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Sarah J. Beal

Paul DeMott

Rich Bowlen

Mary V. Greiner

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The Role of Information Sharing to Improve Case Management in Child Welfare

Sarah J. Beal, Paul DeMott, Rich Bowlen & Mary V. Greiner

Congress enacted the Adoption and Safe Families Act to improve outcomes concerning the permanency, safety, and wellbeing of children in the care of child welfare agencies. However, achieving its goals for the more than 700,000 children who spend time in the custody of child protective services (CPS) every year in the United States is made more difficult by their poorer health compared to the general population.[1] Common health concerns among children in CPS custody include developmental delay (e.g., intellectual delay or disability, gross or fine motor delay, speech delay), infections diseases, mental and behavioral health concerns, and medical concerns. Higher levels of healthcare compared to other children who live in poverty are often required.[2] While health concerns may have been identified before children entered CPS custody, connections to healthcare providers and services are disrupted when children are removed from their families of origin and placed in out-of-home care. Efforts to collect a child's complete medical history upon entering care may be difficult, and incomplete histories negatively impact health and disease management. Moreover, disruptions in healthcare can continue even after children enter CPS custody and out-of-home care—for example, when children change placements or caseworkers—leading to additional challenges managing children's health needs and increasing healthcare use.[3]

The Adoption and Safe Families Act has been instrumental in ensuring that children in CPS custody have adequate access to healthcare services, monitored through child and family service reviews.[4] While this has been beneficial, it has not addressed challenges around disruptions in healthcare access and the sharing of healthcare information with entry into CPS custody or with placement changes while children are in out-of-home care. Better sharing of health information and coordination of healthcare services to address health concerns is essential to close these gaps. This coordination must, at a minimum, span the duration of a child's time in CPS custody.

Cincinnati's Children's Hospital Medical Center and Hamilton County Job and Family Services have worked together to improve health outcomes for children in CPS custody by developing an automated software platform to exchange healthcare and child welfare information between these organizations. In this article, we will discuss why the exchange of information is important, when information exchange can be difficult due to legal and institutional barriers, and how we have overcome these barriers with an automated software platform called "IDENTITY."[5] Finally, we will discuss the benefits of sharing information through this software platform and areas for future development.

HEALTHCARE ACCESS AND UTILIZATION WHILE CHILDREN ARE IN OUT-OF-HOME CARE

Children in CPS custody and out-of-home care (e.g., foster care, kinship care) can have their already elevated health risks compounded when they enter out-of-home care due to disruption of healthcare services and discontinuity with every placement change. This lack of coordination and consistent healthcare means preventive care is missed and chronic disease management is poor due to limited availability of records and lack of follow-up with a consistent healthcare provider. Instead of preventative care, foster and kinship caregivers rely on urgent and emer-

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Footnotes

1. *See* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *The AFCARS Report: Preliminary FY 2019 estimates as of June 23, 2020*, https://www.acf.hhs.gov/sites/default/files/documents/cb/afcarsreport27.pdf; Laura Gypen et al., *Outcomes of Children Who Grew Up in Foster Care: Systematic-review,* 76 Child. & Youth Servs. Rev. 74, 74-83 (2017).
2. Amy D. Engler et al., *A Systematic Review of Mental Health Disorders of Children in Foster Care,* 23 Trauma, Violence, & Abuse 255, 255-264 (2020); Rebecca R. Seltzer et al., *Medical Complexity and Placement Outcomes for Children in Foster Care,* 83 Child. & Youth Servs. Rev. 285, 285-293 (2017).
3. Mary V. Greiner & Sarah J. Beal, *Developing a Healthcare System for Children in Foster Care,* 19 Health Promotion Prac. 621, 621-628 (2018); Sarah J. Beal et al., *Effects of Child Protective Custody Status and Health Risk Behaviors on Healthcare Use among Adolescents,* Acad. Pediatrics (2021).
4. Adoption and Safe Families Act of 1997, Pub. Law. No. 105-89, 111 Stat. 2115; Zlotnik et al., *Improving Child Well-Being: Strengthening Collaborations between the Child Welfare and Healthcare Systems,* Child.'s Hospital Phila.'s Pol'y Lab & Safe Place (2014).
5. Mary V. Greiner et al., *Improving Information Sharing for Youth in Foster Care,* 144 Pediatrics at 1 (2019), https://publications.aap.org/pediatrics/article/144/2/e20190580/38518/Improving-Information-Sharing-for-Youth-in-Foster.

gency care, which is the easiest and quickest to obtain, particularly when these children are limited to Medicaid providers and may face other psychosocial challenges, such as transportation barriers. Use of emergency and urgent care over preventive care can contribute to duplicative care (e.g., multiple administrations of the same immunizations), missed care (e.g., missed vision and hearing screens), poor chronic disease management (e.g., uncontrolled asthma), and overtreatment (e.g., overuse of antipsychotic prescriptions).

