and expertise. The workgroups were charged with mapping out the systems relevant
to this project: the child welfare system, the Denver Health System, funding for behavioral health
care and behavioral health services in Denver.

In order to help the members of the Expert Panel better understand the functioning of the foster
care system and identify gaps in behavioral health services, the child welfare workgroup
presented on the functioning of the foster care system. This presentation outlined the
demographics of the children served, gaps in behavioral health services, and opportunities for
improving the delivery of services. Several issues were identified that the plan for integrating
behavioral health will need to address:

- The screening for behavioral health needs is not standardized and often inconsistent.
- Services to children in the foster care system are funded by a variety of sources; therefore
  the integration plan will need to be designed to take advantage of these multiple funding
  sources.
- Because the foster care system serves children from birth to 18 years old, the plan will
  need to be able to provide services across this age range including specialty services such
  as infant mental health, victims of trauma, developmental disabilities, Department of
  Youth Corrections involvement, substance abuse, teen parenting and pregnancy.
- The foster care system is focused on developing “Minimally Adequate Parenting”. This
  means that the foster care system would not be involved if a parent had the capacity to
  meet a child’s needs and exercised that capacity. Therefore, children will be returned to
  their biological families once this level of care is met. Most community behavioral
  health providers have different parenting criteria than the foster care system, leading
  providers to believe children may be “better off” in settings outside their biological
  family.
- Families served by the foster care system often have few resources and have multiple
  needs. Therefore behavioral health services need to be provided in such a way that they
coordinate with the services provided by other service systems such as TANF, the education system, and the legal system.

- Finally, the current system for managing data is not designed to provide data in a way that allows decision makers to use the data to measure outcomes or develop innovative practice models.

The foster care system workgroup recommended that any behavioral health integration plan must, at the very least, address these areas.

The Denver Health System workgroup reviewed the behavioral health services provided by Denver Health that are available to foster children. The group discussed whether all behavioral health services could be provided in the CFKC, which is located in the Eastside Clinic. The Eastside clinic currently provides limited psychiatric services and has an onsite pharmacy, which is important given the extensive use of psychotropic medications in modern behavioral health care. However, the group identified two reasons why behavioral health services should not be provided exclusively through the CFKC. The first reason is that because the CFKC is located in the Eastside Clinic, which is a Federally Qualified Health Center (FQHC), it must follow all of the rules that govern the billing for FQHCs. FQHCs are reimbursed on a per visit rate, which means that providing additional service during a visit does not result in an increase in reimbursement. Therefore, behavioral health providers would not be able to bill for the services they provide. These limits on the reimbursement for services would make it difficult to sustain behavioral health services within the CFKC. Ultimately the Denver Health workgroup referred this issue to the Finance workgroup and asked them to see if they could identify ways this issue could be resolved. The second reason this workgroup felt that the CFKC shouldn’t be the only location where behavioral health services are provided has to do with the clinic’s location. The CFKC clinic is located in the Five Points neighborhood of Denver and all foster parents living in the Denver metropolitan area are required to bring their children to this clinic. While this may be possible for routine well-child medical visits, it would be almost impossible to do this for behavior health services, many of which are provided on a weekly basis. The Denver Health workgroup decided that that funding should not be a barrier to providing needed services at the CFKC, but that the issues related to the location of the clinic were compelling enough that they needed to find a way to provide services throughout Denver.
The financial workgroup took on the task of determining how to develop sustainable funding streams that could be used to support the integration of behavioral health care into the CFKC. It appears that the most consistent and sustainable source of funding for behavioral health services is Medicaid reimbursement. However, as mentioned above the CFKC is housed within an FQHC, which limits their ability to bill for behavioral health services provided on the same day that medical services are provided. The issue of billing for behavioral health services was discussed extensively and several solutions for this issue were presented to representatives of Denver Health. Denver Health continues to address this issue internally. No matter how this issue is eventually resolved, the financial workgroup recommended that the number of positions added to the CFKC be limited. This will improve sustainability by limiting the number of individuals that need to be supported through reimbursement. The financial workgroup also explored the issue of whether community behavioral health care providers could be offered additional money for serving children in the foster care system. The financial workgroup did not think this model would be sustainable over time, given the limited amount of funding available through the Medicaid system. Finally, the financial group recommended that the Medicaid billing database be used to help identify medical and behavioral health care needs for children in foster care. This recommendation closely mirrors the system used the Fostering Hope program in Oklahoma.

