HEALTH CARE FOR HAWAIIAN FOSTER CHILDREN

by

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ABSTRACT

Foster children represent a vulnerable pediatric population with complex health needs including both acute and chronic conditions that require comprehensive health care management. However, years of research has continually demonstrated a poor provision of health care services to this at risk population including gaps in preventative care and poor follow-up with specialty services. Current literature reveals that the health care management for foster children continues to be fragmented and subpar. Several health care delivery models, standards of care, and interventions have been recommended in an effort to improve the outcomes among foster children. However the perspective of foster parents, key caregivers, has been missing in current evidence.

This investigation serves as a descriptive study utilizing grounded theory methodology to explore health care management from the Hawaii foster parent’s perspective. The purpose of the investigation was two-fold: 1) to describe foster parents' experience obtaining health care for their foster children and 2) to elicit foster parents' opinions about whether or not a health education program designed for foster parents would be helpful. After completing seven individual interviews, which were analyzed using constant comparative analysis, 19 categories were developed describing the foster parent experience related to policy and services, social environment, physical environment, biology, and behavior. The concept of a medical home model was identified as unfeasible for Hawaii foster families, and large variations in health education preparation among foster parents was observed while a significant interest in further education on health-related topics was identified as a necessity. Implications for practice and recommendations for further research were also generated.
CHAPTER ONE: INTRODUCTION

This chapter serves as an introduction to the current trends of foster children in the nation as well as the state of Hawaii, which is the setting of the investigation. The role of foster parenting as resource caregivers is provided with descriptions of their role preparation. The significance of the phenomenon is provided as well as descriptions of the purpose of the investigation and research questions. A theoretical orientation for the health outcomes of foster children is proposed as a framework for the investigation.

Background

The State of Hawaii is home to 1.3 million people, with over 70% of the state’s population residing on the island of Oahu (State of Hawaii Research and Economic Analysis Division, 2011; Unites States Census Bureau, 2011). Over seven million visitors from around the world visit the Hawaiian Islands every year, bolstering the state’s economy and bringing revenue to state and local businesses (State of Hawaii, 2011). This island chain located 2,390 miles off the coast of California is home to a blend of races, ethnicities, and languages from Asia, Micronesia, and North America, creating a multicultural milieu of residents and lifestyles. On the island of Oahu, over 40% of the population identifies their race as Asian, representing the single largest race group on the island (State of Hawaii Research and Economic Analysis Division, 2011). Amidst the cultural mosaic that has formed on the islands, the native Hawaiian culture, dating back before the turn of the first century, remains prevalent in the language, food, music, and customs of the Hawaiian Islands.

The population of children in Hawaii is reported at 288,576, and in 2009 1,455 of Hawaii’s children were placed in out-of-home care due to abuse or neglect (Child Welfare League of America [CWLA], 2011). That same year the state reported 138 children “aged out”
of out-of-home care meaning that these children reached the age of 18, relinquishing them as wards of the state. The children in out-of-home care are as diverse as the adult Hawaiian population, with 149 reported as “white,” 19 as “black,” 70 as “Hispanic,” 2 as “American Indian/Alaskan Native,” and 734 as “other” races (CWLA, 2011). In the most recent report on Hawaii Child and Family Services (2003) it was determined that the state failed to meet the goal outcome: “Children receive adequate services to meet their physical and mental health needs” with the outcome achieved in only 57.1% of cases reviewed, below the required 90% for substantial achievement (p. 8). Contributing factors to failure to provide adequate health care services include lack of access to mental health services as well as insufficient monitoring for preventative and routine health care services (United States Department of Health and Human Services, 2003). The shortfall of services captured in this report not only reflects the health and well-being of Hawaii’s children living in-home care but Hawaii’s foster children as well.

Hawaiian foster children face many of the same health disparities as foster children nation-wide and are in need of a better system to acquire their health care services. Ellermann (2007) cited the 2003 Hawaii Child and Family Services Review stating that “43% of the time Hawaiian foster children do not have their healthcare needs met” (p. S23). The Hawaii Child and Family Services Review also recognized training for current and prospective foster parents as an area that needs improvement. Rationale for the need for improvement in this area was reported:

…because the training does not fully prepare general-licensed foster parents to address the intense and myriad array of problems that foster children bring with them, does not provide timely training to child specific foster homes after the children have been placed, and does not provide or require routine formalized refresher training (United States Department of Health and Human Services, 2003, p. 70).
Foster parents fill an important role in the care of the foster child. Insufficient training could have a negative impact on the foster families’ experience, causing attrition of eligible, licensed foster parents. Most importantly insufficient training for foster parents could negatively impact the health and well-being of the foster child. The unique physical and psychosocial needs require adequate training for appropriate management of the health concerns of a foster child.

Foster parents face daunting challenges in obtaining optimal health care for foster care children in their care. More than 133,000 foster families are licensed in the United States to provide care to more than 500,000 children. Over the past 30 years there has been a steady increase in foster care children and a shortage of available foster parents to provide care. Foster parents care for the physical and emotional needs of the foster child, arrange and transport the child to counseling sessions, medical appointments, and court hearings, as well as arrange visits with biological parents as appropriate (Lauver, 2008). Finally, the foster parent is an advocate for the child and their complex needs. Foster parents must meet licensing requirements, which vary by state, and may have a myriad of background checks, training sessions, home visits, and other obligations. One form of training which is not consistent across the United States is health education programs for foster parents. Health education training includes information about coordinating care, necessary preventative services, health concerns among foster care children, and management of chronic conditions and disabilities.

One area that is often problematic for foster parents is obtaining primary care services and the continuity of that care. This need was captured in the first nation-wide study of its kind where it was discovered that health needs of one-third of foster children were not addressed while they were in out of home placement. Twelve percent received no routine health care services at all, and 34% did not receive immunizations (United States General Accounting
Office, 1995). Since 1995, a study of this scale has not been repeated. However, a multitude of current literature has indicated compromised health status of foster children across the United States as well as lack of preventative care and necessary routine services during out of home placements, compounding the complications of an overall poor health status (Jee, Tonniges, & Szilagyi, 2008; Kools & Kennedy, 2003; Mekonnen, Noonan, & Rubin, 2009; Ringeisen, Casanueva, Urato, & Cross, 2008).

Political, social, biological, behavioral, and system related obstacles have made it challenging for foster children to achieve desirable health outcomes. Foster parents are key players on the interdisciplinary team responsible for foster children's care. The purpose of this practice inquiry is to describe foster parents' experience with health care for their foster children, and to elicit their opinions about whether they would benefit from a health education program designed for foster parents from this study. A grounded theory about foster parents' experience with obtaining health care for foster children will provide a foundation for designing improved strategies for improving health care for foster children.

Foster care is a service established to provide a temporary home for children in perilous circumstances related to violence, abuse, or neglect. When it is determined that the child’s biological family is unable to provide adequate care for the child, they are removed from the home and placed with foster parents who are trained and licensed by the state. An investigation is conducted to evaluate the biological parents and their home. In most circumstances, the goal is reunification of the family and the state will provide services to support the biological family to regain custody of their children (Bass, Shield, & Behrman, 2004). If the biological parents meet the state’s requirements the child may return to their original home. If not, the child may remain in foster care for a prolonged period of time. If the parental rights are terminated, the child will
exit the foster care system once a permanent home is established by adoption (Bass, Shield, & Behrman, 2004).

Rationale for removing a child from their home includes a variety of possible sources of abuse and neglect. Prior to foster care placement many children have experienced “exposure to poverty, and were born to mothers who had poor prenatal care, prenatal infection, prenatal or maternal substance abuse, family and neighborhood violence, and mental illness” (Simms, Dubowitz, & Szilagyi, 2000, p. 911). One term to describe these difficult experiences is known as “complex childhood trauma” (Jee, Tonniges, & Szilagyi, 2008). This trauma and neglect can have significant effects on a child’s health status including their ability to feel safe and form secure attachments with others. This trauma can trigger developmental delays, psychological and behavioral problems, and physiologic illness (Jee, Tonniges, & Szilagyi, 2008; Simms, Dubowitz, & Szilagyi, 2000).

There are many members of an interdisciplinary team who have roles in the child’s life during foster care placement: biological and foster parents, welfare agents, primary care providers, medical specialists, and teachers. The role of foster parents is of particular interest because they are at the center of the social system and may care for the foster children for months or even years through investigations and litigation. Yet, they may need to surrender the child immediately under welfare orders. These specialized care givers can be valuable members of the interdisciplinary team to seek collaboration with in achieving optimal health conditions in these children. This is because of the foster parents’ caring capacity, emotional investment, and their personal experience with the child of interest.
Significance

Foster care is a well utilized resource in the United States. On any given day, there are over 500,000 foster children in the U.S. Welfare system and the numbers are expected to continue to climb (Kools & Kennedy, 2003; Mekonnen, Noonan, & Rubin, 2009). Not every reunification with biological families is successful. Thirty-five percent of foster children who exit the foster care system will re-enter the system, some multiple times within the same year (American Academy of Pediatrics, 2002). This contributes to a child who will be highly mobile lacking permanent residence and a consistent healthcare provider.

Purpose

The purpose of this practice inquiry is twofold: 1) to describe foster parents' experience obtaining health care for their foster children and 2) to elicit foster parents' opinions about whether or not a health education program designed for foster parents would be helpful. Results of this inquiry may be useful to policy makers, health care providers, and researchers with an interest in the health care of foster children.

Theoretical Orientation

A conceptual framework described by the Institute of Medicine as the model of Children’s Health and its Influences (hence forth referred to as the CHI model) is used as the theoretical orientation for this project. This model illustrates the elements that influence a child’s health and development over time from birth to early adulthood. The child's health is the result of the interaction among four primary factors, within the context of health policy and services available for the child. This is depicted as four interlocked circles entitled social environment, biology, physical environment, and behavior (IOM, 2004). Around these four circles is a ring with the elements policy and services. For complete illustration, see the figure below.
At the center of the model is “children’s health,” representing the health status as a compilation of social environment, physical environment, behavior, and biology as it exists at any point in time within the constructs of available policy and services. IOM (2004) defined “children’s health” as:

...the extent to which an individual child or groups of children are able or enabled to: a) develop and realize their potential; b) satisfy their needs; and c) develop the capacities that allow them to interact successfully with their biological, physical, and social environment (p. 3).

The social and physical environments in CHI model may describe the context for child health. For foster children the social environment includes social interaction with care givers
from biological and foster families. The physical environment addresses factors such as safety, substance abuse exposure, domestic or neighborhood violence, and noise in foster homes and the homes of the biological families. Behavior is strongly influenced by the psychological condition of the child, including but not limited to coping mechanisms, ability to self regulate, communicate, and articulate needs. Biology is the component that includes acute and chronic conditions that affect the child’s growth and well-being, including but not limited to developmental delays, physiologic illness, nutritional status, and genetic disorders. Policy and services encircle the inner components because these elements represent the local, state, and national programs and professionals in place to support and manage the care of the foster child in all aspects of their health and development. Examples of such agencies at the federal level may include the Department of Health and Human Services, the United States Environmental Protection Agency (EPA), and the United States Department of Education (IOM, 2004).

The CHI model (IOM, 2004) satisfactorily describes factors contributing to child health. However, foster children have unusual social and physical environments that pose both challenges as well as advantages at certain times. In addition, the foster child’s biological characteristics (or genetic and physiological factors) interact with both the social and physical environments. The child’s behavior interacts with social and physical environments and biological factors. The interrelatedness of all elements clearly applies to foster families as well as other families with children.

Finally, policy and services are of particular importance among the health and development of foster children because they are a key determinant in their access to care and health outcomes. For the purposes of this project, health care services from the perspective of the foster parent and health care provider will be examined to determine if a deficit is identified that
would benefit from an intervention or program. A valuable detail of the CHI model is that health is portrayed on a trajectory of time. Therefore, any of the components described has the potential to influence or explain the child’s current status as well as the future health and development of the child. The CHI model (IOM, 2004) succinctly identifies the key components to consider when assessing the foster child’s health as the primary care provider and the nurse researcher.

**Research Questions**

1. What are foster parents’ experiences obtaining health care for their foster children?
2. How are these experiences described in the context of: physical environment factors, social environment factors, biological factors, behavioral factors, health policy factors, and health services factors?
3. What are foster parents' perspectives on the desirable components of a health education program designed for foster parents?

**Summary**

The background provided lays the context for this study of the foster families of the state of Hawaii and the nation. Foster children are a particularly vulnerable population with essential health needs that are unmet. As primary care providers, it is imperative that nurse practitioners are familiar with the specialized concerns of foster parents. The Children’s Health and its Influences model (IOM, 2004) was provided as the theoretical framework. The significance and purpose of this investigation were provided as well as the research question. By exploring the health services that foster parents utilize and need, the nurse practitioner may be able to shed light on important considerations for these families and positively impact the hundreds of thousands of foster children in the United States.
CHAPTER TWO: REVIEW OF LITERATURE

Chapter two summarizes current research pertaining to foster care children and their health care. The following literature review includes information on: the physical and social environment of foster parent homes, health disparities among foster children, psychological and behavioral challenges, policies and services that influence health care delivery, as well as current standards of care.

Procedures

To complete the literature review for this investigation the Arizona Health Science Library system was utilized including CINAHL, Medline, PubMed, UptoDate as well as the World Wide Web. Other publications and texts were reviewed including pediatric texts, primary care texts, the published Standards of Care set forth by the Child Welfare League of America (CWLA, 2007), and the Standards of Practice established by the American Academy of Pediatrics (AAP, 2005).

For databases and search engines such as CINAHL, Medline, the World Wide Web, and PubMed, several key words were used. Key words included: foster care, health care needs foster children, health outcomes of foster children, health interventions for foster children, medical home model, foster children in primary care, foster parent requirements, Hawaii foster care children, Hawaii requirements for foster parents, Hawaii foster parent license, and more. A total of 47 articles and texts were determined to be relevant for the topic of interest and retained. All sources were available in English. Publications were created as early as 1978 and a recent as 2011. Literature reviewed included a variety of government publications from government websites as well as professional health journals. Sources available varied from peer reviews, systematic reviews, guidelines, and standards of care.
The Physical and Social Environment: Placement in Foster Parent Homes

The notion of substitute care givers for children has evolved over hundreds of years. The care for the orphaned or abandoned has developed from almshouses, orphanages, to “boarding out,” the most primitive form of foster care which often resulted in children as indentured house help (Marcellus, 2004, p. 35).

Foster Parent as Expert Care Givers

Many foster parents “specialize” with a specific age group and provide care for a number of children within the same age bracket over the course of many years (Marcellus, 2004). The healthcare community may not recognize the expertise these parents provide when managing the child’s care. Some foster parents feel that their opinion is not fully appreciated by the healthcare community because they are not biological or adoptive parents (Barton, 1998). However, foster parents can be a valuable source of information and insight on the child’s presentation at home, including developmental concerns and chronic illnesses. Foster parents are a special form of caregiver because they must balance care for the child for months or even years while still being able to relinquish the child with very little notice. Foster parents have many strengths when compared with many first time parents. These strengths often include higher likelihood of: mature age, financial security, marital stability, and supportive understanding between adult parents. In one study, comparing first time foster parents with biological families, the foster families had “more positive expectations and satisfying experiences in their transition to parenthood” than their biological parent counterparts (Marcellus, 2004, p. 35).

Multiple Placements in Foster Care

Complex childhood trauma generates psychological, developmental, and physiological complications that require long term treatment and monitoring by the health care professional.
Family stability fosters healthy development and foster children lack this type of an environment. Constant shifts in physical placement can also exacerbate this trauma and affect a child’s ability to develop trusting relationships with others (Kools & Kennedy, 2003; Mekonnen, Noonan, & Rubin, 2009). Therefore careful consideration must always be taken prior to making any changes in the child’s physical placement. According to the AAP (2002) foster children should be evaluated prior to changes in placement and within 30 days after being placed even if it is returning to the home of their biological parents.