These identified risks have resulted in several measures intended to improve healthcare delivery for youth in CPS custody. First, youth in and formerly in CPS custody are now eligible for Medicaid. Most children in CPS custody are eligible for Medicaid due to title IV-E eligibility through age 21. The Chafee Optional Medicaid Group for Independent Foster Care Adolescents provides Medicaid eligibility for youth in CPS custody at age 18 and for those who are no longer in custody and between ages 19 and 21, depending on the state. The Patient Protection and Affordable Care Act (ACA) extended Medicaid coverage to age 26 for youth currently in CPS custody and those who were previously in CPS custody and remained in care until their 18th birthday to provide parity to children who can stay on their parents' health plans until age 26.[6]

In addition to providing eligibility for health insurance through Medicaid, federal law requires state child welfare agencies to provide health screening and assessments to children entering and living in CPS custody through the Fostering Connections to Success and Increasing Adoptions Act of 2008. While the law does not give healthcare delivery timetables, it requires CPS to develop a healthcare plan for the children in their custody. The Children's Bureau of the federal Administration for Children and Families then conducts biennial Child and Family Services Reviews (CSFR) of the state CPS agencies to ensure that children receive appropriate Medicaid benefits, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

Almost all states have responded to these requirements with mandated initial health screenings and assessments.[7] While they vary in timetables for healthcare delivery (from 1 day to no timeframe depending on the state), 46 states require physical health screenings, 38 states require behavioral health screenings, and 38 states require oral health screenings when a child enters CPS custody.

Medical professional societies also support these requirements for healthcare.[8] The American Academy of Pediatrics (AAP), through the Healthy Foster Care America initiative, recommends a health screening within 72 hours of a child's placement into CPS custody, a comprehensive evaluation within 30 days, to include assessment of mental health, oral health, and developmental and academic needs, and a follow-up health visit 60-90 days after placement.

"[F]ederal law requires state child welfare agencies to provide health screening and assessments..."

The healthcare system has answered the federal and state requirements and AAP recommendations with multiple models for specialized healthcare for children in CPS custody.[9] These programs are often (but not always) located at large medical centers affiliated with an academic institution and vary in personnel and scope of care delivery. Some programs host specialized clinics to deliver healthcare services to children in CPS custody, and others monitor the health of this population. Often referred to as "foster care clinics," these programs use multiple approaches or models to provide healthcare. Foster care consultation/evaluation models provide specialized evaluations when a child enters CPS custody or changes placement. Medical home models provide ongoing well and sick care for a child while in CPS custody. Some foster care clinics focus on developmental milestones, while others focus on mental health. In other healthcare systems, children in CPS custody are cared for by standard pediatric practices alongside those not in CPS custody. In those foster care clinic models, children in CPS custody receive an extra layer of monitoring and support through healthcare coordination or medical case management. Across all foster care clinic configurations, the goal of the healthcare program is to ensure coordinated and consistent healthcare, leading to improved primary care and chronic disease management, and ultimately, improved child health outcomes.

INFORMATION SHARING BETWEEN HEALTHCARE, CPS, AND LEGAL PARTIES

While caregivers, healthcare providers, CPS personnel, and legal professionals who support children in CPS custody all desire to ensure children are healthy and have access to the services they need, the process by which information is shared is less straightforward. Rules addressing procedures for health information exchange, how it is documented, and what pieces of data can be exchanged are complex. Each member of a child's support system must navigate those challenges along with meeting the other high-stakes demands introduced by children and their families while children are in CPS custody. Federally, policies that guide information sharing for children in CPS custody include the following:

1. The Health Insurance Portability and Accountability Act of 1996 (HIPAA).[10] HIPAA limits sharing of protected health information (past, present, or future health conditions, healthcare services, payment information, personal identifiers) without patient (or legal representatives for the patient) permission. Under HIPAA, only a

6. *See* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Child Welfare Inofrmaiton Gateway, *Health-Care Coverage for Youth in Foster Care—and After,* Issue Brief, May 2015, https://www.childwelfare.gov/pubpdfs/health_care_foster.pdf.
7. Kamala Allen, *Health Screening and Assessment for Children and Youth Entering Foster Care: State Requirements and Opportunities,* Ctr. Healthcare Strategies (November 2010), https://www.chcs.org/media/CHCS_CW_Foster_Care_Screening_and_Assessment_Issue_Brief_111910.pdf.
8. Healthy Foster Care America, *Requirements for Health Screenings in Foster Care,* Am. Acad. Pediatrics (Nov. 21, 2015), https://www.healthychildren.org/English/family-life/family-dynamics/adoption-and-foster-care/Pages/Requirements-for-Health-Screenings-in-Foster-Care.aspx.
9. *See* Greiner & Beal, *supra* note 3.
10. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 [hereinafter HIPPA].

"[L]ittle information between healthcare and education systems is shared unless CPS facilitates that information exchange..."

limited set of covered entities can exchange protected health information without the patient's permission or their legal representative's written consent. These entities include individual and group health insurance plans, healthcare providers, and business associates who provide services to health insurance plans and healthcare providers. As a result, except for information related to abuse or neglect concerns, healthcare providers cannot provide comprehensive health information (e.g., diagnoses, current medications) to children's services or the court without permission from the parent or guardian unless a child is in CPS custody. When a child is placed in CPS custody, CPS stands in locos parentis to the child. Accordingly, CPS can access a child's medical information and share it with assigned caseworkers, foster caregivers, and placement providers who have a need to know such information. In addition, HIPAA allows guardians ad litem to access a child's otherwise confidential medical information while the child is in CPS custody when a court order is provided.

