

Exploring Medical Foster Care as a Placement Option for Children With Medical Complexity

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ABSTRACT

BACKGROUND: Medical foster care (MFC) offers a family-home setting for children with medical complexity (CMC) who cannot be cared for by their parents. We explored MFC as a placement option for CMC via in-depth interviews with the individuals providing and monitoring care.

METHODS: In collaboration with an MFC agency, we recruited care team members for 15 CMC. Semistructured interviews were audiotaped and transcribed. Descriptive analyses were performed on care team composition and roles, the placement process, and child medical, placement, and quality of life (QoL) characteristics. Foster parents completed child QoL questionnaires. Conventional content analysis was applied to participant suggestions for MFC improvements.

RESULTS: Fifty-eight interviews were conducted; a median of 4 care team members interviewed per child. An extensive network of individuals and systems are involved in providing care. Each child received care from multiple subspecialists (median = 5). Most children were technology dependent (87%), developmentally delayed (87%), and entered MFC from the hospital (73%) because of medical neglect (86%). Nearly half were in care for >2 years. Changes in placement and/or care team were common. QoL scoring showed impairments in multiple domains, whereas respondent interviews described positive aspects of QoL. Participants provided suggestions to improve care within MFC.

CONCLUSIONS: MFC is a promising placement option for CMC. Because many CMC are entering MFC directly from the hospital and require ongoing care from pediatric subspecialists, pediatricians should be familiar with MFC, the placement process, and the various systems and individuals involved. Pediatricians can play important roles in ensuring that children in MFC receive coordinated and high-quality care.

www.hospitalpediatrics.org

DOI: <https://doi.org/10.1542/hpeds.2018-0229>

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HOSPITAL PEDIATRICS (ISSN Numbers: Print, 2154-1663; Online, 2154-1671).

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: Supported by the US Department of Health and Human Services under HRSA T32HP10025 (to Dr Seltzer). This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by, the Health Resources and Services Administration, US Department of Health and Human Services, or the US Government.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

Dr Seltzer conceptualized and designed the study, collected and analyzed the data, and drafted the initial manuscript; Ms Raisanen assisted with study design, collected and analyzed the data, and drafted the initial manuscript; Ms Williams and Dr Da Silva assisted with study design and collected and analyzed the data; Dr Donohue assisted with study design and analyzed the data; Dr Boss conceptualized and designed the study and analyzed data; and all authors reviewed and revised the manuscript, approved the final manuscript as submitted, and agree to be accountable for all aspects of the work.



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The number of children with medical complexity (CMC) in the United States is rising because of medical and technological advances.^{1,2} CMC have high rates of health care use, intensive daily care needs, functional limitations, and dependency on medical technology.³ Some have medical and social complexities that require out-of-home placements through the child welfare system.

When biological parents cannot care for their child's complex medical needs, they may voluntarily place the child in foster care; reports of neglect and/or abuse to child protective services (CPS) may prompt involuntary placement.⁴ Most reports of medical neglect are for children with serious, chronic medical conditions.⁵ When concerns for medical neglect (ie, poor weight gain, medication nonadherence, missed appointments) are not resolved despite services and supports to the family, then hospitalization and subsequent foster care placement may occur.⁶ Abuse is another reason for placement; children with disabilities are at higher risk of abuse, or the abuse may cause the child's medical complexity.⁷⁻⁹ CMC also enter foster care for the same reasons that children enter generally, such as parental substance use disorder or homelessness.¹⁰

Approximately 10% of the nearly 440 000 children in foster care are medically fragile.^{11,12} Many are placed in medical foster care (MFC), providing a family-home setting with trained foster parents.¹³ MFC is a specialized placement within the broader child welfare system for CMC, with much of the care subcontracted to MFC agencies.

Most data about specialized foster care placements have focused on children with behavioral health problems¹⁴⁻¹⁶; CMC has been targeted in few studies. Difficulty studying this population is partly due to inconsistent designation and identification of children in MFC across states.¹⁷ In our previous analyses of foster care administrative data, we have shown that children with increasing medical complexity are at significant risk of remaining in foster care indefinitely,¹⁰ suggesting that their substantial care

needs are barriers to family reunification and adoption. This highlights the need to examine the role and impact of MFC for children who may spend years, if not their entire childhood, within MFC.

In this study, we aimed to explore MFC as a placement option for CMC via in-depth interviews with individuals providing and monitoring MFC care. In this article, we (1) describe how MFC functions to care for CMC, (2) describe the experiences of CMC in MFC (eg, medical issues, placement characteristics, quality of life [QoL]), and (3) identify opportunities to improve care for CMC in MFC. Because CMC interact frequently with the health care system, insight regarding MFC is particularly relevant for pediatricians across sites of care and specialties.