Many children exit and reenter the foster care system, which may translate to changes in foster parents, case workers, and health care providers. A study in 2010 examined 25 foster children with a mean age of 17 from the state of New York through convenience sampling. The purpose of the study was to explore the experiences and attitudes of foster children towards welfare worker turnover and its effect on youth in the foster care system. Focus groups and demographic surveys were collected. Interviews were analyzed using content analysis. Among the results, there is a high turnover rate for case workers with rates as high as 23-60% annually, which means children who reenter the system often must be managed by a case worker who is less familiar with child and must rebuild a repertoire (Strolin-Goltzman, Kollar, & Trinkle, 2010). The high turnover rate may cause feeling of instability and mistrust among the foster children as well as another obstacle to continuity of care. This is where an interdisciplinary approach and communication among care givers can be so critical.

**Biology: Health Disparities among Foster Children**

Current literature demonstrates an increased incidence of physical, psychological, and developmental ailments among foster children of all ages (Jee, Tonniges, & Szilagyi, 2008; Kools & Kennedy, 2003; Mekonnen, Noonan, & Rubin, 2009; Ringeisen, Casanueva, Urato, &
Cross, 2008; Sanchez, Gomez, & Davis, 2009). The abuse and neglect that prompts placement into foster care services contribute to a myriad of concerns regarding the child’s health and well-being. Children placed in foster care have faced a number of adversities such as exposure to poverty, malnutrition, neglect, poor prenatal care and lack of routine services, violence, substance abuse, physical abuse, or sexual abuse (AAP, 2000; AAP, 2002; Kools & Kennedy, 2003). All these sources of trauma and neglect compromise long-term psychosocial, developmental, and physiological challenges for these foster children.

A study by Chernoff, Coombs-Orme, Risley-Curtiss, and Hiesler (1994) looked at a cohort of foster children over a two year period in a Baltimore, Maryland to evaluate their health status at the time of placement in foster care as well as the provision of services during placement. The sample consisted of 2,182 foster children from birth to 18 years of age, with a mean age of seven years old. Each child was evaluated upon first time entry into a foster care placement. If a foster child entered the welfare system more than once in the two year period, only the data from their first entry were evaluated in the study. Data were collected from social service records and records generated from physical and mental health evaluations and analyzed in a retrospective review of case files. The data generated from this investigation provided rich information on the health disparities of foster children in the area as well as shortcomings in current health care delivery models that serve them. At the time of placement in a foster home 23% of foster children examined failed their developmental screening, 53% were referred for further medical services, 61% presented with skin abnormalities, and 66% of foster children had disorders of the respiratory tract. A number of health concerns were identified such as anemia, lead poisoning, suicidal ideation, behavioral problems, and need for special education services. The nature of this study was unprecedented at this scale and similar studies appear to be lacking.
in current literature on a national or state level. The investigators recommended that, given the complex health needs of the foster children and the fragmented care, further interventions be designed to improve health outcomes (Chernoff, Coombs-Orme, Risley-Curtiss, & Hiesler, 1994).

**Developmental Delays**

Harden (2009) defines child development as “the physical, cognitive, social, and emotional maturation of human beings from conception to adulthood, a process that is influenced by interacting biological and environmental processes” (p. 33). There are a variety of developmental milestones a child is expected to reach as they age. Progression of developmental milestones has been outlined by such popular theorists as Piaget, Erikson, and Freud.

Development occurs in a sequential manner requiring mastering a level of physical skills and mental reasoning prior to advancing to a new milestone. If the child has psychological or physiological needs that go unmet they may struggle to master necessary skills of early development. Physical, psychological, and sensorimotor development should be considered for evaluation and potential delays in foster children (AAP, 2005).

Children in foster care are eligible for evaluation under the Early Periodic Screening Diagnosis and Treatment Program (EPSDT), a federally mandated program providing well-care, physical exams, immunizations, developmental screenings, and more. According to the United States GAO report (1995) only 1% of children surveyed received EPSDT services. This may explain the high number of developmental delays we see among these children, with 75% requiring additional evaluations to manage developmental delays (Children’s Partnership, 2008). Delays in development may present as “language disorders, social skill deficits, delayed motor skills, learning disabilities, and cognitive impairments” (Sanchez, Gomez, & Davis, 2010, p.
If not properly addressed, delays can have an adverse effect on the child’s academic performance, self-esteem, interactions with others, and behavior management. One of the challenges for caregivers of foster children is that the chronological age of the child before them does not necessarily correlate with their developmental age. This requires careful evaluation and patience for the child to complete necessary therapeutic activities and develop meaningful relationships in order to fill developmental deficits (Pruvis, Cross, Frederici, Johnson, & McKenzie, 2007).

**Complex and Chronic Conditions**

Management of chronic conditions is paramount among foster children. In an effort to understand the magnitude of health concerns among foster children, Ringeisen, Casanueva, Urato, and Cross (2008) completed secondary analysis on the data obtained from the National Survey of Child and Adolescent Well-being. The sample included 5,496 foster children birth to 15 years of age. Descriptive statistics with logistical regression were used to analyze the data revealing 30-60% of foster care children have chronic health conditions requiring management (Ringeisen, Casanueva, Urato, & Cross, 2008). “When behavioral, emotional, and developmental concerns are taken into consideration the estimated proportion of foster children with serious health concerns jumps to greater than 80%” (p. 232).

Despite the high incidence of chronic conditions (GAO, 2003; Jee, Tonniges, & Szilagyi, 2008; Ringeisen, Casanueva, Urato, & Cross, 2008; Sanchez, Gomez, & Davis, 2010) and a lack of preventative services there is considerably higher spending seen among this patient population that has yet to be explained. Foster children represent less than 3% of children enrolled in Medicaid. However foster children represent 25-41% of all Medicaid spending for mental health services (Mekonnen, Noonan, & Rubin, 2009). An approximate difference of
$4,336 (foster) vs. $1,315 (non-foster) per enrollee was observed in one fiscal year for general health services (Children’s Partnership, 2008).

**Psychological and Behavioral Challenges among Foster Children**

Psychological evaluation and services are an integral part of every foster child’s care. Foster children have three times the prevalence of anxiety disorders and twice the incidence of depression when compared with the general pediatric population (Mekonnen, Noonan, & Rubin, 2009). This also manifests in a number of challenging behavioral disorders which put strain on foster parents as well as adoptive and biological parents.

There is a growing concern about the use of psychotropic medications for foster children. According to the CWLA (2010), “children involved in the child welfare system are three to four times more likely than non-child welfare Medicaid recipients to receive psychotropic medications” (p. 15). Psychotropic medications may be necessary in the case of severe mental illness, however close and careful monitoring must accompany this form of therapy. With the poor continuity of care seen in foster care children, this has the potential to create some adverse outcomes due to medication mismanagement.

**Policies and Services Related to Foster Children**

Foster care can be a very rehabilitative healing process for a child. As a matter of fact, evidence has demonstrated that out-of-home placements seem to have a positive association on the child’s health and well-being over time (Fanshel & Shinn, 1978; White & Benedict, 1986). However, placement also comes with a number of challenges for healthcare delivery models. Such challenges include multiple home placements, exiting and re-entering the system, policy issues, reimbursement/coverage for services, lack of health history information, high turn-over in social service agents, and more. Guidelines have been published by the American Academy of
Pediatrics (2005) as well as the Child Welfare League of America (2007) in an effort to improve the quality of care delivered to foster children. However, there is minimal research available to demonstrate how these guidelines are met on state and national levels. The last study of this kind was in 1995 performed by the GAO.

**Fragmented Care and the Medical Home Model**

Fragmentation of care is another potential obstacle for achieving optimal care. Due to multiple placements in a variety of geographic locations foster children may see a number of providers while being place in and out of the welfare system. This translates to multiple records, with different practices, seen by different providers, and a significant number of children being lost to follow-up with a primary care provider or referral services. Current evidence demonstrates that foster children are often taking prescribed medications at a rate two to three times higher than the general pediatric population (Raghavan, Zima, Andersen, Leibowitz, Schuster, & Landsverk, 2005). Medication management with fragmented health care delivery not only poses a challenge, but also a potential danger in these pediatric patients. When a foster child has not established care with a primary care provider, urgent care and emergency services may be utilized to meet acute exacerbations of chronic conditions and other non-emergent health concerns thus potentiating the fragmented delivery of care by multiple providers. Rubin, Alessandrini, Feudtner, Localio, and Hadley (2004) evaluated the use of emergency department visits and other ambulatory clinics among foster children compared with non-foster children covered by Medicaid. The sample included 2,358 foster children birth to 18 years of age who entered the welfare system from 1993 to 1995. The data for foster children were compared with data from a prior study on Medicaid-eligible children who utilized health care services from 1995-1996. The non-foster care children's data were used for comparison but no statistical
analysis was done between the two groups. A negative binomial model was used in multivariate analysis of the data to examine visit rate, emergency visits, other ambulatory visits, and number of placements among the foster children. Results demonstrated a greater use of the emergency department among foster children than non-foster children. A trend was identified with a significantly \( p < 0.05 \) greater number of emergency room visits immediately after placement changes in a foster care home with 75% of emergency room visits occurring within just the first three weeks of a new placement. Thirty-eight percent of the foster children included in the study had more than two changes in placement during this period of time in foster care. In addition, foster children received care at emergency departments more than at any other ambulatory clinic. The children not placed in foster care services who were also covered by Medicaid had fewer health visits during the same period of time with most visits at ambulatory sites rather than the emergency department. The reasoning for foster parent’s high use of the emergency department services for their foster child over other non-emergent sites is not explained by the study.

A “medical home model” is one recommendation found in multiple sources of literature to combat the challenge of fragmented care (Ellerman, 2007; Sanchez, Gomez, & Davis, 2010; Thompson, 2008). A medical home model is a health care delivery model that “advocates that children in foster care have a consistent ‘medical home’ where the child maintains the same practitioner and receives all assessment and referrals for specialized care” (Mekonnen, Noonan, & Rubin, 2009, p. 408). Federal Legislation for Increasing Adoptions Act of 2008 mandates that state child welfare agencies implement the medical home concept as one component of improving services to children in foster care (Sanchez, Gomez, & Davis, 2010). However there is currently no research to evaluate whether or not this is occurring or how obstacles for achieving this mandate are met. A medical home model involves one provider at one institution to provide
all the healthcare services for the child regardless of where the child is placed and with whom (AAP, 2005). This requires commitment from social workers, foster parents, as well as biological parents which may be inconvenient but may improve the continuity of care for the child.

**Records Management**

Health care coordination can be a challenge for the foster care parent, who may not have access to full health information about the child. Without full knowledge of the child’s health history the foster parent may have a limited ability to advocate for their foster child (Marcellus, 2004, p. 35). Furthermore, prior to placement foster children often lack many routine preventative services prior such as immunizations (Simms, Dubowitz, & Szilagyi, 2000). Therefore it is often necessary for foster children to “catch-up” on many basic necessities of primary care that may not have been provided in the past while simultaneously managing other acute or chronic concerns. Children who have received some services may need to have them repeated if records cannot be found, which can be a costly and painful experience for the foster child that could be avoided if there was an efficient way to modify the management of health records.

Maintaining records can be challenge but it is not as daunting as generating records for a foster child who has entered the welfare system with none at all. Some limited records such as immunizations may be able to be obtained from the child’s school. However, the utilization of primary care services may be unknown. In addition, any care and records that are generated while the child is in foster care may not be maintained if the event of reunification with the family. If the child re-enters the system at a later date, a great deal of records reconciliation is
still needed, especially if the child has had numerous providers seeing the child over the previous year or two.

Some states have tried to launch programs to combat the problem with records by instituting a portable health record data base for foster care children. Some state governments, such as Texas, have also designed health passports to accompany the child through multiple placements to store valuable health information (Mekonnen, Noonan, & Rubin, 2009). Costs, privacy issues, audits for consistency, maintenance, and other concerns continue to be an obstacle in developing a state or nation-wide intervention that is proven effective for maintaining health information on foster children.

**Knowledge, Skills and Ability**

Not every provider accepts Medicaid patients, which may limit access in some areas for foster care children who rely on this health insurance plan. Some providers report very low reimbursement for services as well as long waits for payment from Medicaid, which may sway fewer and fewer providers to offer services to Medicaid recipients such as the foster child (CWLA, 2007). Health care providers who accept these clients must be well versed in the standards set forth by the AAP and CWLA in order to meet the comprehensive needs of the foster child. There is no current research available on how many providers there are in the United States that specialize in caring for foster and adopted children in primary care practice. In addition there is little to no evidence demonstrating the implementation of current guidelines. Thompson (2008) suggested pilot programs for a computer based curriculum for health care providers be developed as an educational resources on the health needs of foster care children. Such an intervention for health care providers may be another beneficial approach to improving the continuity of care and deserves further exploration.
According to Marcellus (2004), foster children will spend the greatest proportion of their
time in the welfare system with their foster parents, however, “foster parents are often the least
prepared for and the least supported in their responsibilities” (p. 38). Lauver (2008) described a
study in 1998 by Ward which revealed, “35% of the families licensed to provide foster care in
the United States do not have foster child placements because they lack the desire or skill to care
for children with special needs” thus creating a greater burden on the welfare system (p. 76). At
the same time, “case workers rely on foster parents to exercise sound judgment to determine
when children require health and mental health care, yet foster parents are not empowered to
give legal consent for treatment” (Simms, Dubowitz, & Szilagyi, 2000, p. 914).

Financial resources contribute to challenges with ability to seek care. Surprisingly one-
third of foster children placed in foster homes in the Unites States live below the poverty line
(Vandivere, Chalk, & Moore, 2003). The socioeconomic status of foster parents and their
reimbursement plans may be worth evaluating to determine whether these caregivers have the
appropriate resources to care for their assigned foster care children and if the financial status
affects child outcomes.

**American Academy of Pediatrics Standards of Care**

The American Academy of Pediatrics (AAP) Task Force of Health Care for Children in
Foster Care most revised their standards of care for foster children in 2005. The AAP (2002)
recommends an initial health screening for the foster child “before or shortly after” placement in
out-of home care (p. 539). In addition, a comprehensive health assessment is recommended
within 30 days of placement in out-of home care. AAP encourages any care instructions should
be directly communicated with the welfare agency and the foster parent. If it is safe and
appropriate, biological parents are encouraged to be at the health care visits and to be involved in
the child’s plan of care. Health care providers should have a copy of general consent forms completed by the biological parents through the welfare agency. Health care providers are encouraged to always seek consent from the agency in addition to or in lieu of consent from the biological parents for special interventions or services. However life saving or urgent health interventions should never be delayed by obtaining consent for treatment. The AAP does not explicitly outline what interventions would be considered “urgent” (2005).

The AAP acknowledges that many foster children lack routine immunizations, therefore a reconciliation of immunization history should be completed from all available records. The child should then be immunized according to AAP standard immunization recommendations (AAP, 2012)

If there is any evidence of sexual abuse based on the child’s history or clinical exam, HIV testing should be completed for the foster child as well as screening for specific sexually transmitted infections as indicated (AAP, 2005). Since foster children require more frequent and careful monitoring than the general pediatric population, routine follow-up appointments as needed should be scheduled to continue to assess the child’s transition in placement. At the point in time when a child is being discharged from foster care management a health assessment should be done as well. The purpose of this discharge visit is to evaluate the child’s health progress, identify conditions that will require continuing care after discharge from the welfare agency, and ensure that follow-up care is planned and scheduled. Documentation regarding health care evaluations and plan of care should be generated and shared with the foster parents, biological parents, welfare agency, as well as any other appropriate individuals who are professionally managing the child’s plan of care.
The medical home model is a model of health care delivery encouraged by the AAP, which states that “it is a medical practice that is accessible and family-centered and provides high-quality care that is comprehensive, coordinated, compassionate, and continuous over time” (2005, p. 14). A medical home model of care allows each foster child to have all of their health care services managed by one provider at one institution which simplifies records management, follow-up, and general continuity of care. While one health care provider may manage the child’s care, referrals and collaborations with specialists are to be made appropriately thus contributing to an interdisciplinary approach to care.