2. The Family Educational Rights and Privacy Act (FERPA).[11] FERPA limits information sharing for all education systems receiving U.S. Department of Education funds and requires written permission from a parent or legal guardian to share protected education data unless the information is shared a) among school officials for the educational interests of the child; b) for audit, evaluation, or accreditation purposes; c) to support financial aid; or d) to address health and safety emergencies, comply with a judicial order, or support youth with juvenile justice system involvement. Thus, like the healthcare system, education systems generally cannot exchange information about a child without a parent's written consent before a child has entered CPS custody. Further, healthcare and education systems are not permitted to share information unless a parent or legal guardian has granted permission for them to do so. As a result, little information between healthcare and education systems is shared unless CPS facilitates that information exchange for children in CPS custody.
3. Child protective services and confidentiality. Federal law requires that all states have a comprehensive child welfare information system to store all relevant case information for families with child protective services involvement. Data stored in those systems are available to CPS agencies to assist with quality improvement and other programmatic and service delivery purposes.[12] In addition, these information systems must be designed to a) comply with federal reporting requirements, b) assist with decision making in child welfare, and c) improve cross-system collaboration and coordination of care. For those reasons, child welfare information can be made available to other stakeholders when necessary. Simultaneously, children and their families retain rights to privacy and confidentiality about abuse and neglect, with the Child Abuse Prevention and Treatment Act (CAPTA).[13] This act restricts access to identified child abuse and neglect reports to the individual(s) who are the subject of a report, the court or other entities involved in child protection, or individuals authorized to have access for specific purposes (e.g., citizen review panels, child fatality reviews). Importantly, existing legislation does not entirely prohibit information sharing; instead, it regulates when and how information exchange can occur. Acknowledging this, the Administration for Children and Families has provided a Confidentiality Toolkit to guide children's services agencies in establishing information exchanges and other technologies that enhance interoperability within the boundaries outlined by CAPTA.[14]
4. Court oversight and information sharing.[15] Federal law regulates the context and frequency with which CPS must communicate with the court about removals of children from their parents, placement into least restrictive settings, and reunification or permanency for children in CPS custody. In addition, many states have independently extended those regulations to expand court oversight. Across all states, CPS is required to communicate critical information about children's safety, permanency, and wellbeing with the court. This is accomplished primarily through hearings. Guidelines to facilitate that information sharing have been developed, which support judicial information gathering during review hearings. Those guidelines specify that "Judges are responsible for ensuring the physical, mental, emotional, and reproductive health, and educational success of all children under the supervision of the court."[16] However, in the absence of consistent information sharing among education, healthcare, and

11. 34 C.F.R § 99.1 (2021).
12. *Child Welfare Information Systems,* NAT'L CONF. ST. LEGIS. (June 25, 2020), https://www.ncsl.org/research/human-services/child-welfare-information-systems.aspx.
13. Victims of Child Abuse Act Reauthorization Act 2018, Pub. L. No 115-424, 132 Stat. 5465.
14. *See* U.S. Department of Health and Human Services, Administration for Children and Families, *Confidentiality Toolkit: A resource tool from the ACF Interoperability Initiative* (Aug. 2014), https://www.acf.hhs.gov/sites/default/files/documents/acf_confidentiality_toolkit_final_08_12_2014_0.pdf.
15. SHIRLEY DOBBIN ET AL., NAT'L COUNCIL JUV. & FAM. CT. JUDGES, CHILD ABUSE AND NEGLECT CASES: A NATIONAL ANALYSIS OF STATE STATUTES (1998), https://www.ojp.gov/pdffiles1/Digitization/188288NCJRS.pdf; 42 U.S.C. §670 et seq. (1989).
16. SOPHIE I. GATOWSKI ET AL., NAT'L COUNCIL JUV. & FAM. CT. JUDGES, ENHANCED RESOURCE GUIDELINES: IMPROVING COURT PRACTICE IN CHILD ABUSE AND NEGLECT CASES 15 (2016), https://www.ncjfcj.org/wp-content/uploads/2016/05/NCJFCJ-Enhanced-Resource-Guidelines-05-2016.pdf [hereinafter ENHANCED RESOURCE GUIDELINES].

CPS entities, the information presented to judges to fulfill federal requirements may be incomplete or unavailable. Further, while federal and state legislatures set the standard for information sharing and reviews of safety, permanency, and wellbeing for children in CPS custody, local interpretation of statutes and guidelines differ, sometimes widely, across jurisdictions. Local child welfare agencies may, for example, seek out the opinions of county prosecutors to determine how statutes and guidelines should be applied and then memorialize that guidance as agency procedure. As a result, one policy can result in substantial variation in practice across local jurisdictions, even in the same state.