METHODS

In 2017, we collaborated with a state-wide MFC agency to recruit up to 6 care team members per child for 15 CMC. Eligible care team members included English-speaking foster parents, biological parents, MFC caseworkers, MFC nurses, child welfare agency caseworkers and supervisors, and primary care pediatricians (PCPs). Overlap of some care team members among the 15 children meant they may have been interviewed more than once to capture their experiences with individual children.

Study approval was obtained from the institutional review board and the local Social Services Administration Research Review Board. Informed consent was obtained.

Interviews With Care Team Members

Care team members completed audiotaped, semistructured interviews in person or by telephone. Interview questions were drawn from literature regarding MFC and CMC and included the following domains: (1) general information about MFC (eg, what it is, process for entry); (2) child characteristics (eg, medical, social, placement); (3) care team member roles, continuity, and interactions; and (4) QoL. Questions were tailored to care team member role. Participants received a copy

of their interview transcript for fact-checking.

All participants were asked to describe the child's QoL; foster parents additionally completed the 47-item Infant and Toddler Quality of Life Questionnaire (ITQOL-SF47)¹⁸ for children age 2 to 71 months or the 28-item parent proxy Child Health Questionnaire (CHQ-PF28)¹⁹ for children age 5 to 18 years. The questionnaires were used to measure child-focused physical and psychosocial domains.

Analyses

Qualitative and quantitative analytic techniques were used for this mixed-methods study. Descriptive analyses were performed on transcripts. Two authors (R.R.S. and J.C.R.) independently extracted information about care team roles and continuity; the pathway from CPS referral to MFC; child medical, social, and placement factors; and child QoL. The extracted data were compared, and where there was disagreement, the authors re-examined transcripts until consensus was reached. Similar responses regarding child factors (ie, reason for placement, barriers to permanency) were grouped into categories and modified until agreement among authors was met. Conventional content analysis²⁰ was applied to participant responses regarding suggestions for MFC improvements. Two authors (R.R.S. and E.P.W.) independently coded these responses and grouped codes into themes. All authors then met to discuss the codes and themes and resolve discrepancies as a group. Preliminary results were shared with key stakeholders for member checking. Questionnaire scoring followed manuals provided by HealthActCHQ.^{21,22}

RESULTS

Interviews were completed with 2 to 5 care team members (median = 4) for each child (Fig 1). There was overlap of care team members among the 15 children; 58 total interviews were available for analyses ($n = 37$ participants).

Care Team Roles

Participants described their role and the roles of other care team members in providing care to each child in MFC.