An interdisciplinary approach is highly encouraged by the AAP (2005). Community models may benefit the management of the foster child, utilizing a variety of specialized services. Records management among the health care and welfare team is essential in maintaining a continuity of care. The AAP encourages the use of medical passports as well as other modalities to organize the child’s medical records. While maintaining and sharing records with the appropriate persons, the AAP (2005) acknowledges the importance of maintaining confidentiality of all foster care children’s health information under the Health Insurance Portability and Accountability Act (HIPAA).

In terms of qualifications of health care professionals delivering care, the AAP (2005) provided specific qualifications for the primary care provider, including:

- Be a board-certified pediatrician or family physician or a pediatric or family nurse practitioner.
- Be experienced in providing comprehensive primary care for infants, children, and adolescents.
- Have experience in the areas of child abuse, neglect, and sexual abuse.
• Have experience with developmental and behavioral issues of infants, children, and adolescents.

• Have experience in family dynamics and its effect on children and adolescents and the effect of the foster care placement on children and families

• Participate in continuing medical education focusing on the special needs of infants, children, and adolescents, of foster care

• Demonstrate training or expertise in the area of foster care

• Work collaboratively and cooperatively with caseworkers and legal professionals on behalf of the children and adolescents in foster care.

**Child Welfare League of America Standards of Care**

The Child Welfare League of America (CWLA) revised its recommendations most recently in 2007 for the management of health care services for children in out-of-home care, which includes children in foster care as well as children in kinship care. Kinship care describes a foster parent who is from the child’s family.

CWLA has published a series of recommendations to optimize the health of the foster child (2007). The CWLA calls for a health assessment performed by a health care professional within 1-2 business days of placement into a foster care home. In addition, within 30 days the child should have a comprehensive health assessment, which will serve as the foundation for generating a plan of care for child by prioritizing problems to be addressed and determining what specialty services are needed, such as dentistry or mental health referrals. If a disability is discovered then the welfare agency must collaborate with the child’s school system to ensure that the child’s needs are met.
Each child should receive culturally competent, individualized care, utilizing a multidisciplinary approach. Follow-up evaluations should occur regularly as deemed appropriate, depending on the child’s plan of care. The foster child should be reassessed at any point in which there is a change in placement. This may include reunification with biological parents, adoption, or placement with a different foster care family.

The health care plan should be discussed among the health care providers (primary and specialty), the welfare agency, the parents, foster parents, as well as the child. The child welfare agency is expected to review the health care plan every 6 months to assess progress and any modifications to care. The CWLA (2007) lists the necessary components of the health care plan for the foster child:

- All identified health problems.
- All health needs for preventative and primary health services.
- Supporting data or assessments from health professionals.
- Needed services and interventions as identified by health professionals and documented in their reports.
- Review of current medications, their indications, and potential side effects.
- Anticipated health goals or outcomes and dates for achieving those goals or outcomes.
- Evaluation of the effect of services and interventions provided to date (pg. 48).

Psychological testing is not recommended by the CWLA for all children but only on an as-needed basis. Substance abuse education is recommended for all “older children and youth” in foster care, with referrals for substance abuse treatment only when needed. Children identified as
having a disability should have an Individual Education Plan (IEP) generated by the welfare agency. The IEP is a document that clearly outlines the special education services that the student will receive. The welfare agency must then work with the foster parent and education system to ensure that these needs are met at the child's school (CWLA, 2007).

In the event that a serious accident or injury occurs, attention by a health care professional should not be delayed. In order to expedite care the CWLA recommends that every welfare agency have a policy in place to obtain consent from the parents for treatment when appropriate. Further details about the nature of the consent or policy are not outlined in detail by the CWLA (2007).

The CWLA does recommend that all foster parents receive educational training on health care problems prevalent among foster children as well as services utilized to improve the child’s health. This education should include: recommended schedules for assessments, how to access services, notify the agency of an accident or injury, community services and resources, consent for care, policies regarding documentation of health care services and confidentiality, as well as education regarding how the foster parent’s personal health activities may influence the foster child’s health (2007).

The CWLA has very general recommendations for accessing Medicaid services for the foster child since these are regulated by the state. However, it is recommended that the welfare agency “develop a strong collaborative relationship with their state’s Medicaid agency to ensure that procedures are in place to promptly qualify children in out-of-home care for Medicaid coverage” (CWLA, 2007, p. 82).

CWLA (2007) provides criteria for qualified health care providers for foster children. These criteria include:
• Board certified in general pediatrics, or in subspecialty pediatric or adolescent care.

• Possession of staffing or admitting privileges at one or more local hospitals.

• Willingness to develop a written medical plan for the medically complex child.

This criteria established by the CWLA may greatly limit the number of nurse practitioners who could serve as health care providers for foster children since few states allocate admitting privileges to nurse practitioners who work in primary care.

**Foster Care in Hawaii**

According to the CWLA, in 2009 there were 2,871 reports of child abuse or neglect that required investigation in the state of Hawaii. That same year, 1,455 children placed in foster care services. Of those foster children 1,241 were 15 years old or younger. Of the 1,455 total foster children, 849 were reunited with their biological parents or another family member. In Hawaii in 2009 10,918 grandparents were the primary responsible caregivers of their grandchildren (CWLA, 2011).

Hawaii’s welfare system is over-burdened with more foster care cases then welfare agencies can adequately handle. A 2003 General Accounting Office report demonstrated that staff shortages, high caseloads, high worker turnover and low salaries impinge on delivering services to achieve safety, permanence, and well being for children (GAO, 2003). According to this same report the average case load for a social worker was 24-31, which far exceeds the CWLA recommended case load of 12-15 cases per a social worker (GAO, 2003).

Foster care children of Hawaii enter the foster care system after a social worker for Child Protective Services receives a report of child abuse or neglect, conducts an investigation and finds that the current living situation puts the child’s well-being in jeopardy. At that point the child is placed with a licensed foster care family until the law determines whether the child will
be reunited with their biological parents or available for adoption if the parental rights are severed.

Adults who would like to serve as foster parents for the state of Hawaii must obtain a license to foster children. The United States Department of Health and Human Services (2012) reports a wide variation in the hours of preservice training required among states for foster parent education prior to licensing with some states requiring as little as six hours (Minnesota and Pennsylvania) and other states requiring as much as 45 hours (Connecticut). Content of foster parent training also varies by state. The state of Hawaii requires a background check to be performed as well as a home visit of the potential foster parent’s residence. References are interviewed and employment and financial records are also obtained on potential applicants. TB tests are completed and an 18-hour mandatory training called “H.A.N.A.I.” must be completed by all foster parents through a state wide initiative provided by Partners in Development Foundation (Hawaii Department of Health and Human Services, 2012).

H.A.N.A.I. training was established by Hawaii’s Partners in Development Foundation. H.A.N.A.I. is an acronym which stands for “Hawaii Assures Nurturing And Involvement” (Hawaii Department of Health and Human Services, 2012). Hanai is also the Hawaiian word meaning “to feed or to nourish” or “to care for, to foster, and to adopt a child into a family” (McKinney, 2007, 1). The content of H.A.N.A.I. training includes discussion of the following topics: “Understanding the Department of Human Services, the role of the foster family, working with birth parents, teamwork, child abuse and neglect, human development, medical issues, attachment, separation, loss, grief, discipline, permanency, family interactions, transitions, resources for the family, and culture” (Wallace, D., Personal Communication, October 31, 2012). Medical issues related to training may include safety measures for the child such as safety
around pools, use of bike helmets, and sleeping arrangements (Wallace, Personal Communication, October 31, 2012). Hawaii does not require any foster parents to attend specific training for health education prior to becoming a licensed foster parent. There are health training programs for already licensed foster parents obtaining medically fragile children through a division called Hale Malama Ola. This type of training is required only by this particular organization for their foster parents who will be caring for infants and children requiring specialized medical interventions such as tube feedings, and injections and is not contingent in the licensing process.

There is very little information available regarding health care models as they relate to foster care children or, specifically, Hawaiian foster care children or information on the experience of foster parents obtaining health care services in Hawaii. After completing a review of literature, only one study was found which examined health care concerns from the perspective of foster parent caregivers. This study was published by Lauver (2010) in the Journal of Family Nursing. In this study, Lauver completed individual interviews with 10 foster families from the “northeastern United States” (p. 77) using interview questions and probes. The purpose was to examine the “experience of parenting foster children with chronic illness and complex medical needs” (p. 74). The results of the analysis revealed five themes of the foster parents’ experience, including committing to parenting, learning the needs of the child, intervening, the relinquishment of the child, and a sense of self (Lauver, 2010). Among the recommendations for further research, the investigator proposed exploration of the process that foster parents undergo to fulfill their role as caregivers and child advocates.

A second study by Ellermann (2007) addressed specifically the mental health concerns of foster children in Hawaii using focus groups to interview adolescent foster children, foster
parents, and welfare professionals. Focus group data provided information related to transitions, coping mechanisms, self-perception, interactions with the welfare system, and the need for utilization of medical homes (Ellermann, 2007). While both Ellermann (2007) and Lauver (2010) are bridging the knowledge gap by incorporating the foster families’ perspective, more research as it pertains to their utilization of services, their needs, role development, education, training, and effectiveness of health care delivery models and interventions is needed.

**Gaps in Current Literature**

A review of relevant literature reveals gaps in knowledge about the process for foster parents to obtain health care for foster children in the United States and the state of Hawaii. Information regarding the types of health education available among states and its effect of the foster parent’s self efficacy and child outcomes has not been explored. How widely the CWLA and AAP guidelines are being implemented and how states regulate these remains unclear. What health care models have demonstrated an improvement in health outcomes with foster children has also not been established; specifically, the role of a medical home model and its influence on continuity of care. Much of the available literature takes a top down approach examining patterns and statistical representations of disease prevalence, services needed, and services rendered for foster children by the health care provider. As previously mentioned there is a deficit in descriptive studies presenting the provision of care from the foster families’ perspective. There is scarce evidence available about how foster parents can most effectively meet the healthcare needs of foster children, particularly as it pertains to the state of Hawaii. Further research in these areas may help to provide a greater knowledge base for the provision of care for these children.

Foster parents’ role and responsibility for caring for their foster children makes them ideal partners for the health care provider to work with when addressing the foster child’s health
care needs. However, literature highlighting the perspective of the foster parents in acquiring health care services in Hawaii is virtually unavailable. A better understanding of the foster parent role, obstacles in achieving care, and interactions with the health care system of Hawaii may help professionals support them in fulfilling their responsibilities, which would in turn improve the outcomes of the foster child.

Summary

This chapter presented the review of literature for health care for foster children. Evidence related to the current health status and utilization of services by foster children was framed by elements of the CHI Model (IOM, 2004) including: physical environment, social environment, biology, behavior, policies, and services. Gaps in current literature were described to recognize deficits in current research.
CHAPTER THREE: METHODS

Chapter three addresses the study design and the methodology behind recruitment, sampling, data collection, and analysis that was utilized for this practice inquiry. Human subjects’ considerations and measures to protect the privacy of participants are provided as well.

Assessing the Need for Change

The first step in improving health care for foster children was to conduct an assessment. Rossi, Lipsey, and Freeman (2004) outline four steps to assess whether or not there is a need for a change in practice. The first step is to clearly define the problem, and the extent of the problem. Then, the target of the intervention as well as the target population must be identified carefully as these are not always one in the same. Finally, the nature of the services needed must also be considered.

The problem of interest was identified as poor health outcomes in foster children related to inconsistent provision of primary care services. The extent of the problem was identified in the review of literature demonstrating the significance of the problem on a state and national level. The target of the assessment is the foster parents, since their knowledge base and experience in obtaining health care services for the foster children is the central focus to be enhanced by a potential intervention or program. Foster children are identified as the target population because the purpose of an intervention or program is to benefit the health and well-being of these children. These foster children are indirect subjects of assessment and indirect recipients of a potential program or intervention through the involvement of their foster parents. This is because the foster parents are in the position of active knowledge generation. The element nature of the services needed was examined by identifying what type of program or services may enhance foster parents’ ability to access appropriate health care services for their children. Details of what
types of interventions are needed is revealed through a better understanding of the obstacles foster parents encounter, knowledge deficits, political and financial barriers, as well as individual health concerns of their children.

**Design**

This investigation was a descriptive study with grounded theory methods (Artinian, 1995; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Grounded theory is a method that uses interview data which are analyzed to identify concepts and develop subsequent categories for those concepts which will serve as the “cornerstones” for theory development (Strauss & Corbin, 1990). Design proceeded with Strauss and Corbin’s (1990) technique for grounded theory research using selective sampling and constant comparative analysis of interview data. According to Burns and Grove (2009) the theory generated from grounded theory is “grounded, or has roots in, the data from which it was derived” (p. 25). Grounded theory is a qualitative method appropriate for learning social processes and how people make decisions (Burns & Grove, 2009). Grounded theory was appropriate for answering the research questions, as obtaining health care for foster children is a process experienced by foster care parents.

**Sample**

Seven foster parents completed the interview process which exceeded the recruitment goal for the investigation. The inclusion criteria for foster parents were: 1) currently caring for school-age (6-12 years old) foster care children OR provided foster care for school age children within the last 10 years. 2) Provided foster care for a least a minimum of six months. 3) Able to speak English. The investigation targeted foster parents of school age children in order to establish a focus in order to generate specific recommendations appropriate for a select age group. Selecting children in this school age group allowed for discussion of age specific
developmental milestones, interactions in an academic environment, and participation in a series of similar routine health examinations for health promotion. Therefore, the effects of health care delivery have the potential to impact many similar facets well-being for this age group. In Hawaii, the 6-12 year old age group also accounted for the largest proportion of children in out of home placements in 2009 (CWLA, 2011).

There were no age limitations for foster parent participants in this study. Because the interview was conducted in English, this was an inclusion criterion for participants. Demographic and background data were collected on all foster parent participants. Demographic data was obtained included: age, gender, highest level of educational completed, and details related to foster care experience. See Appendix D for the demographic form.

**Recruitment**

After approval from the College of Nursing and University of Arizona Institutional Review Board (IRB) committees, the process of data collection began. Participants were recruited from local foster care organizations on the island of Oahu including Hope INC, Catholic Charities, and Hui Ho’omalu. The principal investigator contacted organizational leaders by telephone and email. The principal investigator asked the organizational leaders if they would be willing to share the recruitment flyer to members of their foster care organization via email. In addition, organizational leaders were asked if they would allow the principal investigator to speak to foster parents about the investigation at a meeting and provide flyers at the meeting for the purposes of recruitment. A recruitment script for communication with organizational leaders (Appendix B) as well as a script for communication with potential participants (Appendix C) was generated and approved by the IRB committees. These scripts were used for the purposes of recruitment for the investigation. Interested foster parents then
initiated contact with the principal investigator by phone or email. The principle investigator and the participant then established an appointment to complete the interview at a location and time convenient for the participant. To see a copy of the recruitment flyer, see Appendix A.

**Data Collection**

The principal investigator conducted semi-structured interviews (Appendix E) with foster parents in order to gain insight on the multifaceted experiences of families seeking and using health care for their foster children in Hawaii. The goal was to obtain a minimum of five foster parents to discuss their experiences managing the health services on the island of Oahu. Ten foster parents initially responded and seven foster parents met the eligibility criteria and completed the interview process. Each foster parent was required to complete an approved consent form (Appendix F) prior to completing the interview. On each consent form, there was the option for the participant to elect to participate in a follow-up interview by phone if desired. The follow-up interview served as a member check that was completed with two participants selected at random. Participants were informed that not all volunteers would be selected for the follow-up interview.