COURT OVERSIGHT IN CPS CASES: THE LEGACY OF ASFA

Juvenile courts are required to oversee CPS involvement with families and children in CPS custody by the Adoption Assistance and Child Welfare Act, Adoption and Safe Families Act, and state abuse, neglect, and dependency statutes. Under these laws, juvenile courts are required to ensure that children enter CPS custody only when absolutely necessary and that children are expeditiously reunified with parents when possible or placed in alternative permanent placement when necessary.[17] In addition, juvenile courts are charged with overseeing the efforts of CPS to promote the physical and emotional health and educational success of children in CPS custody. Courts exercise their oversight responsibilities through timely hearings where judges have a heightened responsibility to ensure that the needs of children in CPS custody are appropriately addressed. Similar to specialized treatment courts, such as drug courts, veterans' courts, and mental health courts, juvenile courts use review hearings to oversee the treatment of families and children. During these hearings, courts review a broad range of concerns related to child safety, permanency, and wellbeing. Information sharing is vital to effective court oversight. Courts can effectively oversee CPS efforts only when caseworkers are able to efficiently gather and present timely and comprehensive information regarding the health and well-being of children and families with CPS involvement. In addition, because court resources are limited and courts are expected to oversee a wide variety of issues, it is important that caseworkers present information in a concise, comprehensive, and systematic way.[18]

There is no shortage of models, services, programs, and initiatives to facilitate information sharing among parties to prepare for court hearings and ensure that complete information is collected to present to the court.[19] Primarily, this occurs through scheduled in-person meetings among all parties involved in a case. However, such meetings can be difficult to sustain across all cases and during the entirety of a child's involvement with CPS. Moreover, by the time parties attend a family team meeting, the information that triggered a need for that meeting has often changed and other participants or pieces of information may be needed as a result, contributing to significant lags in decision making and case management. Furthermore, information gathering is time intensive. For example, caseworkers in southwest Ohio reported spending an average of one hour gathering health information for each child on a case in preparation for a review hearing. This burden is significant given that health information is only one aspect of child wellbeing that the court needs to be informed about. However, by the time a review hearing occurs, much of the health information gathered and shared with the court ahead of the hearing is out of date, reducing efficiency and limiting the benefits of court oversight for children in CPS custody.

> **"Information sharing is vital to effective court oversight."**

BARRIERS TO INFORMATION EXCHANGE

Youth in foster care are often involved in multiple systems. In addition to involvement with CPS, they may be involved with healthcare systems, juvenile justice, education, community mental health services, and more. Collaboration between multiple systems requires correct and early identification of shared youth and interoperability of each services' data systems.[20] There are multiple reasons why this information sharing can be challenging and time-consuming, starting with identification. There are no shared identifiers between child welfare and healthcare systems. As a result, it may be challenging to identify a child's record in a different information system (e.g., using child welfare identifiers to locate a child's medical record). This challenge is compounded when there are discrepancies in identifying data, such as the spelling of a child's name. Failure to identify youth represented in more than one system due to discrepant data may result in the under-identification of multisystem youth and the perpetration of poor coordination and gaps in information sharing. Once shared records are identified, systems must determine what information needs to be exchanged. Without this step, critical information can be missing from a record request or be lost in pages of unneeded data. Adding to this complexity, children in CPS custody often receive healthcare at multiple institutions or are served by multiple child protective services agencies over the course of their childhoods. As a result, a single record request from only one institution will likely result in incomplete records. This is even more likely as children's needs become more intensive (e.g., children with behavioral health needs who are experiencing placement instability while in CPS custody). Instead, numerous record requests may be required to form a complete history. Professionals working diligently to serve youth in CPS custody are often motivated to gather this information because it is impossible for a

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17. 42 U.S.C. §670 et seq. (1989); Adoption and Safe Families Act f 1997, Pub. L. No 105-89, 111 Stat. 2115.
18. *See* Enhanced Resource Guidelines, *supra* note 16.
19. Saul Singer, Director, Counseling, Consultation and Training, A Workshop for DFS Case Managers (Mar. 2003), (https://www.childwelfare.gov/pubpdfs/nv_casemanagementtrainingfacilitator.pdf); ProtectOHIO Consortium FTM Workgroup, Practice Manual for ProtectOHIO Family Team Meetings, (2011), https://jfs.ohio.gov/ocf/ProtectOHIO-FTMPracticeManual2013.stm.
20. Robert N. Boyd & Philip V. Scribano, *Improving Foster Care Outcomes via Cross-Sector Data and Interoperability,* 176 JAMA Pediatrics e214321, e214321 (2021).

> **"[D]ata can be linked and displayed across systems to provide a complete and holistic view of a given child…"**

provider, magistrate, judge, caseworker, or another support-service professional to establish effective intervention strategies without complete information. Unfortunately, when complete and often voluminous records are finally obtained, extensive time may be required to review and glean critical information from them.

Each hospital and CPS agency may keep records and respond to record requests with very different approaches, further complicating how information is shared and what information is provided. Some organizations have more formalized processes requiring extensive paperwork for submission of a records request; others may be less formal but with additional challenges, such as knowing who to contact and how to get a timely response. Often, Memorandums of Understanding (MOUs) may be in place between CPS agencies and healthcare systems to permit data sharing, but do not establish an efficient and timely manner for doing so. Medical recordkeepers with less experience with children in CPS custody may create unnecessary barriers due to a misunderstanding of governing rules, be short-staffed and unable to respond quickly to requests, or have inefficient procedures in place. Delays in data sharing inhibit effective treatment and case planning for individual children and also prevent population-level analysis to improve outcomes, such as program evaluations and quality improvement initiatives. Finally, unless there is a process for maintaining updated information, it becomes outdated shortly after it is shared, making records less beneficial to both healthcare professionals and CPS agency staff trying to provide the best care for a child in CPS custody.

