

GAO

Report to the Ranking Minority Member,  
Subcommittee on Human Resources,  
Committee on Ways and Means, House  
of Representatives

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May 1995

# FOSTER CARE

## Health Needs of Many Young Children Are Unknown and Unmet







United States  
General Accounting Office  
Washington, D.C. 20548

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**Health, Education, and  
Human Services Division**

B-259319

May 26, 1995

The Honorable Harold E. Ford  
Ranking Minority Member  
Subcommittee on Human Resources  
Committee on Ways and Means  
House of Representatives

Dear Mr. Ford:

Foster children are among the most vulnerable individuals in the welfare population. As a group, they are sicker than homeless children and children living in the poorest sections of inner cities. Of particular concern is the health of young foster children since conditions left untreated during the first 3 years of life can influence functioning into adulthood and impede a child's ability to become self-sufficient later in life. Yet, little comprehensive information is available about the provision of health-related services to meet the needs of young foster children.

Last year, we reported that the population of young foster children—those 36 months of age and younger—changed significantly between the late 1980s and the early 1990s.<sup>1</sup> The average monthly number of children in foster care nationwide increased 53 percent, from 280,000 to 429,000, during this period. The total foster care population in the three states reviewed increased 66 percent between 1986 and 1991, while the number of young foster children more than doubled—increasing by 110 percent. In addition, we found that a greater proportion of young children entered the system because of some form of neglect; came from families where at least one of the parents was abusing drugs; had serious health-related problems; and were at risk for future problems as a result of prenatal drug exposure.

Understanding the ability of state child welfare agencies to meet the needs of foster children is critical as policymakers consider restructuring federal welfare policies and responsibilities. Federal monies are currently used to assist states with the cost of foster care. Legislation being considered by the 104th Congress would give the states even greater responsibility for foster children through block grants.

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<sup>1</sup>We reported on young foster children in Los Angeles County, New York City, and Philadelphia County. See *Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children* (GAO/HEHS-94-89, Apr. 4, 1994).

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Our earlier work responded to your request that we compare and contrast the population sizes and distinctive characteristics of young foster children between 1986 and 1991. This report responds to the remaining issues in that request regarding the service needs of young foster children. Specifically, this report provides information on (1) the health-related services needed and received by young children in foster care, (2) the relationship between the receipt of health-related services and foster care placements with relatives versus placements with nonrelatives, and (3) what responsible agencies are doing to ensure that these children are receiving needed health-related services.

To develop this information we reviewed foster care programs in California, New York, and Pennsylvania, the states with the largest average monthly foster care populations in 1991. In addition, we analyzed random samples of case files from Los Angeles County, New York City,<sup>2</sup> and Philadelphia County from a combined population of 22,755 young foster children. These locations cared for a substantial portion of each state's young foster children: 44 percent in California, 81 percent in New York, and 29 percent in Pennsylvania. We analyzed electronic databases as provided to us by state and county officials to select our samples and determine the number of children placed with relatives and nonrelatives. Our scope and methodology are discussed further in appendix I.

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## Results in Brief

Our work indicates that a significant proportion of young foster children did not receive critical health-related services in the three locations reviewed—Los Angeles County, New York City, and Philadelphia County. Despite state and county foster care agency regulations requiring comprehensive routine health care,<sup>3</sup> an estimated 12 percent of young foster children received no routine health care, 34 percent received no immunizations, and 32 percent had at least some identified health needs that were not met. Furthermore, an estimated 78 percent of young foster children were at high risk for human immunodeficiency virus (HIV) as a result of parental drug abuse, yet only an estimated 9 percent of young foster children were tested for it. Early identification of HIV-infected children begins with HIV risk assessment. Without early identification, HIV-infected children with mild or no symptoms cannot receive the early medical care that is known to be effective with young children.

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<sup>2</sup>New York City comprises five boroughs and is treated in the state database as a county. In this report, we refer to it as a county.

<sup>3</sup>County foster care regulations state the frequency for required, comprehensive medical examinations for well children. We refer to this type of examination as comprehensive routine health care.

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We also found that young foster children placed with relatives received fewer health-related services of all kinds than children placed with nonrelative foster parents. Other research indicates that relative caregivers often receive less monitoring and assistance from caseworkers. For California and New York—the states where placement data were available—the number of young children placed with relatives increased by 379 percent between 1986 and 1991, while the number of young children placed with nonrelative foster parents increased by 54 percent. Consequently, because a larger number of foster children were placed with relatives in 1991 than in 1986, substantially more children were subjected to the lower likelihood of receiving services associated with kinship care.

Local foster care agencies continue to grapple with designing programs to meet the health-related service needs of children. In the locations reviewed, agencies have revised health-related foster care regulations and modified their programs in efforts to improve the delivery of health care to foster children. Although the Department of Health and Human Services (HHS) recently increased its technical assistance to states by contracting for National Resource Centers,<sup>4</sup> none is designated to assist states with health-related programs for foster children. Furthermore, while HHS audits states for compliance with federally mandated safeguards for foster children, these audits omit review of compliance with health-related safeguards. Given the importance of health care during the first 3 years of life, an improved response to the health needs of this vulnerable population is vital.

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## Background

Responsibility for providing care and services to foster children is shared by federal, state, and county governments, with HHS having responsibility for oversight of federal foster care programs. The Administration for Children and Families (ACF) within HHS helps the states to develop plans required under title IV-B of the Social Security Act; reviews and approves those plans; conducts audits to certify states' compliance with the safeguards for foster children, thereby making states eligible for additional federal funds; and allocates funds to states, among other duties.

The Social Security Act of 1935 was amended twice to include safeguards for foster children. The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) added most of these safeguards—such as requirements that

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<sup>4</sup>The National Resource Centers assist HHS' Administration for Children and Families staff in responding to states' questions and provide free technical assistance to states.

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the case file contain a plan for appropriate care and services, as determined by state and local foster care policies; periodic court or administrative reviews; and a reunification program to return children to their parents. This act also authorized HHS to provide technical assistance to aid states in developing programs to meet the requirements of the law. Furthermore, the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) added other safeguards to the Social Security Act, including a requirement to maintain health records for foster children.

A combination of federal, state, and county funds may be used to provide services to young foster children. States may participate in federal programs authorized by the Social Security Act such as title IV-B, matching grants for various child welfare services; title IV-E, an uncapped entitlement for a portion of the maintenance of foster children who are eligible under the Aid to Families With Dependent Children (AFDC) program; title XIX, Medicaid, an entitlement for a portion of medical services; or title XX, block grants for a wide array of social services for children. In addition, the Education of the Handicapped Act, part H, authorizes grants to states for early intervention programs for handicapped infants and toddlers.

Except for federal title IV-E expenditures, data were unavailable to estimate federal, state, and county expenditures for services for foster children. In the last 10 years, federal title IV-E expenditures for the administration and maintenance of AFDC-eligible foster children increased from about \$546 million in 1985 to an estimated \$2.9 billion in 1995. When foster children do not meet title IV-E eligibility for federal funding, states must bear the full cost for maintaining these children. However, some states pass at least a portion of these costs to their counties.