The initial interview with each participant was audio recorded, transcribed, and analyzed by the PI. If a participant requested clarification or elaboration on the question prior to answering, further clarification was provided for them. In addition, participants were allowed to share information pertinent to their experiences in addition to what the principal investigator asked in the interview questions. The interview probing technique was used to elicit further information from the participant in order to clarify a thought or idea expressed in their response.

Interview questions progressed from “broad and general to narrow and specific” (Burns & Grove, 2009, p. 404). Questions were open-ended to generate further discussion regarding
individual experiences. There was no training necessary for interviewers because the principal investigator conducted all interviews. However, the principal investigator did practice and prepare for interviews by reviewing the interview guide and assuring function of the audio taping equipment.

The meeting place for interviews was a central location on the island of Oahu selected at the participant’s convenience. All interviews were conducted in the participants’ home with the exception of one interview which was conducted in a participants’ office. The choice of location allowed participants to sit comfortably and participate in the dialogue facing the principal investigator with adequate privacy.

The PI asked introductory questions to ask each participant to stimulate initial dialogue. Clarifying questions were asked as well as mentioning concerns or patterns seen in current literature to provide the opportunity for feedback from the participants. Audio recording was utilized to document dialogue prior to transcribing the conversations for analysis. In addition, the principal investigator took hand written notes on how participants reacted to questions as well as other details that contributed to an understanding of the dialogue recorded such as physical observations. These notes were completed by the principal investigator throughout the interview process. Constant comparative data analysis occurred simultaneously with the data collection process. Patterns or common concerns stressed in previous interviews were considered in subsequent interviews to determine if there is a pattern among participants’ perceptions and experiences.

When categories and theory had been developed by the principal investigator based on interview results, a member check was completed to test this analysis with members of the participant pool. To complete this member check, two participants were selected at random from
the participant pool who volunteered for the second interview. Both participants were contacted by means of their preferred method as indicated on the consent form (phone or email) to schedule the follow-up interview. The follow-up interview was completed by phone and was recorded and transcribed verbatim by the principal investigator in a process identical to the initial participant interviews. During the member check, participants were presented with the results of the initial interviews in the form of categories and theory development. The participants then had the opportunity to comment whether or not the results are consistent with their experience, or if the results were contradictory, as well as add any additional comments or observations as desired.

**Human Subjects Considerations**

The proposal for this research was submitted to the human subjects committee for the College of Nursing as well as The University of Arizona for approval. There were no known emotional, psychological, or physical risks in participating in the investigation. All participant names remained confidential. Data and results were in no way linked to participant identity. To protect the privacy of the foster children, names were eliminated from the interviews completely, or a pseudonym was used in place of the child’s real name. Audio tapes with recorded interview data were destroyed after data analysis was complete. Records of transcripts were stored securely with The University of Arizona, College of Nursing at completion of data analysis.

Each participant received a copy of the consent form with information regarding their participation in the study. The consent form was reviewed and signed by each participant, and a signed copy retained by the PI. Participants were informed that their names would not be disclosed but that their demographic data would be used to describe the participants involved in the
research collectively. There were no conflicts of interest for the principal investigator involved in the study, facilitating the discussion, and completing the data analysis.

**Data Analysis**

Data analysis was done using Constant Comparative Analysis (Boeje, 2002; Glaser & Strauss, 1967). This process took place in two steps: 1) coding of data and comparisons of data within an individual interview, and 2) coding comparisons among different interviews within the same group of subjects (Boeje, 2002). The nature of constant comparative analysis allows for a systematic way to compare relevant information in the form of qualitative data. First, comparison was done within a single interview from a foster parent in a process known as open coding. At this time the single interview was studied for concepts that reflect the central message of the interview.

After reviewing the entire transcript, many of these concepts during open coding were made into more abstract categories. To develop a category, the “abstract concept must be fully developed in terms of its properties and dimensions, the conditions that give rise to it, the action/interaction by which it is expressed, and the consequences that result” (Corbin & Strauss, 1990, p. 420). Developing these categories allows the investigator to better articulate the patterns that were present in the context of the interview. Following this method of Corbin and Strauss (1990), not all concepts initially identified were made into categories, only those that related to the research questions of the investigation.

A “code tree” was generated in an effort to conceptualize themes in relation to fragments, or codes that were identified as relevant to the focus of the interview. Memos and interview fragments were included in the code tree to explain the relationship between categories and to provide rationale for category development. An example of this could be a participant that
describes that their foster child had challenging behaviors that made it difficult for foster parents to manage. As a result he was placed in multiple foster homes before the child was placed with their family. The concept of *challenging behavior* was associated with the more abstract category of *Foster children often experience multiple placements*.

After open coding within a single interview, the PI embarked on the second step which was to study comparisons between interviews within the same group individuals who share an experience (foster parents). This process is referred to as *axial coding*. Boeje (2002) states that axial coding must begin with “formulating a criteria for comparing interviews” as well as “hypothesizing about patterns and types” (p. 396). Once criteria for comparing interviews had been established, each interview was reconstructed to represent both individuals’ perspectives in relation to the criteria based on code. Codes are ideas or themes that arise out of the dialogue to reflect the key sentiment of the speaker. The process of examining the data from all the interviews resulted in revealing all possible themes related to the phenomenon discussed. These results were also framed within the theoretical framework of the CHI model (IOM, 2004) for comparison.

This process continued in a circular nature constantly comparing new interview data with existing analysis of previous interviews to test the existing categories. Each interview was transcribed and analyzed in the order they were collected. The principal investigator constantly took notes, adding to the code tree as concepts re-surfaced in subsequent interviews as well as being open for the potential for new ideas to present themselves that may challenge or refine existing categories. Categories were continually tested to determine if they shared the same meaning with existing categories. If any variations or contradictions were found, any logical explanation in the context of the interview was considered as well. Notes on the data continued
to be added to the existing code tree with each interview, including concepts, interview fragments, and memos. Coding was determined to be complete when all relevant concepts identified in individual interviews could be associated with an existing category. Concepts determined to be relevant were those “parts of the interview that say something about the research questions” (Boeije, 2002, p. 395).

As mentioned under data collection, when data analysis of the initial interviews was complete, the member check was performed to test this analysis with members of the participant pool. The two participants selected at random completed the member check by phone. During the member check, participants were presented with the results of the initial interviews and had the opportunity to comment whether or not the results are consistent with their experience as foster parents or contradictory, as well as add any additional comments or observations as desired. The principal investigator then reviewed those transcripts for validation of categories and theories by the members of the participant group as well as any new observations or explanations that arose from the member check. These findings are described in a narrative form in the results section of Chapter Four.

**Summary**

To satisfy the research questions for this investigation, interviews provided the most rich and substantial data to describe family experiences and the process of acquiring health care services. Constant comparative analysis of foster parent interviews helped the investigator identify what the needs and obstacles are for foster families acquiring health care services in Hawaii. This information from the families’ perspectives offers a unique contribution to current literature for Hawaiian foster families. The goal for this investigation was to use the information generated by these methods to inform primary care providers, social workers, politicians, and
policy makers insight on the needs of these families. With new information, we may learn how to
better serve foster children’s health care needs in the future and what types of interventions may
yield the greatest benefit to this vulnerable population.
CHAPTER FOUR: DATA COLLECTION AND RESULTS

This chapter presents demographic information about the participants, results of the semi-structured interviews, and details of the member check strategy for ensuring trustworthiness. Results in the form of categories are presented with themes identified using constant comparative analysis and culminating in the grounded theory on health care needs of Hawaiian foster children.

Participants

Ten foster parents initiated contact with the principal investigator, volunteering to participate in the investigation. Seven of those foster parents met the inclusion criteria and completed the interview process. Demographic data were collected on all participants including: gender, age, highest level of education completed, years experience as a foster parent, total number of foster children cared for, longest period caring for a single foster child, and shortest period caring for a single foster child. These demographic data on the participants are represented in tables 1-8. In addition, three foster parents reported raising their own children while caring for a foster child in their home and one foster parent reported raising a grandchild while caring for foster children in their home.

TABLE 1. Gender of Participants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
</tr>
</tbody>
</table>

TABLE 2. Ages of Participants

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>1</td>
</tr>
<tr>
<td>30-39</td>
<td>2</td>
</tr>
<tr>
<td>40-49</td>
<td>2</td>
</tr>
<tr>
<td>50-59</td>
<td>1</td>
</tr>
<tr>
<td>60-69</td>
<td>1</td>
</tr>
</tbody>
</table>
### TABLE 3. Level of Education of Participants

<table>
<thead>
<tr>
<th>Highest Level of Education Completed</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School Diploma</td>
<td>2</td>
</tr>
<tr>
<td>Some College</td>
<td>1</td>
</tr>
<tr>
<td>College Degree</td>
<td>3</td>
</tr>
<tr>
<td>Graduate Degree</td>
<td>1</td>
</tr>
</tbody>
</table>

### TABLE 4. Total Years Experience as a Foster Parent

<table>
<thead>
<tr>
<th>Years</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>1</td>
</tr>
<tr>
<td>1-3</td>
<td>3</td>
</tr>
<tr>
<td>4-5</td>
<td>2</td>
</tr>
<tr>
<td>6-7</td>
<td>0</td>
</tr>
<tr>
<td>8-9</td>
<td>1</td>
</tr>
</tbody>
</table>

### TABLE 5. Total Number of Foster Children Cared For

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>6</td>
</tr>
<tr>
<td>5-8</td>
<td>0</td>
</tr>
<tr>
<td>9-12</td>
<td>0</td>
</tr>
<tr>
<td>13-16</td>
<td>0</td>
</tr>
<tr>
<td>18-20</td>
<td>1</td>
</tr>
</tbody>
</table>

### TABLE 6. Longest Period Caring for a Single Foster Child

<table>
<thead>
<tr>
<th>Years</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

### TABLE 7. Shortest Period Caring for a Single Foster Child

<table>
<thead>
<tr>
<th>Years</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

### TABLE 8. Foster Parents Raising Children or Grandchildren While Caring for Foster Children

<table>
<thead>
<tr>
<th></th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raising Children</td>
<td>3</td>
</tr>
<tr>
<td>Raising Grandchildren</td>
<td>1</td>
</tr>
</tbody>
</table>
Participant Interviews

The plan for the investigation was submitted and received approval from the College of Nursing and University of Arizona’s Institutional Review Board prior to the beginning of data collection (Appendix G). After discussing the project with organizational leaders, site authorization was obtained from three foster care organizations on the island of Oahu: Hui Ho’omalu, Catholic Charities, and Hope INC (Appendices H, I, & J respectively). Recruitment of participants was completed by speaking to foster parents at foster care agency meetings, providing recruitment flyers at the time of the presentations, providing organizational leaders with hard copies of the recruitment flyers, as well as organizational leaders sharing the recruitment flyers via email with their foster parents. Interested participants initiated contact with the PI. Most participants provided a telephone number as their method of contact, others provided an email address. Seven of the original ten responded to the principal investigator’s phone calls or email. Three participants did not respond and did not partake in the interview process. Seven participants were scheduled to participate in five semi-structures interviews. Three foster parents were interviewed individually. Two participants asked if they could be interviewed together, which was accommodated. In addition, a husband and wife pair of participants asked to be interviewed together also.

Interviews were scheduled at a time and location of the participants’ choosing. Six of the participants requested to have the interviews completed in their homes. One participant requested to have the interview completed in their office. Consent was completed for each participant prior to the interview. Data collection was completed through semi-structured interviews utilizing the interview guide (Appendix E), open-ended questions, and clarifying questions. Duration of interview ranged from 30 minutes to 134 minutes. Audio for each interview was recorded using a
digital recorder. The audio recording was played back through the computer using compatible software and transcribed verbatim by the principal investigator after each interview. After transcription was complete, the recorded interview was played back and the transcription reviewed for errors. Any errors or missing information was then corrected in the transcribed copy of the interview. This process was completed for each of the participant interviews.

Results

At the completion of analysis 19 comprehensive categories were developed and successfully tested through analysis, and the process of theory development began. The 19 established categories were associated with the conceptual framework for the investigation; the CHI Model (IOM, 2004). These categories are displayed in tables 9-13 with themes related to each of the subcategories for the CHI Model: social environment, physical environment, biology, behavior, and policy and services.

Social Environment

Discussions of social environment pertaining to the foster family experience centered around the foster parent’s role, what motivated each parent to fulfill that role, the social constructs of the home prior to placement, and the transition to the foster home. Foster parents that participated in the interview verbalized desire for family, or Ohana in Hawaiian, as the primary motivation for beginning foster care prompting development of Category 1: Desire for family as motivation for role as foster parent. Codes pertaining to this category included: desire for bigger family, desire for more kids later in life, infertility, complicated pregnancies, and God’s solution to desire for children.
TABLE 9. Categories for Social Environment

<table>
<thead>
<tr>
<th>Category</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1: Desire for family as motivation for role as foster parent</td>
<td>Desire for bigger family</td>
</tr>
<tr>
<td></td>
<td>Desire for more kids later in life</td>
</tr>
<tr>
<td></td>
<td>Infertility</td>
</tr>
<tr>
<td></td>
<td>Complicated pregnancies</td>
</tr>
<tr>
<td></td>
<td>God’s solution to desire for children</td>
</tr>
<tr>
<td>Category 2: Foster parents as autonomous care givers</td>
<td>Need to be independent</td>
</tr>
<tr>
<td></td>
<td>Seeking assistance</td>
</tr>
<tr>
<td></td>
<td>Finding resources</td>
</tr>
<tr>
<td></td>
<td>Self-taught</td>
</tr>
<tr>
<td>Category 3: Foster children’s exposure to violence, mental illness,</td>
<td>Absence of family</td>
</tr>
<tr>
<td></td>
<td>Substance abuse</td>
</tr>
<tr>
<td></td>
<td>Mental illness</td>
</tr>
<tr>
<td></td>
<td>Physical abuse</td>
</tr>
<tr>
<td></td>
<td>Emotional abuse</td>
</tr>
<tr>
<td></td>
<td>Sexual abuse</td>
</tr>
<tr>
<td></td>
<td>Separation from siblings as well</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Category 4: Culturally sensitive teaching and discipline needed to assist</td>
<td>Speech/language barriers</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
</tr>
<tr>
<td></td>
<td>Predictable schedules</td>
</tr>
<tr>
<td></td>
<td>Teaching respect</td>
</tr>
<tr>
<td></td>
<td>Sharing with others</td>
</tr>
<tr>
<td></td>
<td>Patience with learning</td>
</tr>
<tr>
<td></td>
<td>Incorporating other children in the</td>
</tr>
<tr>
<td></td>
<td>teaching</td>
</tr>
</tbody>
</table>

Many foster parents cited difficult or complicated pregnancies, infertility, or desire for more children later in life as their rationale for choosing foster children as way to expand their family. Multiple foster parents reported adopting foster children and expressing the care and love for these children as one in the same to other biological or adopted children. One participant stated, “I don’t look at it as I’m a foster mom and that’s my foster child, and there’s my biological child. No. I’m a mom and that’s my children” (Participant 1, p. 8, interview 1). Foster parents described their role as independent care givers that exercise problem-solving skills and taking the initiative to acquire services and resources for their foster children. This theme was
labeled **Category 2: Foster parents as autonomous care givers** and included codes: need to be independent, seeking assistance, finding resources, and self-taught.

Some foster parents called on the need to familiarize themselves with state and national laws that protect the needs of their children and validate their request for services. The role was described as a jack of all trades taking on tasks to get the job done. One participant remarked, “I do way more than what is expected of me under the title of a foster mom” (Participant 1, p. 8, interview 1) explaining that her regular duties surpassed even her own expectations before caring for foster children.