HIPAA allows medical professionals to exchange health information for the purpose of patient care, and technology and staff support are often available to facilitate that information exchange;[21] however, medical record gathering remains complex for healthcare systems when a new patient establishes care. This can be an even more daunting task for a caseworker who is unfamiliar with healthcare information exchange, stretched thin with new cases and other critical tasks, and working without administrative support. In that context, a diagnosis may be overlooked or there may be a gap in medication adherence. This can compound existing health risks for children in CPS custody and sometimes creates serious safety concerns. For example, a child may be placed with a caregiver unaware of the child's anaphylactic food allergy. Similarly, medical institutions often do not have processes to gather information quickly and efficiently from child welfare institutions. As a result, healthcare providers may not even know when their patient is in CPS custody or where a child has been moved when placement changes occur. Healthcare systems may not have contact information for the current caseworker, given high caseworker turnover rates. All of this can result in missed appointments, poorly informed treatment plans, or even hospital discharges to the wrong caregiver.

AUTOMATED INFORMATION SHARING MAY IMPROVE INFORMATION ACCESS AND COURT OVERSIGHT

The migration of information management systems in child welfare, juvenile court, and medical and education sectors from paper to digital formats provides an opportunity to securely exchange essential medical, education, and child welfare information among parties responsible for the care and oversight of children in CPS custody. Technology has advanced significantly and affords the ability to safely and securely collect, process, and share information, including recognizing appropriate roles and responsibilities of users. Technology allows for the secure collection and storage of only essential data elements from each database, updated in an automated fashion to ensure appropriate rules are followed when children are in and out of CPS custody. Further, data can be linked and displayed across systems to provide a complete and holistic view of a given child in CPS custody while simultaneously reducing the burden on the caseworker or other personnel to collect and synthesize information relevant to adequately supervise and provide oversight for a given child. We have observed the benefits of implementing such a solution in our local jurisdiction, Hamilton County, Ohio, through a platform called IDENTITY.[22] IDENTITY uses a set of shared identifiers (e.g., child name, date of birth, gender, race, and ethnicity) to match a child welfare record with a corresponding medical record for the same child and displays that information to caseworkers and healthcare providers to review and access. Information is initially linked and displayed within 24 hours of a child's entry into CPS custody, as reported by the child welfare information system, and new information is updated daily. A child's data remains displayed in IDENTITY until CPS custody ends, as indicated in the child welfare information system. At this point, the child is no longer viewable on the IDENTITY platform. IDENTITY was designed to include the information healthcare providers and CPS staff were already trying to exchange on a case-by-case basis through records requests, phone calls, and emails. For that reason, the information displayed in IDENTITY is limited to only those fields necessary for healthcare delivery and ensuring child safety and wellbeing, including placement contact information, caseworker contact information, and substantiated maltreatment history. Health information includes diagnoses, current medications, immunizations, and healthcare use (e.g., completed annual visits, participation in outpatient therapeutic services). Further, caseworkers can generate a pre-populated form that meets requirements for state statutes about medical information sharing with the court ahead of review hearings.

Automated information sharing through IDENTITY has contributed to improvements in several domains in our local jurisdiction. First, CPS staff can now update the comprehensive child welfare information system with accurate and timely health infor-

21. *See* HIPPA *supra* note 10; *See also* Israa Abu-elezz et al., *The Benefits and Threats of Blockchain Technology in Healthcare: A Scoping Review,* 142 Int'l J. Med. Informatics 104246, 104246 (2020), https://doi.org/10.1016/j.ijmedinf.2020.104246.
22. *See* Greiner et al., *supra* note 5.

mation directly from the medical record. This helps CPS ensure compliance with CFSR outcomes requirements[23] that children receive adequate services to meet their physical and mental health needs. Second, we have observed an increase in the quality of documented health information provided to the court at the time of review hearings. As a result, judges and magistrates can more effectively target questions and discussion during those review hearings toward gaps in healthcare or other service needs to support child wellbeing. Third, our healthcare system has observed improvements in compliance with healthcare service recommendations when children are in CPS custody.

Notably, the potential impact of automated information sharing expands beyond better recordkeeping outcomes. Caseworkers and healthcare providers in our community also identified efficient information sharing as a critical factor in preventing placement disruptions. When child welfare systems and courts have expanded access to and use of technology like IDENTITY, they may be able to make better-informed decisions about appropriate placement settings at the outset of a case, where the strengths and needs of a child are better matched with the capabilities of a potential caregiver, thereby improving placement stability. While this is important for initial placement, it may also have relevance for permanency, given that most children adopted from CPS custody find permanency in their existing placement. In that way, IDENTITY may also provide vital information to improve the likelihood that a child's first placement in CPS custody is the only placement. Maximally effective information sharing and decision making could reduce work for CPS and juvenile courts and also aid in ensuring children receive the best services and achieve the best outcomes while in CPS custody.