## Young Foster Children in the Locations Reviewed Did Not Always Receive Needed Health-Related Services

All young children need routine, comprehensive medical monitoring, treatment for minor illnesses, and immunizations to grow up healthy. In the three locations reviewed, state and county regulations require that children in foster care receive periodic medical examinations and treatment.<sup>5</sup> Research indicates that children at risk for serious health problems as a result of prenatal drug exposure often need additional assessments and specialized care. Child development experts generally agree that health care is particularly important during the first 36 months of life as language, motor, psychological, and social skills develop. Conditions left untreated during the first 3 years of life can influence functioning into adulthood.

Some young foster children in the locations we reviewed did not receive even the most basic health service—required routine care. In addition, many children had identified health-related needs that were not met, including the need for specialized services. Foster care agencies refer foster parents to community-based programs and practitioners, rather than providing the services directly. Foster children in the locations reviewed are eligible for Medicaid to cover the cost of these health-related community-based services.

## Routine Health Care May Not Be Ensured

Despite state and county foster care regulations, comprehensive routine health care for young foster children may not be ensured. Specifically, an estimated 12 percent of the children received no routine health care, and 34 percent received no immunizations in the three locations reviewed. Furthermore, case files at all three locations did not reflect the exact nature or extent of what services were provided in many cases. Thus, children we noted as having received routine medical care may have received as little care as one visit with a physician for treatment of a minor illness rather than comprehensive or ongoing medical care. (See table II.1 in app. II.)

While Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are one way to ensure that children receive comprehensive medical examinations, only an estimated 1 percent of the young foster children in the locations reviewed received EPSDT services. EPSDT services are specific, comprehensive medical examinations and follow-up

<sup>5</sup>Regulations include a requirement that children receive an initial examination when they enter foster care. Los Angeles County and New York City require an examination within 30 days of entry into foster care; Philadelphia County requires an examination within 60 days. Children who received a comprehensive examination within 90 days before entering foster care are exempt from this requirement.

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treatment that states must offer to Medicaid-eligible children. EPSDT examinations can serve as an effective safeguard of a child's overall health and development and as a gateway to other health-related services. (See table II.1 in app. II.)

Children with no known health problems were less likely to receive routine care than children who were at risk for or had serious health problems.<sup>6</sup> For the locations reviewed, an estimated 28 percent of the children with no known serious health problems did not receive any health-related services. By comparison, only 6 percent of children who were at high risk for serious health problems because of prenatal drug exposure and 2 percent of children with serious physical health problems did not receive any health-related services. Without routine health care, children with no known health problems are not monitored to identify and treat health and developmental problems as they occur. (See table II.2 in app. II.)

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### Specialized Health Needs of Young Foster Children Were Unmet

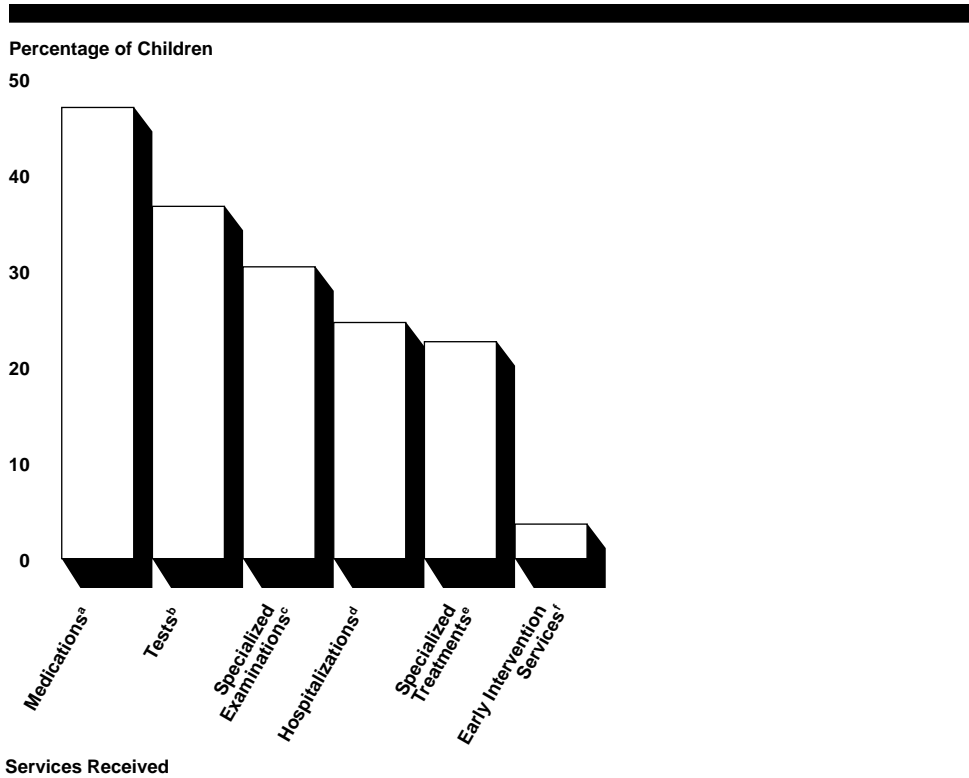
In addition to routine health care, young foster children need many specialized health-related services. As we previously reported, an estimated 58 percent of young foster children in the three locations reviewed had serious physical health problems, and 62 percent were at high risk for serious health problems as a result of prenatal drug exposure. Many of these children may need health-related services and treatment beyond those needed by the average child. (See fig. 1 and table II.3 in app. II.)

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<sup>6</sup>Serious health problems of children in our review include fetal alcohol syndrome, low birth weight, cardiac defects or heart problems, HIV or acquired immunodeficiency syndrome (AIDS), and developmental delays.