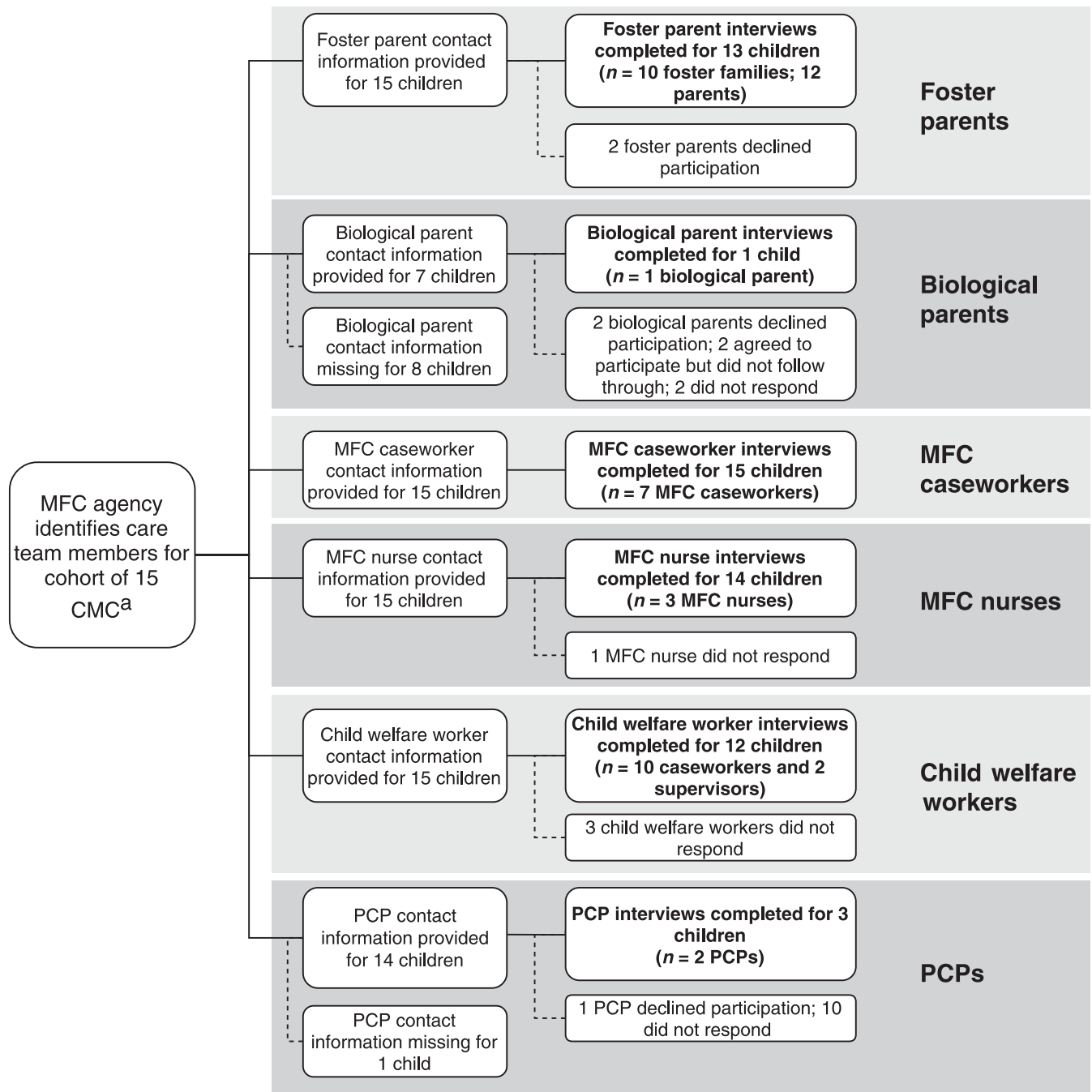


FIGURE 1 Study participant flowchart. ^a Care team members who cared for multiple children in the cohort could be interviewed more than once to capture the experience of each child.

Foster parents provide around-the-clock care for the child, schedule and attend medical appointments, and coordinate care. Biological parents are variably involved with the child, from no recent contact to weekly visits. Unless parental rights are terminated, they contribute to medical

decisions for their child (eg, consent for surgery). MFC caseworkers work for the MFC agency, visit the foster family weekly, provide care coordination and case management, ensure the child is safe and receiving medical care, and facilitate team communication.

MFC agency nurses assess the child at least every 3 months to confirm receipt of medical care, train foster and biological parents (ie, in gastrostomy tube feeding), and are resources for other care team members regarding the child's medical needs.

Child welfare caseworkers work for the child welfare agency and visit the child monthly, ensure a safe and appropriate placement, support biological families toward reunification, and ensure the child receives appropriate services (eg, medical, educational, behavioral).

The PCPs see the child approximately every 3 months and as needed for acute concerns, provide medical care, manage medications, coordinate with subspecialists, communicate with other team members (primarily with the foster parents), and complete health visit reports for the MFC and child welfare agencies.

Participants described numerous additional care team members from multiple systems (eg, child welfare, health care, school) (Supplemental Fig 3).

Pathway From CPS Referral to MFC Placement

In Figure 2, we summarize the pathway from CPS referral to MFC, as described by participants. When MFC placements are not readily available, hospital discharge can be delayed or alternative placement options may be considered.

A child welfare caseworker said, "If a child's in the hospital, and they have special needs...it could take a couple of days [to

find a placement]. It could take a week. It could take longer."

Another child welfare caseworker stated, "If the child has severe medical needs, and we couldn't find a foster home, our last resort would be looking at a group home. . .and the very last resort, you know, we don't like to send kids out of state, but I know in the past I've had kids that have gone out of state."

Child Medical and Placement Characteristics

CMC in MFC have a combination of complex medical and social challenges that contribute to foster care placement. Half (53%) of the children were boys, and age ranged from 1 to 11 years old (median = 4). Participants described the complex medical needs, diagnoses, and placement characteristics for the children (Table 1).²⁵ Most had a developmental delay or disability (87%) and technology dependence (87%). Each had several medical conditions and multiple subspecialists (range = 2–12; median = 5). Eleven (73%) entered MFC directly from a hospital. Medical neglect contributed to placement for most children (87%). Parental rights were terminated for 1 child. Nearly half of the children ($n = 7$) were in MFC for over 2 years (range = 2 months to 8 years). Participants identified several barriers to achieving permanency for each child (eg, reunification with biological family, adoption, guardianship).