The children’s former caregivers prior to placement were also discussed and represented by **Category 3: Foster children’s exposure to violence, mental illness, substance abuse, and neglect prior to being separated from previous care givers.** Codes related to category 3 included: absence of family, separation from siblings as well, physical abuse, emotional abuse, sexual abuse, substance abuse, and mental illness.

In most cases this applied to biological family members and in one instance a former foster care giver was also discussed. Many participants described the previous family environment to include physical, emotional, and sexual abuse, neglect, and malnutrition. Mental illness and substance abuse among biological family members was reported as well as violence. In some cases, siblings were separated for the purposes of placement in foster homes and never united again. These types of family dynamics can have lasting repercussions on the overall health of the child, including their ability to trust others and develop healthy meaningful relationships. Furthermore, a foster care home is typically deemed a safe and therapeutic environment but in one instance a participant reported experience with a child whom suffered abuse at the hands of former foster care parent as well.
Given the wide variety of circumstances that many foster children endure prior to out of home placement, it should come as no surprise that a transition period must be handled delicately in the foster care home. This transition to the foster care home and integration with the family is outlined in Category 4: Culturally sensitive teaching and discipline needed to assist the foster child’s transition to their home. Codes for category 4 included: speech/language barriers, safety, predictable schedules, teaching respect, sharing with others, patience with learning, and incorporating other children in the teaching.

Foster parents identified language and cultural barriers that required consideration while adjusting to the child’s needs. Predictable schedules, expectations, and discipline were concepts that foster parents emphasized provided structure for the children enabling them to find their place in the family unit as well interacted appropriately with other children. Two participants discussed enlisting the help of other foster or biological children in instructing the newest addition to the family (Participants 1 & 3).

I try to pair them up like--if the older one did a recovery on whatever their behavior was and there’s a new doggy that came in I can say 'See this one over here? This is how you used to be. Train him.' And he’ll say 'Oh my God, she’s not listening' and I’ll say 'What made you listen? That’s what you got to instill with her' (Participant 1, p. 16, interview 1).

The participant explained witnessing the growth of one foster child and then giving that child an opportunity to serve as a leader for a new foster child. The opportunity to be a role model was character building for one child while supporting another child in their transition to a new home (Participant 1, interview 1).

Physical Environment

Category 5: Foster children often experience multiple placements was based on the description of frequent changes in physical location of the foster child as reported by the foster
parents. Codes for this category included: may be placed with siblings, separation from siblings, special needs, challenging behaviors, attempts at reunification and homelessness.

### TABLE 10. Categories for Physical Environment

<table>
<thead>
<tr>
<th>Category</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 5: Foster children often experience multiple placements</td>
<td>May be placed with siblings</td>
</tr>
<tr>
<td></td>
<td>Separation from siblings</td>
</tr>
<tr>
<td></td>
<td>Special needs</td>
</tr>
<tr>
<td></td>
<td>Challenging behaviors</td>
</tr>
<tr>
<td></td>
<td>Attempts at reunification</td>
</tr>
<tr>
<td></td>
<td>Homelessness</td>
</tr>
<tr>
<td>Category 6: Foster children change schools with relocation to new placement</td>
<td>Location</td>
</tr>
<tr>
<td></td>
<td>Convenience to home</td>
</tr>
<tr>
<td></td>
<td>Services available</td>
</tr>
<tr>
<td></td>
<td>Traffic obstacle</td>
</tr>
<tr>
<td>Category 7: History of violence in foster child’s previous environment contributing factor in placement</td>
<td>Physical abuse</td>
</tr>
<tr>
<td></td>
<td>Sexual abuse</td>
</tr>
<tr>
<td></td>
<td>Shaken baby syndrome</td>
</tr>
<tr>
<td></td>
<td>Suicide</td>
</tr>
<tr>
<td></td>
<td>Firearms</td>
</tr>
</tbody>
</table>

These changes in location most often referred to changes in foster care placements. However children are also often reunited with their biological families in reunification efforts only to return to foster care at a later time. This phenomenon is consistent with the current literature (Strolin-Goltzman, Kollar, & Trinkle, 2010) and was an expected finding. According to participant interviews, there were several possible explanations behind multiple placements for each foster child. Reunification with biological family is a concentrated effort that may explain entering and exiting the welfare system early on. However other reasons may include unsuccessful efforts to place siblings together or a child requiring special needs or challenging behaviors that previous foster families felt ill-equipped to provide care for. A related finding was that some foster children were homeless, living in tents, hotel rooms, or with inadequate shelters,
changing location frequently before entering the foster care system. These factors contribute to instability in the physical environment of the foster child.

Every foster parent reported changing the foster child’s school enrollment due to location, convenience, and traffic, giving the investigation *Category 6: Foster children change schools with relocation to new placement*. Codes related to category 6 included: location, convenience to home, services available, and traffic obstacle. Special considerations when relocating schools included safety and necessary special education services. However, according to interviews these considerations were not the rationale for the change in school. Rationale for changing the child’s school included convenience, proximity to home, and particularly traffic. In one case the foster family was willing to make a significantly extended commute to allow the foster children to finish the academic year with their school before changing their enrollment:

*We felt like that was the only stable thing in their life at that time and it was a small school where the teachers knew who these kids were and the kids had relationships with some of the teachers and workers at the school. So I talked to the principal and asked for a district exemption so that they could continue to go to this school and she said, “Are you crazy? You know how far you live” and I knew but we were really thinking about our children’s best interests and that’s the reason she allowed us a district exemption so they could go there* (Participant 3, p. 4-5, interview 3).

But the one hour commute was more than the family could commit to long term. So after the children finished their academic year they enrolled in a closer school to their foster home the following fall.

*Category 7 was established to encompass the physical environment as it pertains to physical interaction entitled, Category 7: History of violence in foster child’s previous environment contributing factor in placement*. Codes recorded for category 7 were: physical abuse, sexual abuse, shaken baby syndrome, suicide, and firearms.
This category includes the physical and sexual abuse that results in an unsafe physical environment for the child. Deadly use of firearms, suicides, and other injuries reflect a dangerous environment that is unfit for raising children and prompts their placement in foster care homes. These concepts also appear in the social environment portion of the conceptual framework because they are as much of a physical threat as they are a component of the unhealthy social environment of the families that the children lived with.

<table>
<thead>
<tr>
<th>TABLE 11. Categories for Biology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categories</td>
</tr>
<tr>
<td>Category 8: Poor health status of child upon placement in foster home</td>
</tr>
<tr>
<td>Category 9: Limited availability of the child’s health information posed challenges for making health care decisions</td>
</tr>
<tr>
<td>Category 10: Developmental delays were often identified and treated in the foster children.</td>
</tr>
</tbody>
</table>

**Biology**

*Category 8: Poor health status of child upon placement in foster home* developed after concepts of acute and chronic illnesses were emphasized by the foster parent participants. Codes for category 8 included: skin lesions, uncontrolled asthma, malnutrition, lack of immunizations,
incomplete immunizations, increase in acute illness early on, poor hygiene, unkempt, lack of clothing, and inadequate clothing. Foster parents reported children arriving with a variety of concerns from skin conditions, uncontrolled asthma, malnutrition, to unkempt, poor hygiene, and lice. One participant described a foster child who arrived with lesions stating, “This little girl had sores, open sores all over. […] She had it all on her legs. Her legs were so swollen because the sores were so…so intense they were almost black all over” (Participant 1, p. 10, interview 1).

Three foster parents reported more acute illnesses such as sore throats, ear infections, or upper respiratory infections early in placement but stated that the frequency of these acute complaints decreased over time (Participants 2, 4, & 5; interviews 2 & 3). Lack of immunizations was a large concern as many foster parents reported inadequate records or complete lack of preventative care on children and needing to “catch-up” the children on the necessary immunizations.

_He [the physician] took six months and broke down the immunizations into a couple- - I think it was three sessions is how we did it. To catch him up. Because we couldn’t get anything out of his records or the information we were given. It was really sad. He wasn’t really thrilled. He wasn’t happy. And we tried to contact the school and all they could say was “sorry we don’t have anything” and I’m looking at the state going, “Where is all his medical records?” and they were like, “Well, this is what we have” (Participant 6, p. 5, interview 4)._  

The description above echoed the experience of many foster parents who struggled to compile health history on their foster children described in Category 9 as _Limited availability of the child’s health information posed challenges for making health care decisions_. Codes included: immunization records, allergies, health history, unknown preventative care, previous health care, providers, and record maintenance. Immunization history was a common cited example for many foster families. One foster parent described obtaining the health history in a hit or miss fashion stating it was often unpredictable. “You’re supposed to get a folder pertaining
to all of that. Sometimes you don’t get it until maybe…when the child is ready to leave. Sometimes you get it, sometimes you don’t get it” (Participant 1, p. 4, interview 1).

When foster parents did get information at times they felt it was inadequate or incomplete requiring further investigation. In the case with emergency placements many children may arrive to a new foster home with very short notice and just the clothes on their back. Another factor that comes into play is the cooperation of the biological family. If records are available and preventative care has been established, the cooperation of the child’s birth parents is key in obtaining that information to share with the foster family. Acquiring that information from the biological family is outside the responsibilities of the foster parent and usually left up to the child’s social worker.

The continuous relay of that information in the case of placement changes is equally important. In one case a foster parent described an incident in which she identified an unknown allergy: “We learned with her ear infection that she was allergic to amoxicillin and we didn’t know that. So she was ok but we passed that onto the social worker” (Participant 3, p. 8, interview 2). None of the foster parents interviewed followed a set protocol for relaying or maintaining medical records. No health passports or other form of health records maintenance appeared to be common practice. The majority of foster parents let the institution or primary care practice maintain the child’s records and only requested copies on an as needed basis. Or they let the social worker request the records if there was a change in placement for the foster child. In addition to this approach, one foster parent also maintained a copy of all health care visits in a folder at home for each foster child (Participant 1). Finally a second foster parent stated that she similarly maintained a folder at home for the foster child containing copies of all records and
sent a copy of every new addition to that folder to the social worker with each health care visit (Participant 3).

Literature has demonstrated the prevalence of developmental delays in the population of foster children and the experience of this sampling of foster parents was no exception (Sanchez, Gomez, & Davis, 2010; Children’s Partnership, 2008). *Category 10: Developmental delays were often identified and treated in the foster children.* Codes associated with category 10 included: identified developmental delays, tying shoes, dressing oneself, potty training, speech, counting, interventions, specialists, consultants, and school accommodation.

Foster parents reported identifying developmental delays themselves as well as with their primary care providers. Some examples provided included inability to dress oneself, tie shoes, and count numbers. Interventions included referrals to specialist, special education programs, school accommodations, as well as a watch and wait approach with follow-up evaluation with the primary care provider.

**TABLE 12. Categories for Behavior**

<table>
<thead>
<tr>
<th>Category</th>
<th>Codes</th>
</tr>
</thead>
</table>
| Category 11: Psychological services for the foster children were a paramount need to manage a variety of conditions. | Attachment disorders  
Trust vs. mistrust  
Depression  
Anxiety  
Oppositional defiance disorder  
PTSD  
Mood disorders  
Effects of abuse  
Counseling  
Medication use |
| Category 12: Managing challenging behaviors is an expected part of caring for foster children. | Incorporated in training  
Teaching socially acceptable behavior  
Linked to psychological disorders  
Coping with anger  
Expressing feelings  
Opposition |
Behavior

The need for psychological services and support was verbalized in every participant interview which resulted in the development of *Category 11: Psychological services for the foster children were a paramount need to manage a variety of conditions*. Codes associated category 11 included: attachment disorders, trust versus mistrust, depression, anxiety, oppositional defiance disorder, PTSD, mood disorders, effects of abuse, counseling, and medication use. Children’s exposure to abuse, violence, and unhealthy relationships resulted in a significant need for specialist attention. A foster parent recounted a particularly devastating example that required extensive psychotherapy:

*We had a nine-year old girl that witnessed her daddy die. She watched him shoot himself. And before he did that he told her “It’s all because of you.” And she’s walking around my house like - - beautiful, beautiful young girl but she was out of control (Participant 1, p. 7, interview 1).*

The types of psychological conditions addressed in the foster children cared for included: depression, anxiety, oppositional defiance disorder, post traumatic stress disorder, trust and attachment deficits, and other mood disorders. Counseling and psychotropic medications were mentioned to be among the interventions utilized for managing such conditions. Therapy to treat these conditions was considered to be very important to foster families and requiring consistent long term treatment with a child psychologist, child psychiatrist, and play therapist. These results were also consistent with the literature review which identified an increased incidence of psychological disorders among foster children when compared with the general pediatric population (Mekonnen, Noonnan, & Rubin, 2009; CWLA, 2010).

*Managing challenging behaviors is an expected part of caring for foster children* is the title of Category 12 and was also supported by the literature review with increased prevalence in
foster care children. The following are codes that related to this category: incorporated in training, teaching socially acceptable behavior, linked to psychological disorders, coping with anger, expressing feelings, and opposition. Foster parents identified managing challenging behaviors as a very routine aspect of caring for foster care children. As a matter fact, many participants verbalized this expectation as a part of their training in preparation for their role as foster parents. Challenging behaviors may be associated with psychological disorders. Other explanations can be due to complex childhood trauma, fear, or mistrust. Foster parents emphasized the importance of teaching children acceptable behavior and safe, healthy ways to express their feelings. It was also expressed that challenging behaviors could be transient and present themselves at unexpected times.

TABLE 13. Categories for Policies and Services

<table>
<thead>
<tr>
<th>Category</th>
<th>Codes</th>
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</table>
| Category 13: No problems with acquiring Medicaid coverage or eligibility for any foster care children. | No delays  
No trouble accessing insurance                                      |
| Category 14: Changes in health care provider common while a medical home model not accepted as feasible to foster families | Frequent provider changes  
Pediatricians provider selected  
Location & traffic determinants  
Repertoire important  
Preferred providers  
Foster expertise desired  
Interference with school |
| Category 15: Difficulty accessing provider for routine and specialty services linked to Medicaid coverage | Budget cuts  
Limited primary care providers  
Limited specialty providers  
Waitlist for specialty care  
Limitations on number of visits  
Limitations on frequency of visits |
| Category 16: Health education programs offered and participated in vary among foster families | General overview offered  
Liability discussed  
Specific additional courses offered  
No recollection of program offered  
Some education but unable to recall details |
TABLE 13. Continued

<table>
<thead>
<tr>
<th>Category</th>
<th>Codes</th>
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</thead>
<tbody>
<tr>
<td>Category 17: Foster parents identified value and interest in additional</td>
<td>More information</td>
</tr>
<tr>
<td>health education programs related to their role but convenience of</td>
<td>Information about colds/common concerns</td>
</tr>
<tr>
<td>classes was identified as an obstacle.</td>
<td>Time obstacle</td>
</tr>
<tr>
<td></td>
<td>Time is valued</td>
</tr>
<tr>
<td></td>
<td>Child care needed</td>
</tr>
<tr>
<td></td>
<td>Pertinent topics needed</td>
</tr>
<tr>
<td></td>
<td>Interest expressed</td>
</tr>
<tr>
<td>Category 18: Protocol and experiences acquiring consents varied among</td>
<td>Complete freedom</td>
</tr>
<tr>
<td>foster parents</td>
<td>Via social worker</td>
</tr>
<tr>
<td></td>
<td>Documentation confusion</td>
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<tr>
<td></td>
<td>Protocol confusion</td>
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<tr>
<td></td>
<td>Delayed info on protocol</td>
</tr>
<tr>
<td></td>
<td>HIPPA</td>
</tr>
<tr>
<td>Category 19: Collaboration with social worker did not meet initial</td>
<td>Delayed responses</td>
</tr>
<tr>
<td>expectations</td>
<td>Accessing information</td>
</tr>
<tr>
<td></td>
<td>Coordination of care</td>
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<tr>
<td></td>
<td>Support needed</td>
</tr>
<tr>
<td></td>
<td>Overburdened workload</td>
</tr>
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<td></td>
<td>Insufficient involvement</td>
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**Policy and Services**

*Category 13: No problems with acquiring Medicaid coverage or eligibility for any foster care children* was a relatively self-explanatory category that was developed with unanimous feedback that the Medicaid enrollment process and coverage eligibility was seamless and without delay. The codes listed for this category were: no delays and no trouble accessing insurance.