**Figure 1: Specialized Services Received in Three Counties**



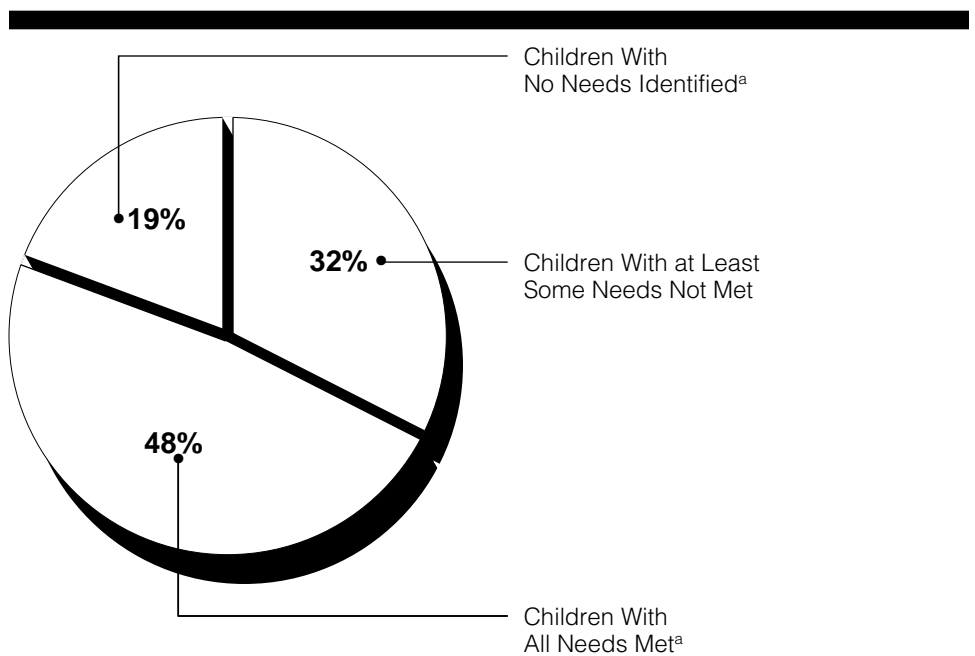
<sup>a</sup>Includes treatment for asthma, syphilis, seizures, and kidney problems.  
<sup>b</sup>Includes blood, laboratory, and radiology.  
<sup>c</sup>Includes developmental, psychological, and cardiological.  
<sup>d</sup>Includes care for HIV, pneumonia, and failure to thrive, as well as surgery.  
<sup>e</sup>Includes apnea monitors, infant stimulation, and speech therapy.  
<sup>f</sup>Includes therapeutic day care and Head Start services.

Source: Case file review.

Although young foster children received a wide variety of services from health care providers, many children had identified health-related needs that were not met. Based on information collected from case files, we matched the health-related needs identified and the services received for each child and estimated that one-third of the children in the locations

reviewed had some identified needs that were not met.<sup>7</sup> These unmet needs included pulmonary and speech therapy; psychotherapy; developmental assessments; infant stimulation services; cardiological, urological, and neurological examinations; and testing for sickle cell anemia, syphilis, and HIV. (See fig. 2 and table II.4 in app. II.)

**Figure 2: Extent to Which Identified Needs Were Met in Three Counties**



Note: Point estimates do not total 100 percent because of rounding and records lacking data on identified needs.

<sup>a</sup>The point estimates for the three locations varied widely in these two categories.

Source: Case file review.

Of those children with no identified health-related needs, about one-half in each location received no routine health care, and less than one-half received a toxicology screen at birth to detect recent prenatal drug exposure. Thus, many of these children may have had health-related needs that were not identified and, consequently, were not met.

<sup>7</sup>The number of identified needs per child ranged from 1 to 14 and averaged approximately 5.

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## HIV-Infected Children Need to Be Identified Early, but Risk Assessments Often Did Not Take Place

One particularly critical health need of young foster children is HIV risk assessment<sup>8</sup> because most young children in the locations reviewed are at risk for the infection as a result of parental drug abuse. Without risk assessment, a child's HIV status may not be determined early because HIV-infected children can remain asymptomatic or exhibit only minimal signs of infection for years. Recent medical advances in early identification and treatment can enhance and prolong the lives of these children. Early identification is also critical because HIV-infected children should receive modified immunizations to prevent adverse reactions, and their exposure to infectious illnesses such as measles or chicken pox—which are particularly hazardous to these children—should be minimized.

While state laws, and the county policies based on them, do not prohibit HIV testing or the disclosure of test results, some can hamper HIV testing and disclosure. State laws and county foster care policies, where they exist, vary widely. In some locations, including the three reviewed, these laws and policies impede HIV testing and disclosure by specifying the risk factors that must be present in order to request HIV testing; who has the authority to consent to testing; and to whom HIV test results can be disclosed. For example, for the 36 states with HIV testing policies as of 1992, one-half of the foster care agencies in the states with testing policies may not have authority to consent to an HIV test for a child, even when the child was identified by the agency as being at high risk for HIV.

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## The Number of HIV-Infected Children Is Largely Unknown as Few Children Are Tested

Foster care agencies in the locations reviewed do not know the full extent of their caseloads that is at high risk for HIV since no mechanism exists to ensure that all young foster children are assessed for HIV risk. While two of the three locations we reviewed currently have some HIV risk assessment requirements, one location did not require risk assessments for all foster children until recently, and the other has not implemented clear assessment procedures. HIV risk has long been associated with intravenous drug use, but more recent research has established an equally strong link between HIV risk and the lifestyle of nonintravenous cocaine and crack users. Using New York City's current HIV risk factors, which include nonintravenous drug use, we assessed our 1991 population of young foster children on the basis of one risk factor, parental drug abuse. Accordingly, we estimated that at least 78 percent of the children in the three locations reviewed were at high risk for HIV.

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<sup>8</sup>An HIV risk assessment compares a child's family history and health condition against the foster care agency's specified HIV risk factors to make an informed determination about whether a child should be tested for HIV.

We estimated that only 9 percent of the young foster children in the locations reviewed were actually tested for HIV, despite the large proportion at high risk and statistics indicating that these are locations with a high incidence of HIV. The American Academy of Pediatrics Task Force on Pediatric AIDS recommends HIV testing for all foster children with high-risk factors or in areas with a high incidence of HIV to facilitate appropriate medical treatment and follow-up. We estimated the HIV infection rate for children born in 1993 and found that the three states reviewed ranked 2nd, 14th, and 26th, based on national data from the Centers for Disease Control and Prevention (CDC) on blind HIV testing of newborns. (See table II.5 in app. II.)

Few data are available on the number of foster children infected with HIV. One study reported that the number of foster children in New York City known to be born to HIV-infected mothers increased 26 percent from 1991 to 1993. While data were not available for California and Pennsylvania, 1988 research found that Los Angeles had the fastest growing rate of AIDS cases in the nation. Furthermore, anecdotal evidence suggests that in the Los Angeles area, and the west coast in general, most AIDS in women is due to heterosexual contact. However, according to experts on pediatric AIDS, foster care agencies do not commonly recognize a history of high-risk heterosexual contact as sufficient grounds for HIV testing.