Changes in care team members were common; since initial entry into foster care, 53% had a change in foster parent and 67% had a change in child welfare caseworker. Reasons for foster parent placement changes included the following: child reentry into foster care after unsuccessful reunification, poor fit with child's needs, foster parent physical or health challenges, hostile relationship between biological and foster parent, and foster parent not compliant with agency regulations. Since being placed with this MFC agency, 60% had a change in MFC caseworker and 27% had a change in MFC nurse. In regard to PCP continuity, 75% (9 out of 12 responses, 3 missing responses) had a change in PCP at entry into foster care ($n = 3$) or during time in foster care ($n = 6$).

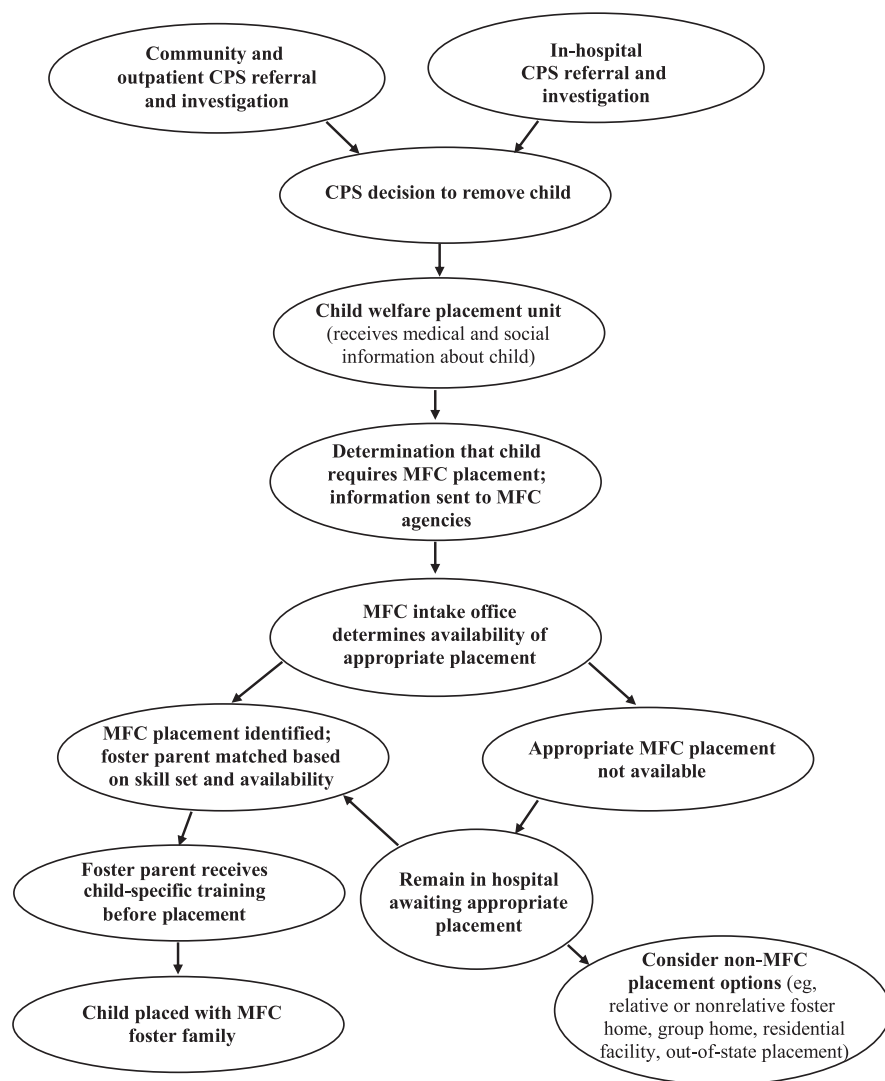


FIGURE 2 Pathway from CPS referral to MFC placement.