The Mental Health services workgroup reviewed the resource mapping and gaps analysis. Based on this information the workgroup determined there are sufficient resources in the community to meet the behavioral health needs of children in foster care. Therefore rather than dedicating resources to developing a new system of behavioral health care, the behavioral health integration plan should focus on better identifying behavioral health needs and coordinating care between the CFKC and community behavioral health providers. The Mental Health workgroup spent a considerable amount of time discussing how the behavioral health needs of children in foster care should be identified. Since studies have reported between 40 to 85 percent of children in foster care have a behavioral health need, the workgroup initially recommended all children seen by the CFKC be given a comprehensive behavioral health assessment (Clausen et al., 1998). However, it soon became clear these children would likely receive another full assessment once they were referred to a community behavioral health provider. Therefore, the group
recommended that only a brief screen be administered to ensure the children were not overwhelmed by repeated assessments. The workgroup further recommended that these screening instruments must be shown to be valid and reliable when used with children in foster care. Since these screening instruments are likely to be completed by foster parents who may have had the children in their care for only a short period of time, the instruments should be based on self-report or objective and observable behavior. Two screening instruments were recommended: the Ages and Stages Questionnaire (ASQ) which is a broad based developmental screening instrument with a particular focus on social-emotional concerns for children up to 5 ½ years old and the Child Behavior Checklist (CBCL) on which adults can rate the strengths and needs of children ages six to eighteen years old. These two instruments are widely used for screening behavioral health needs in both clinical and research settings. These two instruments can also be used to measure children’s needs over time. Therefore, they are able to measure the effectiveness of treatment. Once behavioral needs are identified, a child needs to be referred to a behavioral health provider. In order to coordinate services between the CFKC and community behavioral health providers, the workgroup recommended that a database be developed that could gather medical data, data from behavioral health providers, Medicaid, and the Department of Human Services. This database would allow for the sharing of data, within the limits of confidentiality, so that services could be coordinated to create a true medical home.

**Focus Groups**

Finally, the opinions of foster parents, community behavioral health service providers and foster care case managers were solicited to ensure the plan would best meet the needs of those most affected by it – the children in the Denver foster care system.

**BEHAVIORAL HEALTH INTEGRATION PLAN**

As a result of the above planning process, the following plan to integrate behavioral health services into the CFKC was developed.

**Conduct a Behavioral Health Screening for All Children Severed by the Clinic**

Every child seen in the CFKC should be screened for behavioral health needs using screening tools that have been shown to be valid and reliable. Because of the frequent moves experienced by children in foster care, the screening tools should also rely on self-report by the child or
objective observable behavior so that even caregivers who know little about the child’s history can complete them. To achieve this, two new positions should be added to the CFKC; a Behavioral Health Clinician and a Support Position. The Behavioral Health Clinician will have primary responsibility for screening children seen by the CFKC for behavioral health needs. When needs are identified, this individual will be responsible for referring the child to the appropriate behavioral health professional and ensuring that the child attended his or her appointment. Finally, this individual will be available to provide brief intervention and education to foster parents as needed.

Since the screening tools will be mostly comprised of self-report instruments completed by the child or foster parent, it is anticipated these tools will be completed in the waiting room. The Support Position will be responsible for assisting the foster parents when they check-in at the clinic as well as distributing, collecting, scoring and forwarding the screening tools on to the behavioral health clinician for interpretation. In addition, this individual will assist the behavioral health clinician in confirming that children referred for services attended their appointments. Finally, this individual will ensure that data about the children’s behavioral health needs and services are entered into the appropriate data systems.