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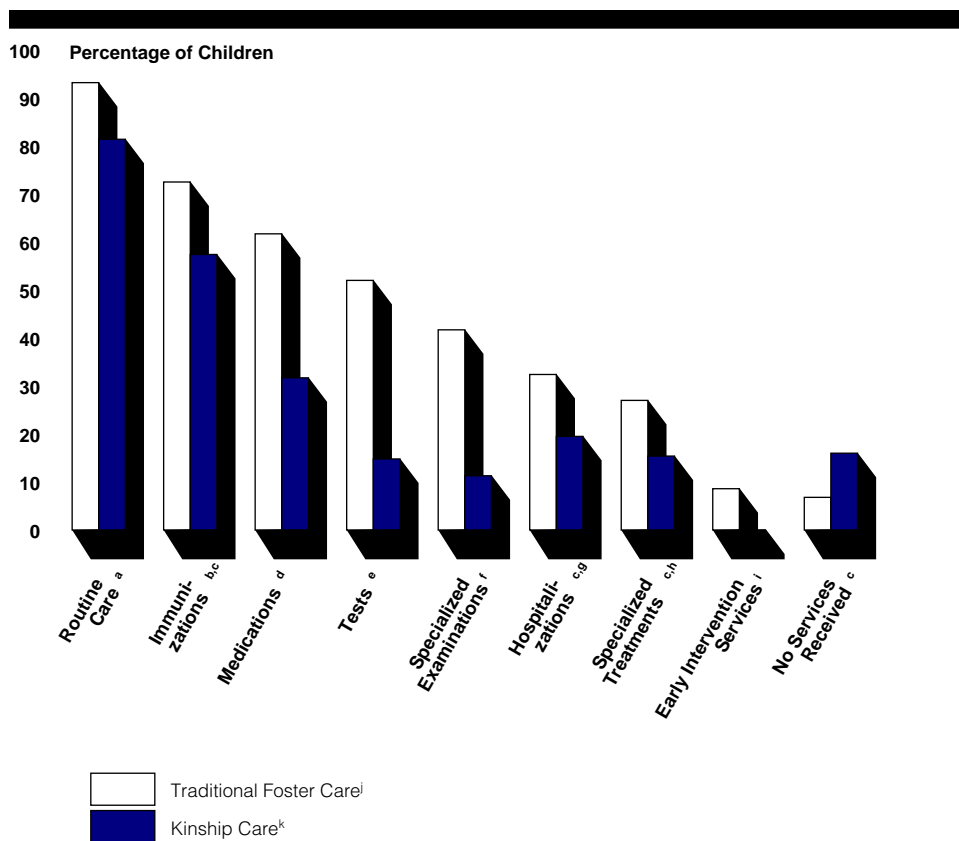
## Children Placed With Relatives in Los Angeles County and New York City Were Less Likely to Receive Health-Related Services

Young children placed exclusively with relatives—known as kinship care—were less likely to receive health-related services than children placed exclusively with nonrelatives—known as traditional foster care.<sup>9</sup> Specifically, children placed in kinship care were nearly three times as likely as those placed in traditional foster care to have received no routine health care. Moreover, these children were less likely to receive health-related services of all kinds. Since studies indicate that children in kinship care remain in foster care longer, and they receive a lower level of service, the likelihood is greater that these children will go without needed services for longer periods. (See fig. 3 and table II.6 in app. II.)

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<sup>9</sup>We used only Los Angeles County and New York City data in our analysis of county case file data regarding kinship and traditional foster care placements. Because the sample for Philadelphia County contained only one child who was placed exclusively in kinship care, we eliminated that location from this analysis.

**Figure 3: Services Received by Placement Type in Los Angeles County and New York City**



<sup>a</sup>Consists of varying amounts of medical practitioner care and/or EPSDT examinations.

<sup>b</sup>Includes children who received at least one immunization and excludes children who were under 90 days of age.

<sup>c</sup>Differences are statistically significant at the 90-percent confidence level.

<sup>d</sup>Includes treatment for asthma, syphilis, seizures, and kidney problems.

<sup>e</sup>Includes blood, laboratory, and radiology.

<sup>f</sup>Includes developmental, psychological, and cardiological.

<sup>g</sup>Includes care for HIV, pneumonia, and failure to thrive, as well as surgery.

<sup>h</sup>Includes apnea monitors, infant stimulation, and speech therapy.

<sup>i</sup>Includes therapeutic day care and Head Start services.

<sup>l</sup>Consists of children placed exclusively in traditional foster care.

<sup>k</sup>Consists of children placed exclusively in kinship care.

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Young children placed in kinship care in the two locations reviewed were also an estimated three times more likely than those placed in traditional foster care to be at risk for future problems because of prenatal drug exposure.<sup>10</sup> Furthermore, because drug-exposed children are more likely to be at risk for HIV and developmental delays, the need for health-related services for children in kinship care is even more critical. Yet, only 11 percent of children placed exclusively in kinship care received specialized examinations, such as developmental evaluations; whereas, 42 percent of those placed exclusively in traditional foster care received specialized examinations. (See table II.6 in app. II.)

While we did not determine why children in kinship care received less health-related care, or compare other aspects of care by placement type, we reviewed key studies on kinship care. Research found that foster care agencies treat kinship care placements and traditional foster care placements differently. Studies indicate that caseworkers generally provide less monitoring and assistance to kinship care placements. Some states have policies requiring less frequent caseworker visitations to kinship care homes, although these homes are more likely to be unlicensed. For example, a 1992 HHS study found that in 30 states, children may be placed in kinship care homes whether or not the homes meet minimum standards designed to ensure the safety and suitability of foster homes and foster parents. Mandatory orientation and training for foster parents are the most frequently waived licensing requirements for kinship caregivers. A 1994 Child Welfare League of America report on kinship care found few studies that focused on either kinship care providers or the children in their care. These studies, which were limited in scope, provided little information regarding the advantages of different types of placement.

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## Kinship Care Increased Dramatically

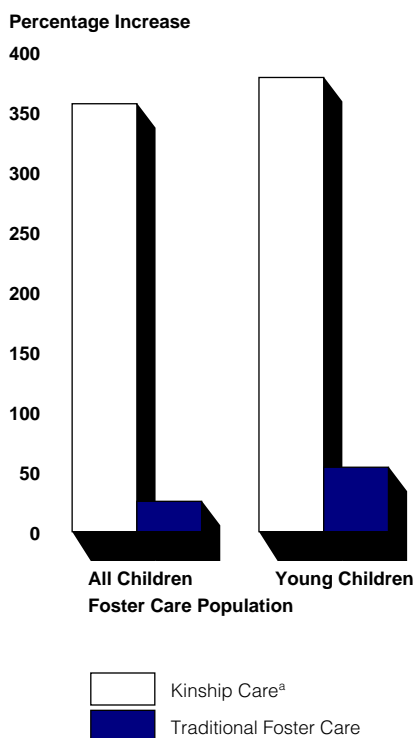
Analysis of the California and New York state databases showed the number of children of all ages in kinship care increased by over 350 percent between 1986 and 1991, and this percentage increase was even higher for young foster children, at 379 percent.<sup>11</sup> (See fig. 4 and table II.7 in app. II.)

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<sup>10</sup>This analysis excluded children who were at risk for serious health problems and also had serious health conditions. When these children were included in the analysis, young children placed exclusively in kinship care were about as likely as those placed exclusively in traditional foster care to be at risk for future problems as a result of prenatal drug exposure.

<sup>11</sup>Pennsylvania does not have a statewide foster care database.

**Figure 4: Increase in Kinship and Traditional Foster Care in California and New York Between 1986 and 1991**



Note: Counts represent all children in foster care at the end of the calendar years.

<sup>a</sup>Part of the increase in kinship care placements is due to a lawsuit filed in the New York Supreme Court, *Eugene F. v. Gross*, which sought to require New York City to follow regulations to formally include children who are placed with relatives in the foster care caseload and make them eligible for services.

Source: State electronic databases.

The dramatic increase of children in kinship care between 1986 and 1991 resulted in nearly equal numbers of placements in kinship and traditional foster care in the three counties reviewed. We estimated that 49 percent of the young children had been placed in kinship care at some time during the 1991 review period, while 53 percent had been placed in traditional foster care. (See table II.8 in app. II.)