TABLE 1 Child Medical and Placement Characteristics

| Characteristic | Children, % (n) | Characteristic | Children, % (n) |
|---|-----------------|--|-----------------|
| Sex | | Developmental factors and therapies ^a | |
| Male | 53.3 (8) | Developmental delay or disability | 86.7 (13) |
| Female | 46.7 (7) | Visual or hearing impairment | 46.7 (7) |
| Age category | | Physical therapy | 93.3 (14) |
| <2 y old | 33.3 (5) | Occupational therapy | 86.7 (13) |
| 2–5 y old | 40 (6) | Speech therapy | 53.3 (8) |
| 6–11 y old | 26.7 (4) | Medical devices and equipment ^a | |
| Complex chronic condition categories ^{a,b} | | Feeding tube | 86.7 (13) |
| Technology dependence | 86.7 (13) | Hardware ^c | 53.3 (8) |
| Gastrointestinal | 66.7 (10) | Adaptive equipment ^d | 53.3 (8) |
| Other congenital or genetic defect | 60 (9) | Respiratory support ^e | 40 (6) |
| Respiratory | 46.7 (7) | Entered foster care from | |
| Neurologic and neuromuscular | 46.7 (7) | Hospital | 73.3 (11) |
| Cardiovascular | 33.3 (5) | Home | 26.7 (4) |
| Premature and neonatal | 33.3 (5) | Reason for entering care ^a | |
| Hematologic or immunologic | 20 (3) | Medical neglect | 86.7 (13) |
| Renal and urologic | 13.3 (2) | Inadequate housing | 46.7 (7) |
| Transplant | 6.7 (1) | Parental substance use disorder | 46.7 (7) |
| Metabolic | 6.7 (1) | Physical abuse | 20 (3) |
| No. categories per child, median (range) | 4 (1–9) | Voluntary | 6.7 (1) |
| Specialists ^a | | Permanency plan | |
| Gastroenterology or nutrition | 93.3 (14) | Reunification | 46.7 (7) |
| Ophthalmology | 66.7 (10) | Concurrent reunification and adoption | 26.7 (4) |
| Developmental pediatrics | 60 (9) | Adoption or guardianship | 26.7 (4) |
| Neurology | 53.3 (8) | Parental rights | |
| Pulmonology | 46.7 (7) | Intact | 93.3 (14) |
| Genetics | 40 (6) | Terminated | 6.7 (1) |
| Cardiology | 33.3 (5) | Placement continuity ^f | |
| Orthopedic surgery | 33.3 (5) | No | 53.3 (8) |
| ENT | 33.3 (5) | Yes | 46.7 (7) |
| Audiology | 26.7 (4) | Length in care | |
| Neurosurgery | 26.7 (4) | <1 y | 13.3 (2) |
| Behavioral health | 20 (3) | 1–2 y | 40 (6) |
| Endocrinology | 20 (3) | >2 y | 46.7 (7) |
| Hematology or oncology | 13.3 (2) | Barriers to permanency ^a | |
| Nephrology | 13.3 (2) | Parental disengagement | 60 (9) |
| Pediatric surgery | 13.3 (2) | Parental incarceration | 33.3 (5) |
| Transplant team | 13.3 (2) | Lack of adoptive parents | 33.3 (5) |
| Immunology | 6.7 (1) | Parental inability to comprehend medical needs | 26.7 (4) |
| Urology | 6.7 (1) | Parental housing instability | 20 (3) |
| Plastic surgery or wound care | 6.7 (1) | Court or legal system barriers | 20 (3) |
| Dermatology | 6.7 (1) | Parental physical or mental health | 20 (3) |
| No. specialists per child, median (range) | 5 (2–12) | Parental substance use disorder | 13.3 (2) |

ENT, ear, nose, throat.

^a Percentages sum to >100% because multiple responses per child were permitted.

^b Complex chronic condition categories are modified from Feudtner et al²³; malignancy was not included because it was not reported by any participants.

^c Hardware includes ventriculoperitoneal shunt; cardiac shunt; orthopedic rods, pins, or screws; and central line.

^d Adaptive equipment includes orthotics, wheelchair, ramp, Hoyer lift, hospital bed, gait trainer, stander, and walker.

^e Respiratory support includes tracheostomy, ventilator, continuous positive airway pressure, and/or supplemental oxygen.

^f Placement continuity is defined as a child in the same placement since initial entry into child welfare system.

TABLE 2 QoL of Children in MFC (ITQOL-SF47 Questionnaire)

| ITQOL-SF47 Questionnaire ^a | Normative Values ^b | | |
|--|---|---|--|
| | MFC Cohort, <i>n</i> = 9, Median (Range) | Age 2–71 mo, <i>n</i> = 1468, Median (Range) | ≥2 Chronic Conditions ^c , <i>n</i> = 102, Median (Range) |
| Physical abilities | 70 (3–93) | 100 (0–100) | 100 (0–100) |
| Growth and development | 80 (35–100) | 100 (0–100) | 95 (35–100) |
| Bodily pain or discomfort | 62 (25–100) | 87.5 (0–100) | 75 (25–100) |
| Temperament and moods | 77 (62–95) | 83.3 (25–100) | 83.3 (25–100) |
| Combined behavior | 62 (37–85) | 80 (20.8–100) | 65.4 (20.8–97.9) |
| General health perceptions | 35 (12–75) | 79.2 (22.5–100) | 64.2 (30.8–97.5) |
| Change in health over previous year ^d | 4 (3–5) | — | — |

—, not applicable.