Develop a network of community based behavioral health providers

Many foster parents, even though they live in Denver, have to drive considerable distances to the CFKC. Since behavioral health services are often delivered on a weekly basis, it is unrealistic to think that children served by the clinic will be able to receive all of their behavioral health services directly from the clinic. Therefore, a network of community based behavioral health providers should be developed to provide services to children in foster care near their homes. This network should be made up of behavioral health providers that already serve the Denver metropolitan area and who agree to utilize evidence based practices that have been shown to be effective in the treatment of children in foster care. These providers should receive training on the special needs of children in foster care. Also these providers should, within the limits of confidentiality, agree to share information on an ongoing basis. This will include information about a child’s need for behavioral health treatment, general information about the child’s progress in treatment, and data collected through the use of standardized measures that can be used to track the effectiveness of treatment. Children served by the CFKC will only be referred
to providers that are part of this network to ensure that the behavioral health treatment that they receive is evidence based and integrated with their physical health care. We believe that behavioral health providers in the community will be interested in joining this network due to the volume of children that will be referred, all of whom have insurance. We also believe that the no-show rate for these children will be considerably lower since foster parents are paid to ensure that the children in their care attend all health care appointments.

**Hire staff to coordinate care for children in foster care not served by CFKC**

As mentioned above, the CFKC does not serve children that have entered the Denver foster care system, but then have been placed in a foster home outside the Denver metropolitan area. The health care of children in foster care living outside of Denver is coordinated by a team of individuals known as the Passport Team. This team ensures that these children receive routine health care through providers in the communities where they live. It is recommended that a Behavioral Health Clinician and a Support Position be added to the Passport Team. These individuals will be responsible for ensuring that children living outside the Denver metropolitan area receive integrated medical and behavioral health care. The Behavioral Health Clinician will have primary responsibility for ensuring children are screened for behavioral health needs with the same tools used by the CFKC. Since children living outside of the Denver metropolitan area will not be able to access the network of behavioral health providers, Behavioral Health Clinician will be responsible for referring children to the appropriate behavioral health professional near the child’s home and ensuring that the child attended his or her appointment.

It is anticipated that for remote placements the screening tools will be sent to foster parents, who will then complete the instrument and return them to the passport team. The Support Position will be responsible for helping the Behavioral Health Clinician distribute, collect and score the screening instruments. In addition, this individual will assist the Behavioral Health Clinician in confirming that children referred for services attend their appointments. Finally, the Support Position will ensure that data about the children’s behavioral health needs and services are entered into the appropriate data systems.
Develop a database for facilitating care coordination

As the literature clearly points out, health care for children in foster care is often fragmented due to frequent placement changes. One of the benefits of the CFKC is that it centralizes and coordinates the health care of children in foster care. The network of behavioral health providers described above will allow children to receive behavioral health services near their home, but it will also threaten the centralized coordination of the CFKC. Therefore, the Child Health Passport database should be expanded to allow the sharing of data between the Denver Department of Human Services, the CFKC, and the network of providers. For children living outside the Denver metropolitan area served through the Passport Team, the database will also store information about the services these children received. These additions will allow for a more comprehensive health record for the child and will allow the providers to more easily integrate physical, oral and behavioral health.

In addition to a more complete medical record, the database will allow physical and behavioral health data to be combined with data collected by the foster care system. In theory the combination of this data could be used to improve life outcomes for children in foster care. This data could be used to better match children to the types of treatment that are most likely to lead to successful outcomes. The data may also lead to the development of models that predict when children are most likely to experience behavioral health needs. While the potential for this database is great, it must be developed so that information is shared in a secure manner and only authorized individuals have access to the data in order to protect the confidentiality of children.

NEXT STEPS

Developing the Network of Behavioral Health Providers

In order to develop a network of behavioral health providers, a workgroup will be formed to bring together behavioral health providers and representatives of the foster care system in Denver. Since all children in the foster care system will be served, it is anticipated the network will need to meet the behavioral health needs of children from birth to 21 years of age. This means that the network will need to provide a full range of services, including specialty services. Because of the varied circumstances that lead to children being involved in the foster care system, the network should at least include the following services:
• Children exposed to drugs or alcohol in utero
• Attachment disorders
• Trauma exposed children
• Sexual abuse or incest
• Children and adolescents with developmental delays
• Children and adolescents with a severe behavioral disorders (particularly children who have entered the foster care system because their parents can no longer manage their behavior)
• Substance using teens
• Pregnant teens
• Children involved with the criminal justice system
• Out of Home Placement providers which also provide behavioral health services (these include child placement agencies and residential treatment programs)

One of the first phases of the planning process will be to identify providers in the community that can meet each of these needs. Once agencies are identified, they will be invited to become part of the workgroup.