Participants reported very occasional use of emergency or urgent care services and identified using primary care and specialty referrals when acquiring most of their children’s health care needs. Pediatricians were identified as the provider for primary care services for all foster families. Frequent changes in health care providers and the obstacles in achieving the medical home model of health care delivery formed *Category 14: Changes in health care provider common while medical home model not accepted as feasible to foster families*. Codes
for category 14 were: frequent provider changes, pediatricians, provider selected, location and traffic determinants, repertoire important, preferred providers, foster child expertise desired, and interference with school.

Every foster parent who participated in the investigation stated that they have changed the primary care doctor of the foster children in their care. There were multiple factors that motivated this decision including location, convenience, provider preference, and interference with school participation. Location and traffic was a major concern among foster families when considering whether or not to change health care providers.

*I am in the process of moving the doctor to Pearl City because Kahala is really far and by the time I can go in the afternoon when we’re done with school work, I’m stuck in traffic then… I went a couple of times and they do reimburse you for gas but you can’t make up the time* (Participant 3, p. 6, interview 2).

A component of the conditional matrix (Corbin & Strauss, 1990) that influences these circumstances is that the state of Hawaii has been identified as having the worst traffic in the nation out ranking such competitors as New York, San Francisco, and Los Angeles (Hawaii News Now, 2012; Inrix, 2012). Due to the island’s geography there are three interstates established. Interstates H-2 and H-3 run north and south up the center as well as the windward side of the island respectively. The third interstate is H-1 which is the only single level freeway that runs east and west for commuters to Honolulu and the leeward coast. This interstate is causing some of the greatest congestion, leading to approximately 58 hours in grid lock in 2011 (Hawaii News Now, 2012). Participants explained that not only distance but this traffic is what is depleting valuable resources to their family such as fuel, time, and even school participation. Upon receiving her foster son, one participant explained that the child had already missed 45 days of school that year and was under-performing in all subjects. Improving his attendance and
performance in school was made a priority for the family. However, the child’s psychiatrist was located far from his school and foster family’s home. In order for the child to make necessary routine visits which occurred at a rate of once or twice weekly, the parents needed to remove him from class early on a regular basis to combat the traffic to their destination. “You have to pull them out of school in order to get them there in time. And they already had so many missed days of school and I didn’t want to add to missing so much teaching time” (Participant 4, p. 3, interview 3). The solution the foster parents came to was to change health care providers by finding a psychiatrist closer to home. That way driving time related to distance and traffic was minimized, which reduced the interference with school activities.

Participants identified these barriers to the medical home model as enough to render the approach unfeasible or unreasonable for Hawaii foster parents. However, two participants verbalized taking an alternative approach to primary care. Instead of the foster child maintaining a “medical home” the foster parent establishes a “medical home” and uses the same provider for all of their foster children (Participants 1 & 3, interviews 1 & 2). Benefits of this approach was described as establishing a repertoire with a single preferred provider, combining visits and follow-up with multiple children, while avoiding the obstacles of distance, time, and traffic to meet with an unacquainted provider who may have limited experience working with foster children. A provider who is prepared to work with foster families was valued by participants. One participant remarked, “if you found someone who is great with foster kids and is very proactive then I would totally stick with them because they understand who I am, what I’m doing and maybe they would be more alert because they understand this kid is not from my house […] it makes a difference when you know the mom is bringing them in and when a foster mom is bringing them in” (Participant 3, p. 13, interview 2).
But the decision to change health care providers was not met with ease. *Category 15: Difficulty accessing provider for routine and specialty services linked to Medicaid coverage.*

Codes related to this category included: budget cuts, limited primary care providers, limited specialty providers, waitlist for specialty care, limitations on number of visits, and limitations on frequency of visits.

Participants described identifying a provider for both routine and specialty services that would accept patients on Quest (Medicaid) as a significant obstacle in acquiring care.

*One of the biggest challenges was trying to find service providers. Pediatricians. Because their former health providers were in Waianae and it was really inconvenient for us. So we were trying to find health care providers but at the same time Hawaii was going through a time of budget cuts so because the state provides medical insurance through Quest...some of the service providers weren’t getting paid. There was like a six month lag and because of that a lot of service providers said “Forget this I’m not taking any more Quest patients.” So it was really hard to find providers that would take new patients with Quest insurance (Participant 4, p. 2, interview 3).*

One foster parent who was interested in adopting her foster child requested special permission to have him placed on her insurance plan to supplement the Medicaid benefits and to locate a provider stating, “If we’d stayed on HMSA I called about six different doctors and none of them would take him” (Participant 6, p. 13, interview 4). Participants described finding an appropriate provider as time consuming and some stated that they were on waitlists for specialty services. Two participants expressed that even once a provider was established they experienced restrictions in the number of visits or the frequency of those visits. Their health care providers explained to them that these restrictions were due to what Medicaid would reimburse for their services. State budget cuts became another component of the conditional matrix affecting foster families. Two participants explained that they believe the budget cuts for the state of Hawaii
were responsible for limitations in Medicaid reimbursement and delayed reimbursement, which in turn meant fewer providers willing to accept Medicaid patients.

*Our service provider was saying that because of the budget cut you know they- - they also wanted to have less hours working with them. And I would say, you know- - I don’t want to reduce it because it would be really hard to keep them where they’re supposed to be I don’t want them to go back to the way they were. The therapy is important. And she’d say “Maybe we can meet only once a month,” and I’d say “I don’t think so. […]” Sometimes they have unexpected problems and…we don’t know when. So when they cut back on the services the person may not be there to see them and then we’re going to have a hard time bringing them [the foster children] back up to where they were* (Participant 5, p. 9, interview 3).

Access to health education programs were also discussed with foster parent participants and results were mixed. Category 16 was developed entitled Health education programs offered and participated in vary among foster families. Codes for category 16 included: general overview offered, liability discussed, specific courses offered, no recollection of program offered, some education but unable to recall details. Three participants interviewed stated that they did not participate in any program that gave them instruction on how to manage health care concerns when caring for foster children prior to being licensed. Two participants stated that they could recall some form of preparation in their licensing process that related to the health of foster children but they could not recall the details. Two participants described participating in some form of health education program prior to being licensed as foster parents. These two participants described the education to include such items as what to do in case of an emergency, when to notify the social worker, and obtaining consent for treatment. Aside from initial preparation for matters related to health, two participants stated that their organization offers additional courses on a continuing basis by topic:

*There are courses that you can take through the foster care agency. You can even refer a topic, ‘what to do with an asthmatic child’ and they will bring in a speaker*
to reinforce what are the signs to look for. I think the next one they have is on gay, lesbian, and transgender children in the youth system’ (Participant 1, p. 14, interview 1).

While initial instruction on matters of health appeared to vary greatly among participants, most participants verbalized interest in access to more education materials to manage the health concerns for their foster children. This data led to the development of Category17: Foster parents identified value and interest in health education programs related to their role but convenience of classes was identified as an obstacle. Codes for this category included: more information, information about common concerns, time obstacle, time is valued, child care needed, pertinent topics needed, and interest expressed.

When asked what type of information would be helpful one participant remarked, “Anything. Stuff about colds, fevers, that kind of thing would have been helpful. And ukus [Hawaiian for head lice] […] because the lice is very common” (Participant 5, p. 9, interview 3). While the interest in further education was present, obstacles such as time and child care were identified. Even periodic participation in special topics presented by foster care organizations posed a challenge for some foster parents. “If it was something that I was interested in or something I was having trouble dealing with I would totally go. But just because - - with our lifestyle and our home you can’t go to every meeting” (Participant 3, p. 11, interview 2). Family schedules and the need for child care were concerns verbalized that posed a barrier to attending current educational opportunities and hypothetical ones. “Because even if you’re interested, you need someone to watch the kids in order to go or they might have appointments or sports practice” (Participant 2, p. 15, interview 1).

When the experience and protocol of obtaining consents was discussed, a wide variety of feedback was shared by participants, leading to the development of Category 18: Protocol and
experiences acquiring consents varied among foster parents. Codes related to this category were: complete freedom, via social worker, documentation confusion, protocol confusion, delayed info on protocol, and HIPPA (Health Insurance Portability and Accountability Act). Some participants verbalized contacting the social worker to obtain consent for treatment, such as one participant stating, “I have to call her social worker to get consent. And there’s another after hours number that I have in my phone to get consent. Because they have to be the ones to give consent because they are the guardian” (Participant 3, p. 7, interview 2). Another foster parent reported a contradictory experience and denied utilizing their social worker stating that they (the foster parent) had authority to provide consent for medical treatment. The participant explained, “You don’t need to get the social worker because you’re acting like a surrogate for the state” (Participant 1, p. 15, interview 1). This participant verbalized no trouble or delays in providing consent for treatment in this manner. After an emergency placement with their first foster child, one participant explained that they did not receive any information about how to handle acquiring consent for treatment prior to placement:

I think we ended up hearing about all of that about a year after we had him because- - well it was an emergency kind of thing so we didn’t actually go through the training until way after. It was a long time. So I think we did a lot of things that...we weren’t supposed to do (Participant 7, p. 7, interview 5).

Those parents who verbalized contacting the social worker to arrange consents for treatments described personal inconvenience with this protocol but no significant interference with acquiring needed services for the child. Foster parents seemed to understand and respect the purpose of the process: “Fax paperwork to the case worker for consents. That was a pain but it was for the safety of the kid. And we understood that. And we didn’t have total control and everything had to be approved. And we understood but sometimes it was a pain” (Participant 6,
p. 12, interview 4). In one event, poor planning nearly required cancellation of a surgery but consent was obtained in time:

_There was one time where actually one of the children had to have surgery and it was a planned surgery- we knew that. He had some issues that needed surgery so we scheduled that but we needed to have the parents’ consent and so- - it wasn’t planned- - I don’t know- - it wasn’t planned I think well enough so that on the day of the surgery all of a sudden I’m on the phone with the birth parents and I had to have them come down and sign these forms“ (Participant 4, p. 5, interview 3).

When problems obtaining consents did arise, privacy regulations were cited as one of the obstacles that arose for one foster parent. This foster parent stated “we cannot just let the social worker go to the parents to give them the form […] No, she has to- - we have to give them permission for them to call us so that we can get this problem solved” (Participant 5, p. 5, interview 3). The reason for the variety of descriptions regarding consents in unknown. Instruction and education regarding protocol for obtaining consent is one possible explanation for the variation in practices reported by the participants.

The relationship with the social worker came into discussion with each participant interview and _Category 19: Collaboration with social worker did not meet initial expectations_ was created after several shared experiences relevant to this interaction between foster parents and social workers were presented. Codes for category 19 included: delayed responses, accessing information, coordination of care, support needed, overburdened workload, and insufficient involvement.

Participants clearly described social worker’s involvement to be less than what they anticipated prior to serving as a foster parent and concerns included: delayed response times, trouble coordinating care, greater involvement needed, desires for more support, as well concerns for over-burdened workload. One foster parent stated that his expectations changed
immediately after receiving their first foster child: “When they first brought him to our house they didn’t even turn off the car. (Laughs) They just dropped him off […] so we weren’t expecting much after that” (Participant 7, p. 6, interview 5). Obtaining necessary information from social workers proved to be a challenge for many participants, “We tried to get more and more information from their social worker but communication was really difficult. […] they’re just so busy it was just so difficult to get information a lot of the time” (Participant 4, p. 1, interview 1). This dilemma of communication with the social worker appeared to be at the root of many struggles for collaboration. One foster parent described feeling an expectation to fulfill coordination roles of the social worker assigned to her case:

Sometimes I felt like the social worker was giving us too much freedom to the point where she would say, “Ok you just work it out with the birth mom,” when I felt like I needed them to intervene or facilitate. So I would have to tell them that I would not feel comfortable dealing with this issue with the mom and I need you to handle it. Because sometimes issues that would come up that the social worker should really address (Participant 4, p. 8, interview 3).

The collaboration and communication with the social worker was illustrated as inconsistent and unpredictable. Foster parents compensated for this relationship by taking the initiative to manage their child’s care. “In the beginning I thought they would be really involved but they’re not. I feel like I’m very independent. In the beginning I asked them permission for stuff but honestly…I don’t think about them. I know what needs to get done and I just get it done” (Participant 3, p. 9, interview 2). Two participants also mentioned that maintaining a daily journal for each foster child helped to document issues and concerns on a regular basis. That way when they did have access to their social worker, they could have any information they needed to share on hand in an organized manner.
Member Check

To further validate the categories that were developed utilizing Constant Comparative Analysis (Corbin & Strauss, 1990) a member check was completed. The member check was “an opportunity for members (participants) to check (approve) particular aspects of the interpretation of the data they provided” (Carlson, 2010, p. 1105). The member check involved contacting two participants who were selected at random. Participants considered for the member check were those who elected to volunteer to participate in the follow-up interview by indicating so on their consent forms.

The two participants selected for the member check were contacted by email or phone based on the preferred method of contact provided and an appointment for the follow-up interview was established. Member checks were completed by phone which and were recorded and transcribed verbatim by the PI. During the interview, participants were informed about what the purpose of the member check was and that their expertise was needed to verify the categories and theory developed from the data. Participants were encouraged to explain if descriptions were consistent or contrary to their experience as a foster parent. The categories that were developed from the data were discussed as well as what the categories represented in the context of participant interviews. The participants had the opportunity to provide any feedback on the results of the data, including any concerns, contradictions, or agreements. The two interviews lasted 15 minutes and 29 minutes in length.

The first member check participant referred to as participant A, verbalized agreement with the categories developed based on the interviews with all participants stating, “The information that you have gotten is what our experience was as well” (Participant A, p. 4, interview A). No categories were contested or rendered inaccurate by the participant. Participant
A reinforced the concern that state budget cuts affecting Medicaid reimbursement had a negative impact on providers willing to accept Medicaid patients. The participant emphasized that poor reimbursement for services rendered to their Medicaid patients made them reluctant to accept new Medicaid clients. However, this participant also added that health care providers were not the only ones affected by the state budget cuts. The financial hardship of the state resulted in furloughs, closing schools and other government funded agencies on a regular basis. This included the offices of social workers, which could be another explanation for why collaboration with social workers was so challenging at times. “There was just a huge budget cut all across the board. The department of health was affected, which trickled down to department of human services, and so it was just a trickle down affect where everyone had to make cuts […] they had cuts in their business hours and they were unavailable. So that was another thing that probably affected that- the government furlough” (Participant A, p. 4, interview A).

The second member check proceeded in identical fashion as the first member check. The second participant, participant B, also verbalized agreement with category development and theory. Participant B stated that she could relate to many of the experiences captured in the analysis. In reference to obstacles with Medicaid, participant B stated that she tried to use the insurance plan for two months, contacting several doctors, and could not find a provider that would accept new Medicaid clients (Participant B, interview B).

A possible explanation for the variations in experiences obtaining consents was offered stating that the procedure may vary slightly with each child, depending on the parent’s involvement. For example, if the parent’s rights are completely severed and the child was a ward of the state (as was the case for this participant’s son) the process maybe more streamlined since the social worker is not acting as a middle man between the biological and foster family. “It was
much quicker,” stated the participant (Participant B, p. 6, Interview B). Whereas, when attempts at reunification are still being made and the biological family is still involved that may be a slightly different process or take longer to complete. However, even in the case that the parental rights are severed, participant B verbalized always contacting the social worker to obtain consent for anything related to monetary expenses or medical/dental care.