^a The domain standardized scores range from 0 to 100, with a lower score being more impaired in that domain.

^b ITQOL-SF47 normative values for the general US population age 2 to 71 mo and subgroup with ≥2 chronic conditions were provided by HealthActCHQ, Inc.²⁴

^c Per HealthActCHQ US-based norms guide, parents were asked to report whether a doctor, nurse, or other health professional had indicated their infant or toddler had any of 13 chronic conditions: attention or executive functioning problems, autism spectrum disorder, chronic bone (eg, juvenile idiopathic arthritis), chronic respiratory, cardiovascular, developmental delay, diabetes, hearing or vision problems, metabolism disorder, neuromotor, neuropsychological, seizure, or other chronic condition.²⁴

^d Change in health over last 12 mo is scored 1 to 5, with 1 representing worsening health in the past year and 5 representing improvement in health in the past year. If a child was not in MFC for 12 mo, then responses reflect change in health since entering MFC placement.

Reasons for PCP changes included foster parent preference, PCP unable to handle medical complexity, placement changes (ie, previous PCP too far from new placement), and PCPs retiring or moving.

QoL Data

In Tables 2 and 3, we compare QoL scores for CMC in MFC (*n* = 9 for ITQOL-SF47; *n* = 4 for CHQ-PF28) to normative

data.^{22,24} QoL scores were lower (more impaired) across nearly all domains for CMC in MFC compared with both the age-matched general population and children with 2 or more chronic conditions. When asked “how would you describe this foster child’s quality of life?” the care team members noted the individual child’s limitations while also highlighting positive aspects of the child’s QoL.

An MFC caseworker said, “She has two [foster] parents who are very caring and well equipped to take care of her. They love her very much. She obviously had some feeding issues, which I believe could interfere with her quality of life. But she doesn’t know any better, so I believe her quality of life is very good.”

A PCP said, “His quality of life is about as good as you can expect for a [child his age] who’s developmentally a 1-month-old or lower. He can’t even eat, but he is loved. He is well cared for. He is warm, dry, fed, and all of those things. The biggest one is that he is loved, and he’s appropriately stimulated.”

When asked on the surveys how the child’s health has changed over the past year in MFC (or since MFC placement, if <1 year), all foster parents scored the child’s health as stable or improving (Tables 2 and 3). This change in QoL was echoed during interviews with foster parents and other care team members.

A foster parent said, “Call me biased, call me whatever; since he’s been here, his quality of life has improved greatly.”

An MFC nurse said, “I think that when she first came in, she did have pain; she was struggling to breathe often. She was throwing up quite often, had very severe reflux, wasn’t thriving, wasn’t gaining

Table 3 QoL of Children in MFC (CHQ-PF28 Questionnaire)

| CHQ-PF28 Questionnaire ^a | Normative Values | |
|---|---|---|
| | MFC Cohort, <i>n</i> = 4, Median (Range) | Age 5–18 y ^b , <i>n</i> = 391, Median (Range) |
| Physical functioning | 0 (0–21.5) | 100 (0–100) |
| Role or social limitations: emotional or behavioral | 16.5 (0–100) | 100 (0–100) |
| Role or social limitations: physical | 24.8 (0–66) | 100 (0–100) |
| Bodily pain or discomfort | 40 (0–100) | 80 (0–100) |
| Behavior | 87.2 (40–95) | 71.3 (0–100) |
| Mental health | 75 (57–100) | 83.3 (16–100) |
| Self-esteem | 83.5 (50–100) | 83.3 (0–100) |
| General health perceptions | 49.2 (32–60) | 75 (0–100) |
| Change in health over previous year ^c | 4.5 (3–5) | — |

—, not applicable.

^a The domain standardized scores range from 0 to 100, with a lower score being more impaired in that domain.

^b CHQ-PF28 normative values for the general US population age 5 to 18 y was provided by HealthActCHQ, Inc.²²

^c Change in health over the last 12 mo is scored 1 to 5, with 1 representing worsening health in the past year and 5 representing improvement in health in the past year. If a child was not in MFC for 12 mo, then responses reflect change in health since entering MFC placement.