Some studies contend that the increase in kinship placements may have been due, at least initially, to a shortage of traditional foster homes. Other

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studies posit that this increase may be the result of state and county interpretations of the Adoption Assistance and Child Welfare Act of 1980 as implying a preference for relative placements. In recognizing that foster care would continue to be a necessary child welfare service, this act required states to place children in the “least restrictive (most family-like) setting available,” which has been interpreted by many states as implying a preference for kinship care. As of 1992, 44 states commonly placed foster children in kinship care, and 29 states had policies in place requiring foster care agencies to give preference to relatives of foster children.

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## Health-Related Needs of Foster Children Often Go Unmet Despite Agency Efforts

The foster care agencies reviewed struggle to ensure that the health-related needs of children in their care are met. About one-third of all states, including the three reviewed, have established only broad guidelines within which counties administer foster care programs. Thus, counties in these states develop and implement programs with considerable autonomy, which results in a variety of approaches being used.

County foster care agencies in the locations reviewed have altered their health-related policies, regulations, and programs in efforts to improve the agencies’ ability to meet the health needs of foster children. For example, one of the foster care agencies we reviewed continues to develop and implement recordkeeping systems in an attempt to improve its ability to ensure that foster children receive needed services. The agency is currently implementing its third variation of a medical recordkeeping system in recent years. Implementation of the first two versions was unsuccessful, and the third was too recently implemented for us to determine its success. However, because the third version is substantially similar to its predecessors, its likelihood of success is limited.

Other efforts by this agency have focused on establishing medical clinics for foster children. It established a comprehensive assessment center at the county-run children’s emergency shelter, but that effort appears to have met with only limited success. Medical staff at the center told us that it is seldom used by foster children of any age who reside outside the shelter. The foster care agency is also supporting the development of an ambitious and complex system of multidisciplinary assessment and medical clinics for foster children. This most recent effort, while promising, depends on factors largely outside the control of the foster care agency, such as the continuing involvement of the academia-based physicians who proposed the system and the viability of a complex design



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for funding services. Furthermore, the system needs strong support from within the agency and procedures that direct foster children to the new system if—unlike the current assessment center—it is to reach even a sustainable level of utilization.

Recognizing that states need assistance in improving their child welfare programs, including foster care, ACF recently increased its technical assistance efforts. Within the past year, HHS contracted for 10 National Resource Centers to assist ACF staff in responding to states' questions and to provide free technical assistance to states. Each resource center specializes in a child welfare issue such as permanency planning, abandoned infants, or special needs adoption. However, none of the resource centers is designated to help states with ensuring health-related services for foster children.

ACF also audits states to certify states' compliance with the safeguards for foster children specified in the Social Security Act. However, the audits do not examine compliance with all safeguards. The safeguards include a requirement that case files of foster children contain up-to-date health-related information, such as records of immunizations and a child's health conditions. We previously reported that HHS did not audit states on their compliance with all required safeguards for foster children, and we recommended that it expand its audits to include all safeguards.<sup>12</sup> In March 1995, ACF officials confirmed that their audits still do not examine whether states are complying with the health-related safeguards. An HHS determination that a state has passed its compliance audit entitles the state to receive the full federal child welfare funding available by law. However, since HHS does not audit for compliance with the health-related safeguards, states have no federal financial incentive to comply with them. ACF plans to include these safeguards in future audits, according to the same officials.

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## Conclusions

Important health-related needs, including routine medical examinations and various specialized services, remained unmet for nearly one-third of the young foster children in the locations reviewed. Additionally, most young foster children in the locations reviewed were at high risk for HIV as a result of parental drug abuse, yet few children were actually tested for the infection. Furthermore, those in kinship care were less likely than

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<sup>12</sup>Foster Care: Incomplete Implementation of the Reforms and Unknown Effectiveness (GAO/PEMD-89-17, Aug. 14, 1989).

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those placed in traditional foster care to receive needed health-related services.

Despite federal safeguards for foster children, as well as regulations of responsible agencies to ensure adequate health care for foster children, agencies continue to struggle to meet the complex health needs of young children. Federal efforts to help states design and implement effective foster care health programs have been extremely limited, as evidenced by the lack of both ACF audits and technical assistance to states on health-related issues. Our work confirms our earlier recommendation that ACF audits be expanded to include all foster care safeguards. We continue to believe that ACF should take this action.

Finally, foster care agencies have been slow to respond to one critical health need—HIV risk assessment—which is the first step in identifying HIV-infected children so that they can receive appropriate and timely health care. Yet, even if all foster children were systematically assessed, HIV testing of high-risk children can still be hampered by state laws and county policies. Finally, while we do not know why children in kinship care generally receive fewer health-related services than children in traditional care, research indicates that kinship caregivers receive less monitoring and assistance from foster care agencies than traditional foster caregivers.

These findings are particularly disturbing given the vulnerable nature of the population of young foster children. Whether the federal government retains the foster care program in its current form or creates block grants to the states, these issues warrant attention.

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## Agency Comments and Our Evaluation

We provided HHS as well as the cognizant social services agencies of the three states and locations reviewed with the opportunity to comment on a draft of this report. We received comments<sup>13</sup> from the state of New York, New York City, and Los Angeles County. Philadelphia County responded that it could not comment on the specifics of the report because of a pending lawsuit. However, it indicated a few general concerns. We did not receive comments from HHS, the state of California, or the state of Pennsylvania.

One aspect of our report was commented on by three respondents. New York State, Los Angeles County, and Philadelphia County expressed

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<sup>13</sup>We received comments from the New York State Department of Social Services, the New York City Human Resources Administration, the Los Angeles County Department of Children and Family Services, and the Philadelphia Department of Human Services.

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concern about the age of our data. While our report is based on 1991 data, those were the most current data available when the study began. To ensure the continuing usefulness of the data and other aspects of our study, we continued to monitor the locations reviewed through spring 1995 to determine if any changes in policies and programs had occurred that could substantially alter our conclusions. While some promising changes have occurred, either the locations that provided comments to our draft provided us with no data to support their assertions that the delivery of services has improved or it is too early to determine the impact of the changes. For example, New York City commented that it is implementing a state early care intervention program and has trained staff in the use of the program. However, it is too early to judge the impact of this new effort.

Another aspect of our report was commented on by two respondents. New York State and Philadelphia County questioned the appropriateness of combining the results of our analysis of cases across the three locations reviewed. As we stated in the report, we determined that the conclusions drawn from our analysis were similar for each location with two exceptions: Philadelphia County was dropped from analyses of kinship care, and data depicted in figure 2 included two categories where the results varied widely by location. With these exceptions, the results were sufficiently consistent across all three locations that we do not believe that presenting the aggregate results unfairly portrays the situations in any of the locations.

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## The State of New York and New York City Comments

The state of New York questioned the adequacy of the sample size. We arrived at our sample size using accepted statistical procedures that gave us an adequate level of precision at the 95-percent confidence level to support our findings. Our detailed methodology is presented in appendix I and the confidence intervals are presented in appendix II.