The workgroup will then identify the basic level of knowledge that behavioral health providers need to effectively treat children in foster care. A training curriculum will be developed and members of the network will be provided with this training. The workgroup will identify evidence based practices that have been shown to be effective with children in foster care. The workgroup will be asked to develop a protocol for sharing clinical data between providers. Also the workgroup will be asked to help develop a process for referring children to the services they need.

Finally the workgroup will develop the policies and procedures that will govern the network of providers. It is anticipated the group will, at minimum, develop policies around: wait time for services, coordination of care, training of behavioral health providers, compensation for services, release of information and treatment consent. It is hoped the developed system will follow a child even as they move from one foster home to another. Ideally a single provider would follow
a child, but even when this is not possible the system should ensure the care that children receive is seamless. It is hoped that by involving community providers in the development of the network, not only will the system meet the needs of the children, but that the behavioral health providers will have ownership in the project.

**Developing the Database**

The second workgroup will focus on issues around the sharing of information. This group will provide recommendations on how data should be shared between the CFKC and behavioral health providers. This group will develop a plan for how to create a database that can ensure all medical records are gathered in one centralized place. In order to do this, the group will need to determine how confidential information can be shared and stored securely. This centralized database will be invaluable for ensuring that children in foster care have access to their medical histories when they leave the foster care system. The system will also allow the CFKC to measure the effectiveness of the services provided so effective services can be replicated and ineffective services can be discontinued.

**SUSTAINABILITY**

The sustainability of the CFKC has been a primary concern since its inception. A number of grants have been sought out to help build the CFKC, however the clinic can’t be funded solely through the use of grants. Therefore, only positions that can be sustained through billing for services have been added to the clinic. This model has proven successful. A nurse case manager that was hired through grant funds has begun to be institutionally supported through Denver Health, based in part on an increase in Medicaid billing by the CFKC.

Not only has the CFKC led to increased billing, but it is also likely to led to long term cost savings. Data provided by DDHS has indicated that children’s behavioral health issues are a likely cause for moving from one foster home to another. It is hoped that by connecting children as early as possible to their needed behavioral health services, there will be a decrease in the number of moves from one foster home to another. In the long run this added stability should lead to better outcomes for these children. Additionally, fewer moves in the foster care system will lead to cost savings. Through careful analysis of the data, the CFKC should be able to
identify these types of cost savings and advocate that the money saved be reallocated to help the CFKC continue to grow.
References