TABLE 4 Participant Suggestions to Improve the Care of CMC in MFC

| Themes and Subthemes | Quotes |
|---|---|
| Care-team related Enhance communication | “Communication of each team member, meaning the doctors, foster care, child welfare, and the parent...One person can't see everything, so if you got an opinion from each branch of it, we can make this thing work. Like I said, it takes a village to raise a child now because you have all different kinds of things going on...we could communicate a little better.” –Foster parent |
| Ensure accountability across team members and systems | “Somebody does need to make sure that everybody's on top of what they're supposed to be doing. Because it would be terrible if something was to happen because somebody dropped the ball and wasn't really paying attention. With [this MFC agency], they're in the house. They come in every week, checking on the kids, and there is a lot of people, work that needs to be done, and the backup systems that the child welfare agency has...they have a file, they make sure the appointments are being made. All the extra precautions that they take are good.” –Foster parent |
| Increase medical training for care team | “What I could say is to add more training, not just for the foster parents. For parents, for the agencies, for us as well. More training would be really good for everyone...For us, if we had more trainings about different disorders and different diseases out there, not just once in a while but more frequent, that will help us to have an idea of what to expect.” –Child welfare worker |
| Child welfare–system related Create medically fragile unit in child welfare agency | “They need to have a special unit here, a specialized unit that only deals with children, medical children. They need a special team with less caseload, maybe 5–6...to make sure nothing happens to the children, make sure their needs are well maintained.” –Child welfare worker |
| Timely permanency | “Sometimes I think that the kids get stuck in limbo because the goal to find permanency isn't rolling as fast as it should be...parents are given way too much time to show that they're able to take care of their kids. . .[There is] just not enough cut and dry of what's appropriate, what's not, 'this is what you need to do'. . .If you don't do it, they [should] just move it forward as opposed to giving too many chances and letting it linger for way too long.” –MFC caseworker |
| MFC-system related Need for more MFC placements | “I had to go [out of state] to get her because there was no one in her area that did medically fragile. Child welfare was thinking of putting her into a...like an institution. There's that need for us, a lot more parents.” –Foster parent |
| Increase awareness of MFC programs | “I think our [MFC agency] is really good. I didn't even know about them. I lived in the same area as they are. . .Some of the child welfare workers don't even know, and so I'm letting the social workers know about our program.” –Foster parent |

weight. She definitely is a different child now...she's growing and thriving, interacting, laughing, and babbling.”

Participant-Suggested Areas for Improvement

Participants provided suggestions to improve care within MFC (Table 4). Care team members could benefit from increased medical training and enhanced communication and accountability across the myriad of systems involved with these children. A medically fragile unit within the child welfare agency could promote optimal care for CMC. Participants advocated for more MFC placements, awareness of MFC programs, and support for foster parents. Finally, the health care system could better facilitate access to medical records and equipment.

DISCUSSION

Across the United States, there is a growing population of CMC.¹² Because of intensive care needs, some children cannot be cared for by their biological parents and require out-of-home placements.¹³ MFC is in increasing demand as a promising placement option offering consistent medical supervision in a family home, as opposed to a more-restrictive setting. To date, children in MFC have been largely invisible in the medical and child welfare literature.

With this study, we offer insight into how individuals from child welfare, an MFC agency, and the medical system collaborate to care for CMC. In our convenience sample of CMC in MFC, most entered MFC directly from the hospital, underscoring the importance for hospitalists to understand MFC, learn to navigate MFC services, and recognize their role in assuring high-quality care.

Pediatricians should be aware that MFC is a placement option for CMC who cannot be cared for by their families. Despite their significant daily care burdens, extensive problem lists, need for subspecialists, and dependence on therapies and technologies, MFC permits these children to live in a home setting. Despite their limitations, their

TABLE 4 Continued

| Themes and Subthemes | Quotes |
|-----------------------------|---|
| Ensure adequate supports | <p>"I think giving the foster families as much support, whatever that may mean, is best. Sometimes that does mean making changes to their houses or whatever to meet the needs of that child." –Child welfare worker</p> <p>"I think having a little bit more respite providers in this area would be helpful." –Foster parent</p> |
| Health care–system related | |
| Access to medical records | <p>"That I could get access to all of her medical records. See what has been done in the past and who has done it. Sometimes you need to go back and find out. Sometimes that's not available." –Foster parent</p> |
| Access to medical equipment | <p>"I know particularly with this client there's been barriers with getting her some of the equipment things that she needs...There may be a better system of getting equipment to the client when she's in need of it. It would be a more-expedited process. Usually these things take a while." –MFC caseworker</p> |

care team describes them as well cared for with stable or improved health during MFC placement. This may reflect the additional resources and supports that children receive within MFC that they often did not get before entering care, including intensive case management, nursing support, and consistent health supervision.⁴ We have previously argued that providing a similar bundle of MFC resources and supports to biological families may prevent out-of-home placement for some CMC.⁴

With so many people involved in the child's care, participants highlighted the importance of communication and accountability across team members as an essential component of MFC. Coordination of care is particularly important for CMC who are at risk for fragmented care.²⁵ This likely requires more intentional care team interactions. Currently, medical team members meet to plan a child's medical management, and child welfare and MFC team members meet separately to discuss the child's placement, but these care plans should be intimately informed by each other. Routine interdisciplinary meetings could ensure that the MFC placement is appropriate to deliver recommended care and services.