The state also expressed doubts about the accuracy of several of our statistical findings, conveying its belief that an ongoing state study regarding foster care medical services will produce different results. It believes that its ongoing study will produce a more favorable picture of its ability to meet the needs of foster children. However, we cannot evaluate this opinion because the state did not provide us with any results from this study. Furthermore, the state provided little information on the methodology being employed, and we do not know whether the state

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plans to conduct such analyses as would make it possible to compare their results with ours.

New York City raised different issues related to our methodology. It questioned whether inadequate caseworker recordkeeping provided an incomplete depiction of the health-related services received by young foster children. Before beginning the case file review, to test the feasibility of using this method, we reviewed the case files of a small sample of children and then requested the foster care agencies in the three locations reviewed to provide information on those same children from all possible sources, including service providers and foster parents. In general, we found that the additional information provided from these other sources did not change the conclusions we had reached on the basis of our case file review regarding the level of services these children received. On this basis, we concluded that the information in the case files would be sufficient for our analytical purposes.

New York State agrees with the importance of risk assessment for HIV and agrees that it does not know the full extent of HIV-infected children in foster care. However, it disagrees that this occurs in New York City because of a lack of a mechanism to carry out risk assessments. Furthermore, the state asserted that more children are now being assessed and tested for HIV as a result of changes in its policies. We agree that this state has the most comprehensive policies on risk assessment of the three locations reviewed. For this reason, we used a portion of their risk assessment policies as criteria in one analysis. However, the large gap we reported between the number of children who were at risk for HIV, based on one New York City risk criterion, and the number actually tested indicated that the mechanisms in place did not ensure that their procedures were consistently carried out. While it is possible that recent changes in New York State or New York City policies may have improved the ability to identify HIV-infected children, state officials pointed out that they have not been able to formally implement regulations that would put their latest policy changes in place because of a state moratorium on regulatory action.

New York State agrees that children placed in kinship care were less likely to receive services than children placed in traditional foster care, and this finding was confirmed by the state's own study. However, it disagrees with the inclusion in the report of data on the growth in kinship care because it asserts that such data do not reflect the proportion of children actually in kinship care and traditional foster care. We agree that it is useful to

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understand the proportion of children in different types of care, and this information is included in the report. However, we believe that presenting data on the large growth in kinship care placements between 1986 and 1991 is also useful to understand that the utilization of kinship care has changed significantly since the mid-1980s.

New York State agrees with our conclusion that periodic reviews for compliance with federal standards are appropriate. It also made technical comments on our characterizations of county versus state regulations and of New York City as a county, and our description of HIV testing policies. On the basis of these comments, we modified the report as appropriate.

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## Los Angeles County Comments

Los Angeles County commented that its current internal audits of medical assessments show that compliance is at approximately 90 percent. We agree with that estimate of the receipt of required medical examinations, which we refer to as routine care. As stated in our report, about 12 percent of young foster children did not receive any routine health care; Los Angeles County's current estimate of 10-percent noncompliance with its regulations regarding medical assessments falls within our 95-percent confidence interval cited in appendix II.

Los Angeles County also commented that it has made a number of changes over the last few years that were designed to meet the health care needs of foster children. Specifically, it discussed the HIV risk assessment policy, the comprehensive multidisciplinary assessment center it established at a children's emergency shelter, and the new system of multidisciplinary assessment and medical clinics. We acknowledge that Los Angeles County has a policy of evaluation for risk of exposure to HIV as an ongoing process for all foster children. However, in September 1994, numerous county program officials told us that the county has no procedures to systematically ensure that risk assessments take place; consequently, this policy does not ensure that foster children who are at high risk for HIV will be identified and tested. In addition, in fall 1994, we visited the assessment center at the children's emergency shelter and interviewed key program officials and medical staff. We acknowledge that this assessment center was designed to provide a variety of comprehensive health-related evaluations. However, as stated in our report, this assessment center is little used by foster children who reside outside the emergency shelter. Finally, as we stated in our report, we agree that the multidisciplinary medical clinics are a promising approach to meeting the complex health-related needs of young foster children. However, it was not until

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September 1994 that the first of the seven planned assessment center clinics was funded to hire staff; thus, this system is in its infancy and is substantially untested.

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We will send copies of this letter to the Secretary of Health and Human Services and program officials in the states reviewed. We will also send copies to all state welfare program directors and make copies available to others on request. Please contact me at (202) 512-7215 if you or your staff have any questions. Other GAO contacts and contributors are listed in appendix III.

Sincerely yours,

A handwritten signature in cursive script that reads "Jane L. Ross".

Jane L. Ross  
Director, Income Security Issues

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**Abbreviations**

ACF	Administration for Children and Families
AFDC	Aid to Families With Dependent Children
AIDS	acquired immunodeficiency syndrome
CDC	Centers for Disease Control and Prevention
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus

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# Scope and Methodology

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To accomplish the objectives of our review, we obtained and analyzed data on state foster care programs and the children in them from the three states with the largest average monthly foster care populations in 1991—California, New York, and Pennsylvania. Over 50 percent of the nation’s foster children are under the jurisdiction of these three states.

We used a variety of approaches to meet our objectives. We analyzed electronic state and county foster care databases; conducted a case file review based on generalizable random samples; interviewed HHS, state, and county foster care officials; conducted a telephone survey of child welfare advocacy groups and other child welfare experts; conducted group interviews with foster parents and caseworkers; reviewed foster care and related literature; reviewed applicable portions of the Social Security Act and other legislation; and reviewed foster care agency regulations and other documents. Studies cited in this report are listed in the bibliography.

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## Statewide Data

To determine the number of foster children in different types of placements in the states, we analyzed electronic foster care databases for the two states where they were available, California and New York. State officials provided us with automated records for all children who were in foster care at any time during calendar years 1986 and 1991. We could not obtain comparable electronic records for Pennsylvania as that state has not established an automated case record system.<sup>14</sup>

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## County Case File Data

To determine the health-related services needed and received by young foster children, their health conditions, and the types of placements they were in, we reviewed statistically representative samples of foster care case files for the county with the largest foster care population in 1991 for each of the states reviewed: Los Angeles County, New York City,<sup>15</sup> and Philadelphia County. To identify those locations, we again used the state foster care databases for California and New York; for Pennsylvania, we relied on information provided by state officials. Philadelphia County officials provided us with an electronic database of the records for foster children in that county in 1991.

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<sup>14</sup>For the three states reviewed, the 110-percent increase in young foster children that was previously reported combines data from electronic databases and aggregate state data. For California and New York, states with electronic databases, the counts are for foster children under the age of 3 years. For Pennsylvania, the count is for foster children under the age of 5 years, as that state’s aggregate data did not break out children under age 3 years.

<sup>15</sup>New York City comprises five boroughs and is treated in the state database as a county.

Before drawing the sample, we narrowed the databases to include only foster children whose third birthday occurred no later than December 31, 1991. This resulted in population sizes of 8,249 for Los Angeles County, 13,171 for New York City, and 1,335 for Philadelphia County. Then we selected random samples from each of these locations resulting in a total sample of 414 children. The population sizes and initial sample sizes are shown in table I.1.

