GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

CFSA FY 2024 APSR

HEALTH CARE OVERSIGHT AND COORDINATION PLAN

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Prepared by the CFSA Office of Planning, Policy, and Program Support in collaboration with the Health Services Administration

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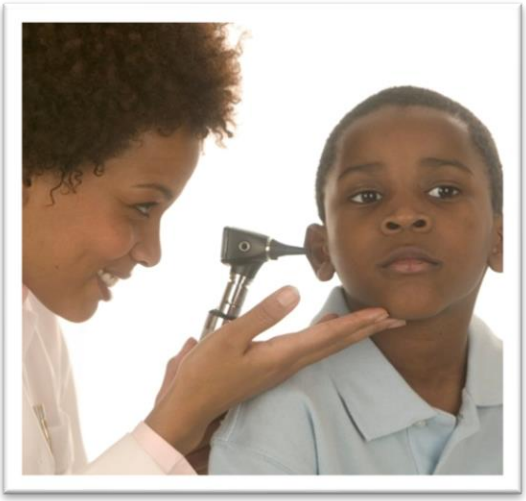
INTRODUCTION

The Child and Family Services Agency (CFSA or Agency) provides quality health-related service delivery to children and families, including oversight and coordination of health services, educational support, and family teaming. CFSA's Health Services Administration (HSA) has primary responsibility for assessing, coordinating, and maintaining the services to ensure optimal health and well-being of children in foster care.[1] HSA further manages CFSA's Healthy Horizons Assessment Center (HHAC), an onsite, 12-hour (9:00 a.m. – 9:00 p.m.), 5-days-a-week clinic staffed with three nurse practitioners and two certified medical assistants. HHAC is not operational on weekends, nights, or holidays; rather, a nurse practitioner is on-call during those hours.



HSA is staffed with a total of 16 registered nurses. Within HHAC, and under the auspices of HSA, CFSA has also established the nurse care management program (NCMP) for children requiring more tailored health-related services. This program is staffed with seven registered nurses who collaborate with ongoing social workers to develop the necessary, comprehensive health plans for children with these needs.

The NCMP purposefully integrates health and social services planning to intensify well-being, and permanency outcomes. NCMs ensure timely completion of clinical recommendations and engage caregivers and social workers to bridge health-related knowledge gaps. Training is also provided for the NCMs and the social workers to guide assessments of a child's current emotional trauma, as well as past treatment for trauma-related issues and the potential need for future treatment.

There are five nurses specifically assigned to the Agency's Child Protective Services (CPS) administration to provide consultative support to CPS investigative social workers, as well as to the nurses who are available on general assignment to HSA. There are also four registered nurses assigned to support the in-home community social workers (co-located at the Collaboratives).

[1] For purposes of this document, the term "children" is inclusive of infants and older youth as applicable.

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HSA is staffed with 14 registered nurses, compared to 16 from last year, as one nurse retired and one nurse resigned. Positions were not back-filled due to right-sizing of Health Services to reflect the decline in foster care entry rates and the overall foster care populations. This program is now staffed with five CPS nurses located at CFSA headquarters and four community-based nurses (located at the Collaboratives) who support the In-Home Administration. One of the community-based nurses, assigned to the CFSA Project Connect substance use program, also supports CFSA's Community Partnerships Administration through cases managed by CFSA's Office of Well Being.

Collectively, HSA and HHAC, along with the NCMs and CPS nurses, directly administer and coordinate well-being services for children in care to ensure timely, comprehensive, and effective medical, dental, and mental health care along with any related service delivery needs. HSA also provides supportive resources and consultative services for social workers, foster families, and biological families. CFSA has partnerships with the following DC government agencies to ensure that comprehensive health care-related services from sister agencies are also readily available for clients:

- DC Health: CFSA partners with the District's Department of Health (DOH) on protocols to address fetal alcohol syndrome and to decrease infant mortality rates in the District. This collaboration includes access to the DOH immunization registry for the retrieval of children's immunization history and safe sleep education materials and pack-in-play portable cribs. In addition, CFSA participates in the Maternal Child Health Advisory Council.