The successful implementation of technology and platforms like IDENTITY has contributed to meaningful shifts in approach and expectations around information exchange in our community. Incomplete health information was once commonplace during reviews and in the documentation submitted to the court. Now, hearing officers expect that health information will be more complete. Similarly, child welfare administrators in our community now perceive that they can attain the goal of updating the child welfare information system to be compliant with documentation requirements around child health and wellbeing. Our healthcare providers now expect to know when children are in CPS custody and with whom they are placed. Previously, that information was rarely available or accurate at the time of a healthcare encounter. Juvenile court judges and magistrates can take on a new role as they are able to exercise more effective oversight. Rather than spending time to see that information is gathered and shared, they can expect that complete and up-to-date information will be presented. Most importantly, they can incorporate that information into their decision making. These shifts are aligned with new federal guidelines, for example, the Comprehensive Child Welfare Information Systems (CCWIS) guidance, which encourage communities to use technology to look for opportunities to strengthen data sharing and, in doing so, create meaningful opportunities for prevention and improved outcomes through that strengthened data.[24]

"[I]ncreasingly important that juvenile courts have access to comprehensive information about children's health and wellbeing..."

AUTOMATED INFORMATION SHARING AND THE FUTURE OF ASFA

Legislation continues to shift toward ensuring services are provided to protect and maintain families and prevent the disruptive placement of children into CPS custody, through the Family First Prevention Services Act[25] and other initiatives. With these shifts, it will become increasingly important that juvenile courts have access to comprehensive information about children's health and wellbeing from the time they enter CPS custody until they exit care. Prevention services aimed to decrease maltreatment and preserve families are expected to safely reduce the need for out-of-home care. As a result, only those youth with the highest needs are expected to enter CPS custody.[26] Enhanced information sharing among healthcare providers, child welfare agencies, and courts is vital to accomplish goals of documenting 1) efforts to prevent the removal of children from their families of origin, 2) efforts to place children with relative caregivers and maintain those placements, 3) justification for placement in non-family settings only when necessary due to children's physical or behavioral health needs, and 4) ongoing support for older youth as they exit care. There are multiple opportunities to expand upon existing automated information exchange platforms to support prevention and ensure children remain with families. A few of those opportunities are outlined below.

1. Expanded access to existing automated information exchange platforms. One critically novel aspect of IDENTITY, which is distinct from information-sharing systems in other jurisdictions,[27] is that information is made available to two different user groups: child welfare and healthcare providers. The opportunity to reciprocate access to information to ensure both systems benefited and could serve youth in CPS custody better was a key component that made IDENTITY a success. While this is notable, the provision of IDENTITY data to the court system through case plans and court reports demonstrated that providing access to informa-

23. Nat'l Ctr. Substance Abuse & Child Welfare, Child and Family Services Review: Outcomes and Systemic Factors, and Associated Items and Data Indicators, https://ncsacw.samhsa.gov/files/TrainingPackage/MOD5/CFSROutcomesSystemicFactors.pdf (last visited Jan. 11, 2022).
24. *See* U.S. Department of Health and Human Services, Administration for Children and Families, *Federal Guidance for Child Welfare IT Systems* (Oct. 5, 2021), https://www.acf.hhs.gov/cb/training-technical-assistance/state-tribal-info-systems/federal-guidance.
25. Bipartisan Budget Act of 2018, Public L. No. 115-123, 132 Stat. 64.
26. FamilyFirstAct.org, https://familyfirstact.org/about-law (last visited Jan. 11, 2022).
27. *Ventura County Foster Health Link: Connecting Foster Families with Their Essential Records,* Child.'s P'ship (Jan. 2016), https://www.childrenspartnership.org/research/ventura-county-foster-health-link-connecting-foster-families-with-their-essential-records/.

"Information exchange platforms can also be designed to generate detailed, individualized reports..."

tion from integrated data sources for parties who are not contributing a data source themselves is also extremely valuable. There is an opportunity to expand access to existing platforms like IDENTITY, which could include granting access to the child's legal representation (e.g., the guardian ad litem or court-appointed special advocate) who could use that information to advocate for the best interest of the child, as well as to the temporary caregiver who is meeting the day-to-day health needs of the child in CPS custody. Using updated child welfare information systems data, access to a child's health information could be made available to new caregivers and restricted as soon as the child leaves that caregiver's home. Similarly, access could be granted to families of origin, mainly when the permanency goal is reunification, limiting protected information (e.g., temporary caregiver names and addresses) while simultaneously allowing families of origin to remain involved in medical decision making while children are in CPS custody. With consent, families could establish access and information exchanges before a child enters CPS custody to assist with preventing an out-of-home placement. When children do enter CPS custody, a parent could grant permission to maintain information exchanges and retain access to integrated health information after reunification, providing the parent with a comprehensive history of healthcare services and needs while their child was in out-of-home care and supporting continuity in healthcare following reunification. Further, it may be beneficial to provide young people with access to their personal health information while they are in custody and before they turn 18 as well as after they turn 18, whether they emancipate or remain in custody. Such access would allow young adults to view their complete medical records and use this information to access healthcare services and maintain their health independently.