Table I.1: Initial Population and Sample Sizes for Children in Foster Care

	Population	Initial sample	Final sample	Percentage of initial sample used
Los Angeles County	8,249	137	114	83.2
New York City	13,171	150	142	94.7
Philadelphia County	1,335	127	104	81.9
<b>Total</b>	<b>22,755</b>	<b>414</b>	<b>360</b>	<b>89.8<sup>a</sup></b>

<sup>a</sup>Percentage total is a weighted average showing the percentage of the total population covered by the final samples.

We requested all foster care case files for each child in the sample. A few cases were dropped from the sample because the children did not meet the criterion of being in foster care during the review year or were not of the appropriate age. Other cases were dropped because county officials could not locate the records. Finally, we dropped cases of children who were in foster care during our review period for less than 30 days in Los Angeles County and New York City, and less than 60 days in Philadelphia County. We did this to eliminate cases in which a child's tenure in foster care was shorter than the time foster care agencies were allowed, by their local regulations, to complete initial medical examinations. This resulted in final samples totaling 360 young foster children in our three locations.

We examined the foster care case files for the period covering a child's first entry into foster care until the end of the review year or until the child was discharged from foster care, whichever occurred earlier. We used an automated data collection instrument to record information from the case files. The recorded information was reviewed for accuracy by the individual preparing it before finalizing each electronic record. We also reviewed the case file data for consistent coding among individuals; minor adjustments were made to the coding as a result of that review.

We analyzed the case file data using univariate and bivariate analyses, descriptive statistical methods. We found that for some of the data, the

results varied among the three locations; however, the conclusions we drew from the analyses of each location were similar. Thus, the locations could be combined for analysis. Finally, when combining these data, we weighted them to adjust for disproportionate sampling and produced aggregate estimates. However, the results pertain to only the three locations combined and do not necessarily reflect populations of foster children at the state or national level.

For data derived from the case file review, the percentage estimates reported in the letter and the numerical estimates reported in appendix II are point estimates. Because the estimates are based on combined results from three samples, each is subject to sampling error. The size of the sampling error reflects the precision of the estimate; the smaller the error, the more precise the estimate. Sampling errors for the estimates were calculated at the 95-percent confidence level except where noted. We are 95-percent confident that the actual percentages fall within the confidence intervals reported in appendix II. In other words, there is a 5-percent chance that the confidence intervals do not contain the actual population percentages.

### Analysis of Placement Type and Service Delivery

For the analysis comparing the subpopulations of children in kinship and traditional foster care, we used only records of children who had been placed exclusively in kinship care or exclusively in traditional foster care. Furthermore, because the sample for Philadelphia County contained only one child who was placed exclusively in kinship care, we eliminated that location from this analysis. The subpopulation sizes are shown in table I.2.

Table I.2: Subpopulation Sizes

	Traditional foster care	Kinship care
Los Angeles County	20	33
New York City	41	43
<b>Total</b>	<b>61</b>	<b>76</b>

This is the second report responding to this request. We conducted our review for both reports between November 1992 and March 1995 in accordance with generally accepted government auditing standards. We analyzed the electronic databases as provided to us by state and county officials, and we performed limited tests of the completeness of the case files.

# Analysis Results

This appendix presents the numerical values for the data discussed in the body of this report. Where appropriate, point estimates and confidence intervals are provided. The appendix includes case file review results for the review year 1991 and statewide data for calendar years 1986 and 1991.

**Table II.1: Health Care in Three Counties**

Health care <sup>a</sup>	Point estimate, number	Point estimate, percent	Confidence interval at 95-percent confidence level	
			Upper bound, percent	Lower bound, percent
<b>Services not received</b>				
Routine care <sup>b</sup>	2,434	11.9	15.4	8.4
Immunizations <sup>c</sup>	6,885	34.3	42.7	28.0
<b>Service received</b>				
EPSDT	267	1.3	3.5	0.7

<sup>a</sup>We dropped cases for children who were in foster care during our review period for less than 30 days in Los Angeles County and New York City, and less than 60 days in Philadelphia County. We did this to eliminate cases in which a child's tenure in foster care was shorter than the time foster care agencies are allowed, by their local regulations, to complete initial medical examinations.

<sup>b</sup>Children are exempt from initial examination requirements if they received an equivalent examination within 90 days before entering foster care. Of children who received no routine care during our review period, three were required, because of their age at entry and length of stay, to have an initial examination if they did not have an examination 90 days before entering foster care. We believe, based on the case file data, that these children did not meet the prior examination requirement.

<sup>c</sup>Includes children who received at least one immunization and excludes children who were under 90 days of age.

Source: Case file review.

**Appendix II  
Analysis Results**

**Table II.2: Proportion of Children Receiving No Health Services by Health Condition**

Health condition	Point estimate, number	Point estimate, percent	Confidence interval at 95-percent confidence level	
			Upper bound, percent	Lower bound, percent
No known serious health problems <sup>a</sup>	1,094	28.4	48.6	8.2
At risk for serious health problems <sup>b</sup>	723	5.6	11.4	2.6
Serious health problems <sup>c</sup>	241	2.1	8.0	0.6

<sup>a</sup>Includes children who had minor illnesses.

<sup>b</sup>Consists of prenatal drug exposure (including alcohol exposure) and drug withdrawal or symptoms. We considered a child to be prenatally drug-exposed if any of the following conditions were documented in the child's foster care records: mother reported that she used drugs during pregnancy, toxicology test results for mother or infant were positive for drug use, or infant was diagnosed as having drug-withdrawal symptoms.

<sup>c</sup>Consists of fetal alcohol syndrome, low birth weight, cardiac defects or heart problems, HIV-positive or AIDS, developmentally delayed, and other serious problems.

Source: Case file review.

**Table II.3: Specialized Services Received in Three Counties**

Services	Point estimate, number	Point estimate, percent	Confidence interval at 95-percent confidence level	
			Upper bound, percent	Lower bound, percent
Medications <sup>a</sup>	9,607	47.0	52.9	41.2
Tests <sup>b</sup>	7,499	36.7	42.4	31.0
Specialized examinations <sup>c</sup>	6,211	30.4	35.9	24.9
Hospitalizations <sup>d</sup>	5,025	24.6	29.8	19.4
Specialized treatments <sup>e</sup>	4,619	22.6	27.5	17.7
Early intervention services <sup>f</sup>	725	3.6	6.0	1.6

<sup>a</sup>Includes treatment for asthma, syphilis, seizures, and kidney problems.

<sup>b</sup>Includes blood, laboratory, and radiology.

<sup>c</sup>Includes developmental, psychological, and cardiological.

<sup>d</sup>Includes care for HIV, pneumonia, and failure to thrive, as well as surgery.

<sup>e</sup>Includes apnea monitors, infant stimulation, and speech therapy.

<sup>f</sup>Includes therapeutic day care and Head Start services.

Source: Case file review.