FY 2021 APSR Update

- CFSA partners with the District's Department of Health (DOH), renamed DC Health, on protocols to address safe sleep practices to decrease infant mortality rates in the District. This collaboration includes safe sleep education materials, fact sheets, trainings with return demonstrations or verbal articulation, and video clips. In addition, nurses use Pack 'n Play cribs to educate CFSA clients on safe sleeping practices.

- Department of Health Care Finance (DHCF): As the "state" Medicaid provider, CFSA partners with DHCF to address several aspects of client services, including reimbursement of non-Medicaid services, e.g., following protocols for the

[2] All new and updated descriptions of programs, services, progress, and outcomes are indicated under the heading ***FY 2024 APSR Update***. The remaining content remains unchanged from the submission of the FY 2023 APSR.

administration of pharmaceuticals that are not covered by Medicaid (such as non-generic, high-end medications). DHCF also facilitates reimbursement for HHAC services, such as establishing rate setting, reimbursement structure, and claims adjudication. Included in the DHCF partnership are services provided by the District's Health Services for Children with Special Needs (HSCSN), which covers services for children with special needs as well as services for their parents (e.g., respite benefits, training, and education on specific caregiving). In addition to the above, CFSA signed a Memorandum of Agreement (MOA) with DHCF for sharing, tracking, and monitoring well-child visits.

- Department of Behavioral Health: CFSA has in-house staff who provide mental health evaluations, treatment recommendations, and therapy for children coming into care. CFSA also partners with the Department of Behavioral Health (DBH) to co-locate staff who track and support children and families receiving mental health treatment at city core service agencies. DBH also provides assessment and therapy services to CFSA-involved children and families who are not actively receiving treatment at a core service agency.[3]

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- Department of Behavior Health (DBH): CFSA partners with DBH and co-locates DBH staff at CFSA's Office of Well-Being to track and support children and families receiving mental health treatment at the District's core service agencies.

- Department of Developmental Disability Services (DDS): Pursuant to a Memorandum of Understanding between CFSA and DDS, CFSA prepares for the case management transition of older youth from CFSA to DDS when youth are diagnosed with disabilities. The transition process usually occurs when the youth turns age 21. It is carefully implemented by case-managing social workers (including those in CFSA's Office of Youth Empowerment) in conjunction with the Health Services program specialist.

- Office of the State Superintendent of Education (OSSE): CFSA coordinates with OSSE to provide developmental assessments and treatment for children in foster care.

- Department of Youth and Rehabilitative Services (DYRS): CFSA partners with the DYRS medical director and staff to provide and exchange medical histories and information, specifically for teens who are involved with both agencies (i.e., dual-jacketed youth).

[3] A core service agency is an agency certified by the Department of Behavioral Health (DBH) to provide mental health services, consistent with Mental Health Rehabilitation Services (MHRS) standards and DBH or the Department of Mental Health Establishment Amendment Act of 2001.

- District of Columbia Superior Court: CFSA partners with the Family Court for the identification of and services to victims of human trafficking in the District, including suspected victims and those at risk of human trafficking.

- Office of Chief Medical Examiner: Under the auspices of the Office of the Chief Medical Examiner, the Infant Mortality Review Committee convenes the first Tuesday of every month to review all infant deaths (including those infants with CFSA involvement). This Committee provides analysis of each death and recommends policies and practices to appropriate District entities in order to decrease infant mortality rates in DC.

The above partnerships guarantee availability of the most comprehensive and appropriate array of services to children and families. To further ensure the quality of medical treatment available, CFSA actively consults, involves, and partners with other health care entities and professionals who specialize in different areas of health care.

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CFSA consults and partners with other entities to provide health care for children and youth. These providers include the Children's National Hospital (CNH) and its affiliates, Howard University Hospital, Washington Hospital Center, Georgetown University, George Washington University Unity Medical Center, Hospital for Sick Children Pediatric Center (CNH affiliate), the District's Health Services for Children with Special Needs, managed care organizations, and other DC Government agencies such as Department of Health Care Finance DC Health, Office of the Chief Medical Examiner, Office of the Superintendent for Education, and Department of Behavioral Health. These partnerships help to ensure the appropriateness of available medical treatment and allows access to a larger pool of credentialed providers and board-certified clinicians to minimize any inappropriate diagnoses of children.