Hospital discharge can be delayed when the MFC placement process is prolonged, leading to unnecessary hospital days and costs. Hospitalists can reduce such barriers by facilitating the placement process, for example, contacting the hospital social worker when concerns arise about a family's ability to care for their child. The sooner it is determined whether additional services and supports for the family will suffice or if foster care placement is required, the faster a determination can be made if MFC is an appropriate and available placement option. As participants in this and our previous study of health care providers describe, the search can take time because of a shortage of MFC homes.⁴ We have previously recommended the use of a hospital to MFC discharge protocol with jointly trained child welfare and health care staff to streamline the placement process.⁴

Once the child enters MFC, pediatricians across settings have a continued role in ensuring that the foster parent(s) and care team understand the child's medical complexity. Health information is often lacking on entry into foster care.^{26,27} Foster parents in our study identify obtaining medical records as an area in need of improvement. Because most CMC in our sample entered care because of medical

neglect, their history may include multiple "no-show" appointments, resulting in missing records and fragmented care. Child welfare workers can help track down old records, but the pediatrician should then synthesize relevant information into a meaningful summary for the foster parents and other team members.^{28,29} When children enter MFC from the hospital, sign-out from the hospitalist to the PCP and comprehensive discharge summaries may be the only medical information readily available for the larger care team to review. Although health systems may share electronic medical records across sites of care, there is a need to additionally link records across systems of care (ie, child welfare, schools) to enable information sharing among team members.

Fragmented care has high-stakes consequences for CMC, so ensuring children in MFC maintain a continuous relationship with a medical home should be prioritized. Half of the children in this study experienced a change in foster care placement and most had a change in PCP. Placement changes can exacerbate behavioral and health problems by disrupting relationships with medical providers³⁰; this is a particular risk for CMC who receive care from a network of medical providers, therapists, nursing companies, etc. Because many children enter MFC from the hospital, discharge planning should ensure that PCP and specialist appointments are arranged and additional services are in place. Outpatient providers can assist by expediting appointments for CMC in need of reestablishing medical care. A consistent medical home team (PCP, case manager, social worker, etc) could advocate for these children by facilitating coordination despite placement changes.

Child welfare team continuity is also important for CMC. Participants described the potential value of a specialized unit within child welfare for CMC. Equipped with specific CMC training, this team would oversee the linked medical and social needs of these children. A CMC unit would offer consistent teams with smaller caseloads, which may reduce caseworker turnover³¹ and promote continuity of care. A

designated pediatrician with expertise in CMC could serve as a consultant to this special unit and maintain direct lines of communication. Models for medically fragile units do exist, such as the medical placement unit in Los Angeles County, California, and the medically fragile unit at Summit County Children Services, Ohio.^{32,33}

We offer a deeper understanding of MFC as a placement for CMC with this exploratory study. To the best of our knowledge, this is the first study to describe the pathway into MFC after CPS referral, the children served, and the system of care delivery from the perspectives of various care team members. Although our group of children was small, we interviewed and compared perspectives of multiple team members for each child. Because CMC from only 1 MFC agency from 1 state were included, these results may not be generalizable. The English-language-only requirement for participants is another threat to generalizability. The overlap of care team members may reflect selection bias. Because QoL surveys were only completed by the foster parents, those results are limited to their perspective and may reflect social desirability bias. Challenges recruiting PCPs and biological parents limit their important perspective in our analysis. The fact that the MFC agency lacked contact information for over half of the biological parents suggests that parental engagement for CMC in MFC may be limited. Future research should examine the lived experience of biological families for children in MFC and explore barriers to parental engagement. Additional studies including the broader medical team (PCPs, outpatient subspecialists, inpatient providers, etc) would provide valuable perspectives.

CONCLUSIONS

MFC is a promising placement option for CMC whose biological parents are unable to appropriately provide for their intensive care needs. These children have complex medical and social problems and often spend prolonged periods of time in care. Because CMC often enter MFC directly from the hospital and require ongoing care from pediatric subspecialists, pediatricians

across sites of care can benefit from understanding the placement process and the various systems and individuals involved with MFC. Pediatricians can play important roles in ensuring that CMC in MFC receive coordinated and high-quality care.

Acknowledgments

We thank Jennifer Shepard, CRNP, MBA, for her involvement in study design and data collection.

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DOI: 10.1542/hpeds.2018-0229 originally published online August 19, 2019;

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