2. Enhanced reporting features. Consistent with the intent of the Court Improvement Program reauthorized by the Adoption and Safe Families Act,[28] linked data and automated information sharing can provide mechanisms for identifying ways to improve the safety, permanency, and wellbeing of children in CPS custody. Reports of aggregate data can be made available to key stakeholders and policymakers to improve program and policy decisions while simultaneously protecting the identities of children in CPS custody. This provides the potential to look more explicitly at the impact of court reforms, for example, on child wellbeing using data gathered from the electronic health record.

   Information exchange platforms can also be designed to generate detailed, individualized reports to share with key stakeholders (e.g., judges and magistrates) to improve information gathering and sharing efficiency and completeness. For example, a juvenile court judge could receive a report generated using child welfare and electronic health records data that summarizes relevant information outlined in current enhanced resource guidelines[29] for each child on their docket, at review hearings or through summaries of agency administrative reviews. This information could be used to guide discussion and decision making at review hearings. Written reports could include a table summarizing a child's mental, physical, and dental needs and the services provided to address a child's needs since the last review hearing. In addition, it could include information regarding parental involvement in medical care and recommendations for future treatment to enhance the health and wellbeing of the child.

3. Extended reach. Like the healthcare system, the education system is expected to interact with and exchange information with CPS agencies when a child is in CPS custody. That information is expected to be relayed to the court for review and judicial oversight. The National Council on Juvenile and Family Court Justices (NCJFCJ), following guidance from the Adoption and Safe Families Act, provides guidance to juvenile courts about how to discuss children's participation in school, receipt of accommodations or other educational services, transportation to and from school, and parents' involvement in educational activities during the review hearing. The American Bar Association's Legal Center for Foster Care and Education further advocates sharing education data for children in CPS custody with child welfare and the court. Information sharing is intended to ensure access to educational services, track trends and deficits for individual children and the population of all children in CPS custody, and inform education and child welfare policy and practice.[30] Technical assistance is available to support these efforts, including guidelines for developing capacity for automated information sharing, where processes outlined are similar to those used by our team to build IDENTITY. The integration of education, child welfare, and health data could provide a powerful tool for child protective services systems to manage the day-to-day needs of children in CPS custody and support the court in providing oversight in ensuring child safety, perma-

28. *See* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *Court Improvement Program* (May 17, 2012), https://www.acf.hhs.gov/cb/grant-funding/court-improvement-program#:~:text=Awards%20are%20made%20to%20the,funded%20at%20%2410%20million%20annually.

29. *See* Enhanced Resource Guidelines, *supra* note 16 at 289.

30. *Data and Information Sharing,* A.B.A Ctr. on Child. & L. (lasted visited January 11, 2022), https://www.fostercareandeducation.org/AreasofFocus/DataInformationSharing.aspx.

nency, and well-being. This can be accomplished while fully complying with regulations around information sharing and exchange for youth in CPS custody. Further, by involving families of origin in the consent process, such services could be available to support families receiving assistance to prevent a child's placement in out-of-home care and after reunification, ensuring systems can work collaboratively to prevent both entry and re-entry into CPS custody.

CONCLUSION

Timely and efficient sharing of information between child welfare systems and medical care providers is vital to the goal of enhancing the well-being of children in CPS custody and meeting their healthcare needs. Information sharing can contribute to improving placement stability by better matching children with placement providers and reducing the time necessary to achieve permanency. It could also be a tool to provide courts with the up-to-date information needed to meet oversight responsibilities for children in CPS custody.

The exchange of information between these systems has historically been challenging. From the caseworker's perspective, compiling the initial medical history for children entering CPS custody is fraught with difficulties. It requires knowing where to look for medical records, filling out forms to authorize the transfer of records, and then sorting through what are often voluminous records to glean what is important. Often such records do not become available until weeks or even months after a child enters CPS custody. Caseworkers confront equally difficult and time consuming challenges maintaining up-to-date medical information for their case files. Moreover, when placements or caseworkers change, locating critical medical information may be difficult when it is buried in agency files. New caseworkers may not even be aware of information that was collected and stored prior to a child being added to their caseload. Finally, time spent securing and maintaining medical information reduces the time that can be spent on other equally important tasks for already overburdened caseworkers. Without up-to-date and complete information collected by caseworkers, it becomes challenging to ensure the court is well-informed and able to provide adequate oversight while a child is in CPS custody.

From the perspective of healthcare providers, obtaining timely information from the CPS agencies can be difficult and gives rise to a host of problems. Healthcare providers often do not even know whether a child is in CPS custody when they are providing care in a clinical setting. They may not know who to contact at CPS to discuss medical concerns. As children change placements, healthcare providers may lose contact with the child, making it impossible to provide ongoing medical care. As a result, even when healthcare systems want to deliver the best care for children in CPS custody and partner with CPS agencies to alleviate burden, they are challenged to do so.