Participant B also had another piece of additional information to offer pertaining to foster parent education, stating that viewing videos as a means of “DVD training” at home was another more feasible option for foster families to have access to health education materials for their family. “Hope INC offered DVD videos and were sharing the DVD videos around for families to watch at home. And that was really cool. That was a part of the course that we went through with them. […] It took me about three days to work through the DVDs and it was kind of neat. I learned some really great techniques” (Participant B, p. 5, interview B). The option of borrowing DVDs from her foster care agency helped the participant and her husband to learn more about managing oppositional defiance disorder in their foster child and stated that applying the techniques learned from the instructional DVDs improved their interactions and communication within their family.

**Theory Development**

Based on the categories identified through constant comparative analysis, theory development began in order to illustrate the foster parents’ experience with the process of acquiring and managing health care for their foster children. Corbin and Strauss (1990) state that it is “tight linkages, in terms of the paradigm features and density of the categories, that give a theory its explanatory power” (p. 425). A theory gains its strength by its association with concepts and categories grounded in the data itself. According to Walker and Avant (2005),
“theory synthesis results in a more complex representation of phenomenon than either concept or statement synthesis” and can be represented in a number of forms (p. 135). The results displayed as categories from data analysis could also be viewed as a form of “inventory of determinants” (Zetterberg, 1965) for health care needs of foster children. This association fits nicely since the elements of the data coincide with the conceptual framework discussed in Chapter One.

The multifaceted experience of the foster families falls in line with the conceptual framework of the CHI Model (IOM, 2004), encompassing aspects of the social environment, physical environment, biology, behavior, as well as policy and services. All areas appeared to be relevant considerations in the foster parent’s experience managing the complex health needs of their foster children.

Discussion with the participants revealed that managing the health of foster children is an intricate ongoing process that requires the expert management of caring foster parents. Elements of the contextual matrix, including traffic and geographic issues on Oahu, cultural considerations, as well as budget cuts for the state of Hawaii, are some of the unique forces challenging foster parents in this part of the country. Hawaiian foster children rely greatly on the organization and initiative of their foster parent caregivers to acquire necessary services to achieve optimal health outcomes.

Finding a concise manner to represent the complex needs of Hawaiian foster care children and the management of those needs by the foster care parent was a challenging task. The nuances of these experiences and challenges in achieving desirable health outcomes are both complex and involved with many areas of overlap. Figure 2 was developed to display these relationships.
FIGURE 2. Theory of Health Care Management for Hawaii’s Foster Child

Along the bottom of the model are four circles representative of different systems that interact with each other as well as with the foster parent. These systems may represent the policy and services associated with: the local community, the health care system, the welfare system, and the school system. The foster parent seeks assistance, information, and accommodations from these systems to meet the needs of their foster child. In addition, these systems request information and assistance from the foster parent in caring for the foster child in their placement. This two way exchange is represented by arrows going in both directions from the canopy shape representing the management activities of the foster parent, back to the circles representing the
systems and the process of managing the systems. The foster parent utilizes the support from these systems and funnels the resources at their disposal to fulfill the health needs of the foster child.

Health and wellness is a complex state of being that is defined by the individual. For the purposes of this model, the four elements of child’s health from the CHI model were added since they correspond to the comprehensive health needs of the foster child. These elements include: social environment, physical environment, biology, and behavior of the foster child. The location of these elements in respect to the model illustrate that the services and policies that the systems provide are coordinated by the foster parents in a process to meet these health needs of the foster child, thus supporting their health and well-being of the child which is found at the top of the model. The benefit to the foster child related to these interactions is self-explanatory by achieving optimal health and wellness. However, the benefit or motivation that drives the foster parent to function as a caregiver is also represented with the arrow from the foster child depicting the concept of “Ohana” or family. Foster parents in turn also provide foster children with a sense of “Ohana” which could be associated with the social environment however; it is also represented with an identical return arrow on the opposite side.

Achieving desired health outcomes in foster children is not represented over a trajectory of time in the case of this model. Generally speaking, health and developmental progression for children does comply with a linear process with each milestone influencing the other. However for the purposes of representing these relationships, a diagram of this structure was preferable. Also worth noting is that the foster parent’s time with any given foster child is an unpredictable variable. Some participants had the opportunity to influence the child’s health and well-being for two days and some multiple years. But whether that means managing a chronic psychological
disorder or an acute injury, many of these same systems of interaction are represented in the model above.

If any system fails in providing the appropriate resources for the foster child, one can see how those effects would work their way up the flow chart and compromise the health and well-being of the foster child. However, even in the most reliable seamless public systems with a number of resources at their disposal one can see how the proper utilization of those resources must be conducted by the foster parent to achieve maximal benefit to the foster child. The foster parent’s role in managing the health of their foster children is a constant balance between identifying the needs of the child, seeking accommodations and services to meet those needs, implementing those resources with the child, and determining whether or not the child is improving or worsening in their health status. Some of this may sound similar to any other biological or adoptive parent. However the systems and services at the disposal of the foster family can differ from other families as well as the social, physical, behavior, and biological needs of foster children that set them apart from the general pediatric population. Not just the health status, but the relationship (which may be short lived, strained, or enriching) between the foster parent and the foster child is another unique quality that sets these families apart. Foster families prove to be unique entities that share many of the principle characteristics of family without the permanency associated with this concept by so many people. This relationship is partly why the concept of family, Ohana, to Hawaiian foster parents is such a fascinating driving force that motivates these caregivers to fulfill this role.

**Summary**

In this chapter the study participants and the results was described. Data including demographic information of the participants, as well as category development was expressed in
the form of multiple tables revealing the information. Descriptions of category development as well as interview fragments were provided to expand upon categories created from interview data. Member check process as a means to re-examine the data post-analysis was explained and the feedback from participants was included. Finally, a theory of health care management of foster children was created and depicted in a figure displaying the interactions from the foster parent’s perspective.
CHAPTER FIVE: DISCUSSION

The content of chapter five continues the discussion of the results and their real world inferences. Implications to practice will be described and potential areas for further research will be proposed. Finally, limitations of this investigation will also be disclosed.

Implications for Practice

The United States is facing a shortage of health care providers, particularly those to deliver primary care services to adults and children. The Center for Workforce Studies of the Association of American Medical Colleges (AAMC) predicts a shortage of 63,000 physicians in 2015, and a shortage of 136,000 physicians by the year 2020 (AAMC, 2012). In the United States, 29% of physicians are age 55 and over and approaching retirement (University of Hawaii John A. Burns School of Medicine, 2010). In a report completed by the John A. School of Medicine, it was discovered that 41% of Hawaii’s physicians are age 55 or older. As this large portion of Hawaii’s workforce begins to retire and exit the arena of practice, the shortage of available providers will be further exacerbated with a shortage of over 1,600 physicians by 2020 in the state of Hawaii alone (University of Hawaii John A. Burns School of Medicine, 2010).

Efforts to improve residency admissions and increase graduates of medical schools may not be enough to meet the needs of a growing aging population. Since 1998, there has been a shift with fewer and fewer generalist residency graduates to deliver primary care services (AAMC, 2012). A 2007 survey of U.S. medical schools revealed only 7% of fourth year medical students planning a career in primary care (Hauer, Durning, Kernan, Fagan, Mintz, O’Sullivan, et al, 2008). Instead, many graduates are electing to sub-specialize in other areas of practice leaving a deficit in primary care.
Complicating this present and predicted physician shortage is the implementation of the Affordable Care Act which will soon provide access to public insurance for over 32 million Americans (AAMC, 2012). Many of these patients have health needs that have been neglected over time due to lack of access to affordable care or they have been cared for in our nation’s emergency departments when their health has been significantly compromised. As many of these patients seek to establish care with a health care provider, they may be faced with long waits and limited access to providers who accept the government funded public insurance program. According to a survey of 75 health care providers in Hawaii, less than one third of providers were willing to accept new Medicaid patients (Tice, Ruckle, Sultan, & Kemble, 2011). Rationale for limiting the number of patients on this public insurance plan was due to low reimbursement rates for services and labored processes to justify reimbursement that were described as time-consuming and excessive (Tice, Ruckle, Sultan, & Kemble, 2011).

One can see that with a deficit of health care providers, particularly in primary care, trying to care for an increasingly aging population, with fewer providers accepting public health insurance programs, and the prospect of millions more Americans who will be seeking primary care services there is a great challenge ahead for the health care leaders of the United States. Unfortunately, it is often the most vulnerable and helpless patients that get lost in the shuffle of these challenging environments. Without the attention and advocacy for foster children and their health care management, their prospects of optimal health will be bleak.

The doctor of nursing practice role brings a number of strengths and advantages to the health care industry in meeting the evolving needs of our communities. For decades, nurse practitioners have served roles in family practice, midwifery, women’s health, pediatrics, geriatrics, mental health, endocrinology, palliative care, and more. As autonomous care givers,
nurse practitioners practice as independent clinicians to diagnose, treat, prescribe, and manage a wide variety of health conditions. When compared with the physicians, nurse practitioners have demonstrated equal quality care as measured by health outcomes among patients (Hurrocks, Anderson, & Salisbury, 2002; Mundinger, Kane, Lenz, Totten, Wei-Yann, Cleary, et al., 2000; Rudy, Davidson, Daly, Clochesy, Sereika, Baldisseri, et al., 1998). In fact, some studies have demonstrated that nurse practitioners spend more time spent with patients during visits, have better compliance with treatment plans, and result in higher patient satisfaction (Brown & Grimes, 1995; Hurrocks, Anderson, & Salisbury, 2002). The doctor of nursing practice (DNP) is the most advanced degree available for nurse practitioners preparing not just knowledgeable clinicians, but health care leaders well versed in evidence-based practice, health care policy, leadership, research, and organizational management. Known for their holistic approach to patient care, the doctor of nursing practice centers their focus on health promotion, disease prevention and patient education. These qualities make the DNP an ideal health care provider for primary care services for families with foster children. A comprehensive, holistic approach to the health care management of foster children involves an understanding of the individual factors of biology and behavior in the context of the social environment, physical environment, health policy, and other systems.

The theory generated from interview data is a general representation of what is actually a very intricate process of foster parents striving for optimal health in children who have seen abuse, neglect, malnutrition, and in some cases a complete absence of medical care. The focal point of the theory is the orchestration that takes place on the part of the foster parent in achieving that health and well-being in the child. Foster parents have identified themselves as competent, motivated caregivers that function independently, and those strengths can be called
upon in partnering with health care providers in assessing the needs of the child and understanding what health concerns are being addressed properly.

Access to and participation in health education activities varied among foster parents. However, foster parents did articulate an interest in more preparation in health related topics to enhance their care giving role. This should tell the health care provider that foster parents may have a range of preparation for the understanding health concerns. Therefore it is important to assess the families’ knowledge base as well as their readiness to learn during clinical encounters.

Foster parents in Hawaii rejected the medical home model as a feasible method of health care delivery for foster children. It is important health care providers as well as welfare workers and policy makers to recognize the obstacles identified. Equally as important are weighing the risks and benefits of continuing to push for a model that is not conducive to environments such as Hawaii. If the medical home model continues to be emphasized, consequences could include missed appointments, lower school attendance, and gaps in the provision of care.

The development of a state-wide electronic medical record for children in the welfare system may be a solution to improve the continuity of care even among a variety of providers. Electronic medical records are “computerized medical information systems that collect, store and display patient information. They are a means to create legible and organized recordings and to access clinical information about individual patients” (Boonstra & Broekhuis, 2010, p. 231). Health care providers would face the same challenge of generating a comprehensive medical record with limited information on the child’s health history. However, once information is obtained and a plan of care is established, it may improve the consistency of health interventions while the child is in out-of-home placement. An electronic medical record would have the ability to retain important health information on each child that could be recovered upon re-entry to the
welfare system if reunification with the biological family is unsuccessful. Challenges to this intervention would include supporting access to the interface among a wide variety of institutions, clinics, providers, and specialties. Funding for development of the an electronic medical record as well as ensuring that wide-spread access meets the privacy requirements of the Health Insurance Portability and Accountability Act are also among important considerations.

Telemedicine, or telehealth, is also a tool that may improve access to health care services for foster children. In recent years, research and development in telemedicine has expanded to improve care in rural areas where access to health care providers is limited. Telemedicine utilizes a wide variety of technology including video conferencing to connect patients and providers in a variety of specialties (United States Department of Health and Human Services, 2012). Certain limitations may exist with the implementation of such technology. For example, child psychiatry interventions using play therapy may not be conducive to such an interface. However, adolescents requiring a referral to a psychiatrist may benefit from such a platform when access to a provider nearby is limited.

Access to providers accepting Medicaid as well as frequency or length of visits was identified as an obstacle with many foster parents and interfered with the care of foster children. Health care providers should be aware of reimbursement policies and advocate for vulnerable populations if coverage for services appears inadequate. Keeping this information in mind, health care providers should also strike a balance to ethically and safely managing the health concerns of the foster child within the constraints of such policies whenever possible. Delays in access and availability of specialty providers, particularly in mental health services, should be anticipated. Foster families may benefit from referrals to qualified providers for specialty services accepting new Medicaid clients from their primary care providers. For those seeking to establish care with
primary care services, welfare agencies may want to consider maintaining a running list of local practitioners who accept Medicaid clients to support foster families seeking medical care. Increasing the reimbursement for public health insurance programs and reducing the administrative work load required by such programs to justify that reimbursement may help to attract more health care providers to fill the primary care role as well.

Hawaii foster parents often care for children in poor health with very little information regarding their health history. This problem is similar across the country, based on current evidence regarding the health of foster children. An accurate health history is an extremely important part of the initial examination of a new patient and there is no substitute for that. However, a comprehensive physical exam and verbal history from the child was possible can help to lay some of the foundation for a patient with no records. Health care providers need to complete detailed documentation of physical findings, as well as be well-versed in the common concerns facing foster children. A simple step providers may consider is to simply inquire whether or not a new patient is a foster child on the initial visit. A checklist of sorts published for primary care providers to utilize for visits with foster children may be beneficial in practice to help guide the physician or nurse practitioners through important considerations. Foster parents can also be excellent sources to collaborate with regarding their care and their home observations and should be engaged in the discussion. Providers and parents alike must exercise some creativity to overcome obstacles. For example, in the case of uncertainty of immunological status, immunization records can sometimes be acquired from schools associated with previous placements to reconcile some or all of these records.

Psychological services remain of paramount concern and Hawaii is no exception to that pattern among foster children. Challenging behaviors and psychological disorders are important
topics for health care providers to discuss with foster parents at routine health examinations. Screening for depression, anxiety, or other mood disorders should be considered in foster children regardless of current placement or number of placement. Given the prevalence psychological concerns among foster children, as well as the time it takes to develop a therapeutic relationship between a psychiatrist or counselor and a child, addressing this concern should be a priority for the health care provider.

Given the mixed feedback regarding managing consents, it would be in the best interests of health care providers including nurse practitioners, to familiarize themselves and their staff with state and local laws regarding these requirements. This can be an educational opportunity to discuss with uncertain foster parents who may not be familiar with what constitutes consent and who is within their right to provide it for the treatment of a foster child. More importantly, acquiring the appropriate consent ensures the safety of the child. Ensuring that consent for treatment is handled appropriately also protects the practice from litigation.

Results of this investigation revealed a strained relationship between foster parents and social workers. The state welfare system is indeed an integral part of the systems involved in the processes of health care management in the foster child as depicted in the theory generated from this investigation. However, foster parents’ expectations were not met with the degree of support and manner of communication from social workers assigned to their case, requiring them to perform more tasks and function more independently than they had anticipated. Health care providers should keep this in mind when working with foster parents and support them with any available resources they can, rather than deferring to the social worker to assist them.
Recommendations for Further Research

Given foster parents’ key role in the management of health care needs of foster children, more research should be directed at examining their experience in achieving desirable health outcomes in children. As advocates for these children, they can give additional information about service utilization and caregiver needs to help public services and health care providers to focus their efforts on improving the resources that these families need. Much of the current research available has been generated from the health care provider’s perspective which is an important piece of the puzzle, but may not necessarily be the only integral piece to the health care management of foster children.