## Appendix A

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<thead>
<tr>
<th>Agency</th>
<th>Title</th>
<th>Role</th>
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<tbody>
<tr>
<td>William Betts</td>
<td>University of Colorado Denver</td>
<td>Project Director for the Grant Dr. Betts has a PhD in child clinical psychology and is an expert in developing community based collaboratives. He brings years of experience designing and administering behavioral health programs in the community.</td>
</tr>
<tr>
<td>Rob Bremer</td>
<td>Colorado Access/Access Behavioral Care</td>
<td>Deputy Director Dr. Bremer is the Executive director of Access Behavioral Health Care. Access Behavioral Health Care is a nonprofit health plan that serves the medical and behavioral health needs of the medically underserved in the Denver metropolitan area. Dr. Bremer brings a wealth of knowledge as both a clinician and with his knowledge of developing networks of care</td>
</tr>
<tr>
<td>Rob Clyman</td>
<td>Kempe Center for the Prevention and Treatment of Child Abuse and Neglect</td>
<td>Former Executive Director Dr. Clyman is a psychiatrist who is a nationally recognized expert in the treatment of children who have been abused or neglected.</td>
</tr>
<tr>
<td>Kelly Crane</td>
<td>National Council of State Legislators</td>
<td>Policy Specialist Ms. Crane brings many years of experience in designing child welfare systems. Most recently she was involved with the redesign of services in Illinois.</td>
</tr>
<tr>
<td>KaraAnn Donovan</td>
<td>Health Care Policy &amp; Financing</td>
<td>Survey Director Ms. Donovan currently works in the rate setting division of the organization that administers Medicaid in Colorado. In this position she brings a wealth of knowledge about service reimbursement. Prior to her current position Ms. Donavan presided over the multidisciplinary group that developed Medical Home Standards in Colorado and thus has experience designing integrated health care delivery systems. Ms. Donovan has a MSPH and is a PhD candidate in the University of Colorado School of Public Health.</td>
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<tr>
<td>Patricia Garcia</td>
<td>Denver Department of Human Services</td>
<td>Family-to-Family Coordinator</td>
</tr>
<tr>
<td>Lynn Garst</td>
<td>Mental Health Center of Denver (MHCD)</td>
<td>Associate Director</td>
</tr>
<tr>
<td>Simon Hambidge</td>
<td>Denver Health</td>
<td>Director, General Pediatrics</td>
</tr>
<tr>
<td>Gizane Indart</td>
<td>Denver Children's Advocacy Center</td>
<td>Executive Director</td>
</tr>
<tr>
<td>Jennifer Koch</td>
<td>Denver Health</td>
<td>LCSW - Super School Based MH</td>
</tr>
<tr>
<td>Nancy Koester</td>
<td>University of Colorado Denver</td>
<td>Evaluator for the Grant</td>
</tr>
<tr>
<td>Name</td>
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<tr>
<td>Kristie Ladegard</td>
<td>Denver Health Psychiatry</td>
<td>Psychiatrist</td>
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<tr>
<td>Lora Melnicoe</td>
<td>Denver Health Psychiatry</td>
<td>Pediatrician-Connections For Kids Clinic</td>
</tr>
<tr>
<td>Ron Mitchell</td>
<td>Denver Department of Human Services</td>
<td>Manager Operations</td>
</tr>
<tr>
<td>Gina Robinson</td>
<td>Health Care Policy &amp; Financing</td>
<td>Program Administrator</td>
</tr>
<tr>
<td>Toni Rozanski</td>
<td>Denver Department of Human Services</td>
<td>Child Protection and Safety Division Director</td>
</tr>
<tr>
<td>Gretchen Russo</td>
<td>Denver Juvenile Court</td>
<td>Liaison to the Denver Department of Human Services</td>
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Behavioral Health & Foster Care
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<tr>
<td>Chris Sheldon</td>
<td>Denver Health</td>
<td>Chief Psychologist</td>
<td>Dr. Sheldon is the chief psychologist at Denver Health and brings considerable experience as a clinician and in program design.</td>
</tr>
<tr>
<td>Kerry Swenson</td>
<td>Colorado Department of Human Services-Department of Child Welfare Services</td>
<td>Program Specialist</td>
<td>Ms. Swenson represents the Colorado Department of Human Services and heads up a number of statewide initiatives to improve health care services.</td>
</tr>
<tr>
<td>Ayelet Talmi</td>
<td>The Children's Hospital-Denver</td>
<td>Psychologist</td>
<td>Dr. Talmi is a pediatric psychologist with extensive infant mental health experience both as a researcher and a clinician. She is a graduate Solnit Fellow of Zero to Three/National Center for Infants, Toddlers and Families and is the President of the Colorado Association for Infant Mental Health.</td>
</tr>
<tr>
<td>Kathryn Wells</td>
<td>Denver Health</td>
<td>Medical Director, Family Crisis Center</td>
<td>Dr Wells is the Medical Director of the Denver Family Crisis Center and is the driving force behind the CFKC. Dr. Wells is a nationally recognized expert in child abuse and neglect and is invited to speak around the country on the topics of drug endangered children, maternal substance abuse, and child maltreatment. She also serves as the child abuse and neglect consultant for the Denver Health and Hospital Authority, the Denver Department of Human Services, the Denver Police Department, and the Denver District Attorney's Office. Additionally, she is an attending physician with the Kempe Child Protection Team at the Children's Hospital in Denver. Dr. Wells is an Assistant Professor in Pediatrics at the University of Colorado and is a Governor-appointed member of the Colorado Child Welfare Action Committee which is work to make suggestion for child welfare reform for the State of Colorado.</td>
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families. Prior to moving to Denver Ms. Russo served as a nurse case manager for the “Fostering Healthy Children Program” in Utah.
<table>
<thead>
<tr>
<th>Sherri Woodall</th>
<th>Lutheran Family Services</th>
<th>Foster Parent</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Ms. Woodall is a speech therapist and foster parent of a Denver County foster child with special health care needs. Her experience as both service provider and foster parent has been invaluable to our efforts.</td>
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