Technology that safely and securely leverages automated information exchange, such as the "IDENTITY" platform, can provide a feasible solution to ensure that health and child welfare information is shared in a safe and secure manner consistent with the laws and regulations that govern the sharing of such information. Linked data, when available and accessible to stakeholders, can drive intervention, treatment, planning, and strategies tailored to the unique needs of each child in CPS custody. Aggregating these instances allows systems to identify what is working and what is not. Better information sharing offers the opportunity for improved collaboration between systems, and ultimately, improved outcomes for children in CPS custody.

Sarah J. Beal, Ph.D., completed her degree in developmental psychology at the University of Nebraska-Lincoln in 2011 and completed a fellowship in adolescent health at Cincinnati Children's Hospital in 2014. She joined the faculty of the Division of Behavioral Medicine and Clinical Psychology at Cincinnati Children's Hospital and the Department of Pediatrics, University of Cincinnati College of Medicine in 2014, and has served as scientific director of child welfare research for the Comprehensive Health Evaluations for Cincinnati's Kids (CHECK) Foster Care Center at Cincinnati Children's Hospital since 2018. In 2017 she and her colleagues secured investment from Cincinnati Children's Hospital to establish the IDENTITY data-sharing platform with Hamilton County Job and Family Services and evaluate its impact. In addition, she has received multiple federal grants to examine the impact of child welfare involvement on children's health and wellbeing. https://www.cincinnatichildrens.org/bio/b/sarah-beal (last visited December 7, 2021); @sarahbealphd (Twitter), sarah.beal@cchmc.org (email).

Magistrate Paul DeMott has served as a magistrate in the Hamilton County Court of Common Pleas, Juvenile Division (Cincinnati, Ohio) for over 35 years. He began his appointment as a magistrate presiding over juvenile delinquency hearings. Since 1989, Magistrate DeMott has presided over preliminary, adjudicatory, dispositional and post dispositional hearing in child abuse, neglect and dependency cases. Magistrate DeMott served as a consultant to the National Council of Juvenile and Family Court Judges in the development of its publication, Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases, *National Council of Juvenile and Family Court Judges (1995). Magistrate DeMott was lead author of* Ohio Abuse, Neglect Dependency Law: A Practice Manual for Attorneys, *https://www.supremecourt.ohio.gov/JCS/CFC/resources/ local/practicManual.pdf. He has regularly been invited as a guest speaker on the topic of child abuse, neglect and dependency law at the University of Cincinnati's College of Law and the University of Cincinnati's School of Social Work. In addition to presiding over child abuse and neglect cases, Magistrate DeMott has had a long interest in using computer technology to measure and enhance court performance and caseflow management in child abuse, neglect, and dependency cases. He played a key role in the design and the ongoing use and enhancement of the Hamilton County Juvenile Court's Information Management System that is used to collect and report on a large array of descriptive statistics and court performance measures. Magistrate DeMott earned his Bachelors of Science degree in Economics from Miami University and his Juris Doctorate from the University of Illinois, College of Law.*

Rich Bowlen, completed his degree in sociology and psychology at the University of Muskingum in 1991. Following his education, he began his career as a licensed social worker working as a frontline caseworker for Franklin County Children Services. In 1997 he began serving as Lay Guardian ad Litem with the Franklin County Public Defender's Office in Columbus, Ohio representing the best interest of children in abuse, neglect, and dependency cases in Juvenile and Domestic Relations Court. He then accepted a role with Fairfield County Job and Family Services as Child Protective Services Director. Throughout his career, he has served on the State Behavioral Health Leadership Group and as Co-Chair for the Protect Ohio IV-E Waiver Committee. He joined Cordata Healthcare Innovations as a Senior Vice President in 2021 and leads their Child and Family Services practice to bring meaningful collaboration to public and private partnerships. Today, he continues his direct service to vulnerable children and families as Vice Chairman for the Fairfield Metropolitan Housing Authority Board and as Board Vice President for the Harcum House Child Advocacy Center in Lancaster Ohio. https://www.cordatahealth.com/ (Last visited December 12, 2021), @Rich Bowlen (LinkedIn), @RichBowlen (Twitter), rich.bowlen@cordatahealth.com

Mary Greiner, MD, is a child abuse pediatrician and the medical director of the Comprehensive Health Evaluations for Cincinnati's Kids (CHECK) Foster Care Center at Cincinnati Children's Hospital Medical Center. The CHECK Center provides comprehensive assessments of overall functioning for almost one thousand foster youth each year at the time of entry into foster care and with each placement change. Dr. Greiner has used her work with the CHECK Center to inform the study of issues related to health disparities for youth in foster care, including piloting and studying interventions to address identified needs for youth in foster care, including traumatic stress prevention, developmental and behavioral evaluations, and the role of data sharing (including the IDENTITY data-sharing portal) between healthcare systems and child welfare systems to improve health outcomes. Dr. Greiner is an Associate Professor of Pediatrics in the Department of Pediatrics at the University of Cincinnati College of Medicine and serves on the Executive Committee of the American Academy of Pediatrics' Council on Foster Care, Adoption, and Kinship Care. https://www.cincinnatichildrens.org/bio/g/mary-greiner (last visited December 8, 2021); @CHECKDr (Twitter), mary.greiner@cchmc.org (email).

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Answers to Crossword

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