Participants’ training and preparation for managing health care concerns varied among foster parents’ reports. However, foster parents verbalized interest in access to more training and preparation to manage health concerns for their foster children. Further research regarding what types of foster parent training has been associated with improved health outcomes would benefit welfare agencies who offer these services as well as the foster parents who partake in the programs, and the foster children who are the indirect recipients of the training. The biggest obstacle with attending current health education programs offered by some welfare agencies was family schedules and child care. Alternative methods of educating foster parents on health concerns should be explored. Other modalities such as newsletters, videos, and internet modules would be worth exploring. These alternatives may be beneficial for foster parents to read about select health topics on their own time rather than arranging babysitters and travel to attend presentations in person. In addition, more comprehensive information could be generated online such as handouts, frequently asked questions, and even accompanying videos that foster parents can view at their leisure.
Given that foster parents in Hawaii rejected the medical home model as a feasible method of health care delivery for foster children, other options should be explored including the potential use of telemedicine. Keeping in mind the obstacles identified further research in the feasibility of alternative models of health care delivery and their effectiveness on the health of foster children in Hawaii could benefit these families. Furthermore, the feasibility of the medical home model in other populations of foster children should be explored, as well as its relation to measurable health outcomes in those children nationwide.

Medicaid coverage for health services, including reimbursement for care of Hawaiian foster children is a topic worth additional investigation. Further investigation regarding whether or not Hawaii’s Medicaid coverage is sufficient for the complex needs of foster care children would be of interest to this population. In addition, more information on provider attitudes towards Medicaid coverage and reimbursement process may help to explain foster parents’ reports of fewer providers accepting this insurance plan.

The understanding and protocol for obtaining consent for health related services was mixed among the participant responses. Further research on policies, practices, and errors regarding consent with foster children may be of interest. This could be explored on a state-wide basis to identify where misconceptions or short-falls in training might occur.

According to foster parent reports, the relationship between foster families and social workers failed to meet initial expectations. Identifying obstacles to an enhanced collaboration and additional support may be helpful in understanding this challenge. Further research regarding the number of social workers, their conditions, and attrition for Hawaii may shed light on the demands of this profession.
Limitations

The participants for this investigation were limited to foster parents. The perspectives of social workers, health care providers, insurance providers, or teachers were not included. Therefore, this investigation is not representative of a comprehensive analysis of the health care process applicable to foster children. Furthermore, the participants were limited to school age children, or children between the ages of six and twelve years of age. While the goal of grounded theory is not necessarily generalizability of data, foster parents with children less than six years of age may have different experiences in the health care management of their children. Likewise, foster parents of adolescents were not included, and their experiences could also differ from that of the participants in this investigation. All foster parents cared for children on the island of Oahu. While some foster children were transferred to Oahu from neighboring Hawaiian Islands, all the foster parents that participated in the investigation functioned in their role on the island of Oahu. Oahu is the most populated island of the island chain and could influence results when compared with islands with a smaller population and variability in resources.

Summary

Implications for practice based on this investigation were provided in an attempt to improve health outcomes in foster children and to support the role of the foster parent in managing the foster child’s care. Recommendations for further research were provided that could influence care and explain unanswered questions. Limitations for this study were also addressed but not intended to be exhaustive.
Nursing Research Participant Recruitment

Title of Study: Health Care for Foster Children

Participation Outline: The purpose of this study is to:

1) describe foster parents' experience in obtaining health care for their foster children and

2) to get foster parents' opinion about whether or not a health education program designed for foster parents would be helpful.

If you join the study, I will interview you one time for about 45-60 min. I will ask some participants for a 2nd, shorter interview.

There are four criteria for participation in the study:

☐ You are caring for school-age (6-12 years old) foster care child now OR you provided foster care for school age children within the last 10 years.
☐ You provided foster care for at least six months.
☐ You speak English.
☐ You are over age 18.

If you are interested in participating in this study please contact me to hear more detail about the study.

Principal Investigator: Meghan Updike, BSN, RN Graduate Nursing Student
mupdike@nursing.arizona.edu
(480) 584-9280

Thank you for your time and consideration.
APPENDIX B: SCRIPT FOR ORGANIZATIONAL LEADERS
**Introduction Script for Organizational Leaders**

Hello, my name is Meghan Updike and I am a doctoral student at the University of Arizona, College of Nursing. I am currently completing my Doctorate of Nursing Practice specializing in Family Practice. As a part of my degree program I am completing a Practice Inquiry project which is a study that investigates a clinical phenomenon that may generate new information to influence nursing practice. As a future nurse practitioner I am interested in serving as a health care provider for foster care children and families in our Oahu community. I have decided to focus my Practice Inquiry project on examining the use of health care services of foster care children from the foster parent’s perspective.

I have performed an extensive review of literature and found very little evidence related to foster children’s health in Hawaii and management of health care concerns from the foster parents’ perspective. For this reason, I am looking to interview foster parents about their experiences acquiring health care for their foster children. It is my hope that this project may provide health care providers with a better understanding of the foster family experience. Thus, enabling health care providers to better serve foster families and improve health outcomes among foster children.

Would you allow me the opportunity to speak to foster parents involved in your organization to inquire if any would be willing to participate? With your permission I would be happy to come speak to your organization about my project. No children’s names will be used in interviews with foster parents and no participant identifiers will be associated with data generated from the interview to protect confidentiality of the participants. In addition, foster parents who express interest in participating may withdrawal from the study at anytime. The information that foster parents of your organization may be able to provide would be very beneficial. I would be happy to answer any questions you may have about the project.
APPENDIX C: SCRIPT FOR PARTICIPANT RECRUITMENT
Introduction Script for Recruitment

Hello, my name is Meghan Updike and I am a doctoral student at the University of Arizona, College of Nursing. I am currently completing my Doctorate of Nursing Practice specializing in Family Practice. As a part of my degree program I am completing a Practice Inquiry project which is a study that investigates a clinical phenomenon that may generate new information to influence nursing practice. As a future nurse practitioner I am interested in serving as a health care provider for foster care children and families in our Oahu community. I have decided to focus my Practice Inquiry project on examining the use of health care services of foster care children from the foster parent’s perspective.

I have performed an extensive review of literature and found very little evidence related to foster children’s health in Hawaii and management of health care concerns from the foster parents’ perspective. For this reason, I am looking to interview foster parents about their experiences acquiring health care for their foster children. It is my hope that this project may provide health care providers with a better understanding of the foster family experience. Thus, enabling health care providers to better serve foster families and improve health outcomes among foster children.

If any of you would be willing to let me interview you for this project I would really appreciate it. If you are interested please take a flyer. I can be contacted by telephone or email to set-up an appointment to interview you at your convenience. Interviews will be audio recorded to ensure my accuracy when transcribing data. No children’s names will be used in interviews and no participant identifiers will be associated with data generated from the interview to protect your confidentiality. In addition, if you change your mind and decide not to participate, you may withdrawal from the study at anytime. The information that you foster parents may be able to provide would be very beneficial. I would be happy to answer any questions you may have about the project.
APPENDIX D: DEMOGRAPHIC SHEET
PARTICIPANT DATA
FOSTER PARENT DEMOGRAPHIC INFORMATION

Gender
☐ Male
☐ Female

Age ______

Highest level of education completed
☐ High school diploma
☐ Some college
☐ College degree
☐ Graduate degree
☐ other

How many years have you served as a foster parent?
_________________________________________________________________________________

How many foster children have you provided care for?
_________________________________________________________________________________

What is the longest period you provided care for a foster child?
_________________________________________________________________________________

What is the shortest period you provided care for a foster child?
_________________________________________________________________________________

At the time you were a foster parent, were you also raising your own children?
☐ Yes
☐ No

At the time you were a foster parent did you raise grandchildren in your home at the same time?
☐ Yes
☐ No
INTERVIEW GUIDE FOR FOSTER PARENT PARTICIPANTS

1. Social Environment
   a. How did you come to be a foster parent?
   b. How would you describe your role as a foster parent?
   c. Please describe your family structure including members of your family?
   d. If you had other children in the home, how did they interact with the foster child?
   e. How do you think the social environment of the child's home before coming to live with you might have impacted the child?
   f. How did the social environment of your home affect the child?

2. Physical Environment
   a. Did the child change schools when they were placed in your home?
   b. Was the child exposed to domestic violence or neighborhood violence prior to placement?
   c. Was the child at risk for injury or neglect in their original living situation?
   d. Can you describe how the physical environment of the child's home prior to placement might have affected the child?
   e. How did the physical environment of your home affect the child?

3. Biology
   a. How would you describe the overall health of your foster child when first coming to your home?
   b. Was the foster child current on their immunizations at the time they were placed in your home?
   c. Did your foster child have acute illnesses such as respiratory infections or skin disorders?
   d. What types of chronic conditions did you need to manage?
   e. Where did you bring your foster child for medical attention?
   f. What type of health care provider did you see?
   g. How often did you see the same health care provider?

4. Behavior
   a. What behavioral challenges have you experienced with your foster child?
   b. Have any of your foster children experienced depression, anxiety, or other mood disorders?
   c. Has your foster child struggled with coping with stress or transitions in foster care?
   d. Has your foster child showed distrust?
   e. While you were caring for the child, did they ever have an EPSDT developmental screening? If so, was the child found to be developmentally appropriate?
   f. How well did the child do in the testing of development?
5. **Policy and Services**
   a. Was there any period of time in which a foster child was in your care and was not insured through the state’s Medicaid system?
   b. How are medical records maintained?
   c. When your child was seen by a health care provider, what information regarding past medical history was made available to that health care provider?
   d. Was your foster child ever referred to specialty services for further evaluation and treatment?
   e. What services are available to you as a foster parent to facilitate acquiring health care services?
   f. Do you feel you would benefit from a health education program for managing health care concerns for foster children in your care?
   g. Have you ever encountered an incident where treatment was delayed due to problems obtaining consent for treatment?
   h. What opinions do you have about health care policies that affect foster children?
   i. What types of barriers have you encountered in acquiring care for your foster child?
APPENDIX F: CONSENT FORM
PARTICIPANT CONSENT FORM

You have been invited to take part in a research study. The information on this form is provided to help you decide whether or not to take part.

The purpose of this study is twofold:
1) to describe foster parents' experience obtaining health care for their foster children and
2) to ask for foster parents' opinions about whether or not a health education program designed for foster parents would be helpful.

Why are you being invited to join the study? Because you are
1) Either currently caring for a school-age (6-12 years old) foster care children OR you provided foster care for school age children within the last 10 years.
2) You have provided foster care for a least six months.
3) You speak English.
4) You are over age 18 years

What will I be asked to do?
You will be interviewed for 45-60 minutes about your experience in obtaining health care for your foster children. To maintain confidentiality, you will be asked to pick a pseudonym (fake name) for the interview, and you will be asked to avoid mentioning the names of your foster children. You may substitute alternative names or use codes such as "child A" or "child B" to differentiate between multiple children. The interview will be audio recorded so that I can transcribe it later and then analyze the interviews.

You will be given the option of participating in a brief follow-up interview (10-15 min). You are asked to indicate if you would like to be considered for participation in the follow-up interview. Please check the box below and provide a preferred method of contact so that if you are selected I may contact you to schedule the follow-up interview. No all participants will be contacted for follow-up interview.

☐ I would NOT like to be considered for the follow-up interview in addition to the initial interview.
☐ I would like to be considered for the follow-up interview in addition to the initial interview. I may be contacted by:

    phone: __________________________
    email: __________________________

What are the risks for being in the study? There are no known risks for being in the study, except there is some risk that someone will find out you participated.

What if I change my mind about being in the study? In that case, you can withdraw and stop the interview with no ill feelings, and without affecting your role as a foster parent. Your participation in this study is voluntary. You may decide to not begin or to stop the study at any time.

Will I be paid? No, there is no compensation for participation in this study.

Version: 05/08/12
What will it cost? It will take time for the interviews and you will have to pay any costs for getting to the interview site.

Confidentiality: Your information will remain confidential. You will not be identified in any reports or publications resulting from the study.

Who can I call for information or if I have a complaint? You can obtain further information about the research and voice your concerns or complaints by calling the Principal Investigator Meghan Upliik, graduate student at (480) 384-9280. If you have questions concerning your rights as a research participant, have general questions, concerns, complaints, or would like to give input about the research and you can’t reach the research team, you may call the Arizona Human Subjects Protection Program office at (520) 626-6721. If you would like to contact the Human Subjects Protection Program via the web, please visit the following website: http://www.irb.arizona.edu/contact.

Your signature below indicates that you understand the above mentioned items and that you are voluntarily agree to participate in the study.

(Print Participant Name)          (Participant Signature)          (Date)

I have explained the research to the participant or the participant’s representative before requesting the signature above. There are no blanks in this document. A copy of this form has been given to the participant or to the participant’s representative.

(Principal Investigator Name)     (Principal Investigator Signature)     (Date)
APPENDIX G: LETTER OF APPROVAL FOR HUMAN SUBJECTS REVIEW
Date: 05/08/12  
Investigator: Meghan Updike, Doctoral Candidate  
Advisor: Elaine Jones, PhD  
Project No./Title: 12-0346-00 Health Care for Foster Children  
Current Period of Approval: 05/08/12 – no expiration

<table>
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<th>Administrative Action</th>
<th>FWA Number: FWA000004218</th>
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<td>IRB Committee Information</td>
<td>Administrative Review – New Submission</td>
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Documents Reviewed Concurrently
- F200: Application for Human Research (signed, revised)
- Consent Instruments
- Subject Consent Form
- F107: VOTF
- Recruitment Materials: Flyer, script
- Data Collection Instruments
- Demographic Questions
- Interview questions
- Other (define):
- CV Updike
- COI documentation

Determination
Approved as submitted effective 05/08/12

Regulatory Determination(s)
- Exempt Approval 45 CFR 46.101(b)(2): Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior.

Sheryl Wurl, PhD  
Director, Human Subjects Protection Program  
UA Institutional Review Board

05/08/12  
Date

SW mm
cc: Scientific/Scholarly Reviewer

Reminder: No changes to a project may be made prior to IRB approval except to eliminate apparent immediate hazard to subjects.
APPENDIX H: SITE AUTHORIZATION HUI HO’OMALU
Meghan Upleke, a candidate for Doctorate of Nursing Practice @ University of Arizona, requested permission to interview resource care givers for her project relating to the health of foster children. After discussing her project, with Program Development Administrator, Rosaline Tupou, approval was given for her to interview select group of resource families. She has insured that the confidentiality of both the resource families and children will be maintained for this project.

[Signature]
FIII, Supervisor
9/18/12

Approved:

[Signature]
OSC WSSA, David Kan
9/18/12

AN EQUAL OPPORTUNITY AGENCY
APPENDIX I: SITE AUTHORIZATION CATHOLIC CHARITIES
Site Authorization Confirmation

Meghan Updike contacted me to request permission to interview foster parents associated with my organization (Catholic Charities). After discussing her project it was determined that this was appropriate and we gave her permission to speak with our foster families.

Sarah Antone, MSW, Parent Consultant

Name

Signature
APPENDIX J: SITE AUTHORIZATION HOPE INC
Site Authorization Confirmation

Meghan Updike contacted me to request permission to interview foster parents associated with my organization (Hope INC). After discussing her project it was determined that this was appropriate and we gave her permission to speak with our foster families.

[Signature]

Name: [Signature]
REFERENCES


Association of American Medical Colleges Center for Workforce Studies (2012). Recent studies and reports on physician shortages in the U.S. 1-22.