**Appendix II  
Analysis Results**

**Table II.4: Extent to Which Identified Needs Were Met in Three Counties**

Needs met	Point estimate, number	Point estimate, percent <sup>a</sup>	Confidence interval at 95-percent confidence level	
			Upper bound, percent	Lower bound, percent
Children with at least some needs not met	6,591	32.1	37.7	26.5
Children with all needs met <sup>b</sup>	9,763	47.6	53.4	41.8
Children with no needs identified <sup>b</sup>	3,924	19.1	23.1	15.2

<sup>a</sup>Point estimates do not total 100 percent because of rounding and records lacking data on identified needs.

<sup>b</sup>The point estimates for the three locations varied widely in these two categories. The range of point estimates was 60.6 to 24.6 percent for "all needs met" and 45.6 to 4.9 percent for "no needs identified."

Source: Case file review.

**Table II.5: HIV-Infected Newborns for Three States in 1993**

States	Ranking of selected states by estimated rates of HIV-infected newborns	Estimated HIV-infected newborns per 1,000 live births <sup>a</sup>
California	26	0.14
New York	2	1.43
Pennsylvania	14	0.40

Note: We calculated these rates from data supplied by CDC from its study of blind HIV testing of newborns. Forty-four states and the District of Columbia participated in this study. The six states that did not participate were Idaho, Indiana, Nebraska, North Dakota, South Dakota, and Vermont. While the District of Columbia was the only nonstate location included in this comparison of estimated HIV-infected newborns, it ranked first.

<sup>a</sup>Reflects the estimates of children who are HIV-infected, excluding those who falsely test positive at birth. CDC's estimates of the number of HIV-infected newborns are based on a 25-percent transmission rate; in other words, one-quarter of the number of newborns who test HIV-positive at birth are estimated to be HIV-infected rather than merely carrying their HIV-infected mothers' antibodies.

Source: GAO analysis.

**Appendix II  
Analysis Results**

**Table II.6: Services Received by Placement Type in Los Angeles County and New York City**

Services	Traditional foster care <sup>a</sup>		Kinship care <sup>b</sup>		Difference between point estimates, percentage points	Confidence interval at 95-percent confidence level	
	Point estimate, number	Point estimate, percent	Point estimate, number	Point estimate, percent		Upper bound, percent	Lower bound, percent
Routine care <sup>c</sup>	4,476	93.2	4,689	81.4	11.8	22.1	1.4
Immunizations <sup>d</sup>	3,352	72.5	3,209	57.4	15.1 <sup>e</sup>	31.2	-1.1
Medications <sup>f</sup>	2,963	61.7	1,826	31.7	30.0	46.1	13.9
Tests <sup>g</sup>	2,496	52.0	850	14.8	37.2	52.5	22.0
Specialized examinations <sup>h</sup>	2,002	41.7	652	11.3	30.4	44.8	15.9
Hospitalizations <sup>i</sup>	1,558	32.4	1,124	19.5	12.9 <sup>e</sup>	27.9	-2.1
Specialized treatments <sup>j</sup>	1,300	27.0	888	15.4	11.6 <sup>e</sup>	25.6	-2.3
Early intervention services <sup>k</sup>	411	8.6	0	0.0	8.6	15.8	1.3
No services received	329	6.8	925	16.0	-9.2 <sup>e</sup>	0.7	-19.1

Note: Because the sample for Philadelphia County contained only one child who was placed exclusively in kinship care, we eliminated that location from this analysis.

<sup>a</sup>Consists of children placed exclusively in traditional foster care.

<sup>b</sup>Consists of children placed exclusively in kinship care.

<sup>c</sup>Consists of varying amounts of medical practitioner care and/or EPSDT examinations.

<sup>d</sup>Includes children who received at least one immunization and excludes children who were under 90 days of age.

<sup>e</sup>Differences are statistically significant at the 90-percent confidence level.

<sup>f</sup>Includes treatments for asthma, syphilis, seizures, and kidney problems.

<sup>g</sup>Includes blood, laboratory, and radiology.

<sup>h</sup>Includes developmental, psychological, and cardiological.

<sup>i</sup>Includes care for HIV, pneumonia, and failure to thrive, as well as surgery.

<sup>j</sup>Includes apnea monitors, infant stimulation, and speech therapy.

<sup>k</sup>Includes therapeutic day care and Head Start services.

Source: Case file review.



**Appendix II  
Analysis Results**

**Table II.7: Increase in Kinship and Traditional Foster Care in California and New York Between 1986 and 1991**

<b>Placements</b>	<b>1986</b>	<b>1991</b>	<b>Percentage increase</b>
<b>All children</b>			
Kinship care <sup>a</sup>	15,241	69,590	356.6
Traditional foster care	64,225	80,443	25.3
<b>Young children</b>			
Kinship care <sup>a</sup>	2,941	14,072	378.5
Traditional foster care	12,007	18,457	53.7

Note: Counts represent children in foster care at the end of the calendar years.

<sup>a</sup>Part of the increase in kinship care placements is due to a lawsuit filed in the New York Supreme Court, *Eugene F. v. Gross*, which sought to require New York City to follow regulations to formally include children who are placed with relatives in the foster care caseload and make them eligible for services.

Source: State electronic databases.

**Table II.8: Distribution of Children in Kinship and Traditional Foster Care in Three Counties**

<b>Placement type</b>	<b>Point estimate, number</b>	<b>Point estimate, percent</b>	<b>Confidence interval at 95-percent confidence level</b>	
			<b>Upper bound, percent</b>	<b>Lower bound, percent</b>
Kinship care	9,976	48.8	55.0	42.7
Traditional foster care	10,773	52.7	58.9	46.6

Note: Point estimates represent the proportion of children who were in each type of placement at any time during the review period. Since some children were in both types of placements during the review period, point estimates total more than 100 percent.

Source: Case file review.

# GAO Contacts and Acknowledgments

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## GAO Contacts

Kerry Gail Dunn, Evaluator-in-Charge, (415) 904-2000  
Robert L. MacLafferty, Assistant Director, (415) 904-2000

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## Acknowledgments

In addition to those named above, the following individuals made important contributions to this report: Susan Riggio led the fieldwork in California and Pennsylvania and coauthored the draft; Ann Walker led the data analysis and coauthored the draft; Helen Cregger, Sheila Murray, Tranchau Nguyen, and Cameo Zola conducted case file reviews and interviews.

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# Related GAO Products

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Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children  
(GAO/HEHS-94-89, Apr. 4, 1994).

Childhood Immunization: Opportunities to Improve Immunization Rates at Lower Cost (GAO/HRD-93-41, Mar. 24, 1993).

Drug Abuse: The Crack Cocaine Epidemic: Health Consequences and Treatment (GAO/HRD-91-55FS, Jan. 30, 1991).

Drug-Exposed Infants: A Generation at Risk (GAO/HRD-90-138, June 28, 1990).

Foster Care: Incomplete Implementation of Reforms and Unknown Effectiveness (GAO/PEMD-89-17, Aug. 14, 1989).

Pediatric AIDS: Health and Social Service Needs of Infants and Children  
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