The following relationships with the medical community, including pediatricians, provide ongoing discussions and consultations to ensure seamless coordination of services:

- The Town Hall Education Arts Recreation Campus (THE ARC): The Children's National Health System operates a pediatric community clinic at THE ARC that is the medical home and referral source for many children in foster care.

- MedStar Georgetown University Hospital: Georgetown University Hospital offers a Pediatric KIDS Mobile Medical Clinic that provides direct services for children in the custody and care of CFSA. Services range from immunizations to medical management for chronic illnesses like diabetes and asthma.

- MedStar Washington Hospital Center: For CFSA's pregnant or parenting teens (including teen fathers), CFSA coordinates with MedStar Washington Hospital Center (WHC) and the Teen Alliance for Prepared Parenting (TAPP) program. TAPP is a community service initiative within WHC's division of Women's and Infants' Services (WIC) that addresses the high rate of teen pregnancy in the nation's capital. It is a comprehensive youth services program that provides a unique mix of clinical and psychosocial services to help young parents avoid an unintended subsequent pregnancy during adolescence. The program also helps young parents to continue and complete their education, to master life management skills, and to improve the future for their children. CFSA teens in this program receive prenatal and post-partum clinical care, prenatal education, parental education, and referral services.

Before HHAC opened in December 2009, CFSA struggled to ensure that each child entering or re-entering foster care had a pre-placement screening and comprehensive physical examination within the required 30–day timeframe. For example, only 50 percent of children were reported to have had pre-placement screens prior to a placement change and only 34 percent had comprehensive physical examinations. In fiscal year (FY) 2018, 321 children received an initial or re-entry health screening by HHAC before entering a foster care placement. By the end of the first quarter (Q1) of FY 2019, 109 children served by HHAC received an initial or re-entry health screening before entering foster care. CFSA attributes these improvements to HHAC's key onsite functions, which ensure that health concerns related to abuse and neglect are quickly identified and treated before CFSA places a child into a resource parent's care. Equally important is the Agency's ability to capture a medical baseline with readily available data for each child. This additional information equips CFSA with the information needed to support strategic planning and justify future program development specific to children's health needs.

FY 2023 APSR Update

In previous years, CFSA measured performance on a quarterly basis. However, for this reporting period, data measurements are reported in 30 and 60-day timeframes. CFSA's benchmark requires 85 percent of children to have received completed medical evaluations within 30 days of placement. The benchmark is 95 percent for children within 60 days of placement. From January to June 2021, there was a monthly range of 80-97 percent of children who had received a comprehensive medical evaluation within 30 days of entering care. The monthly range for children receiving these evaluations within 60 days of entering care was 90-97 percent. From July to December 2021, a monthly range of 85-96 percent of children received comprehensive

medical evaluations within 30 days. Within 60 days, a monthly range of 87-100 percent of children received comprehensive medical evaluations.[4]

FY 2024 APSR Update

CFSA's benchmarks remain the same for children receiving medical evaluations, i.e., 85 percent within 30 days of placement and 95 percent within 60 days of placement. From January 2022 through September 2022, there was a monthly range of 86 to 100 percent performance for children receiving a full medical evaluation within 30 days of entering care, and a monthly range of 91 to 100 percent performance for children receiving a full medical evaluation within 60 days of entering care.

With all of the above efforts in place, CFSA's Health Care Oversight and Coordination Plan (HCOCP) is designed to reflect the Agency's latest practices and efforts to meet the service needs cited above. Accordingly, HCOCP is a living document that will be updated to address the changing and evolving needs of CFSA's foster care population whenever new strategies are implemented. Further, as is required by *the Fostering Connections to Success and Increasing Adoptions Act of 2008*, HCOCP addresses the following health care plan components:

- Scheduling initial health screenings and assisting with follow-up screenings that meet reasonable standards of medical practice
- Procedures to identify and monitor health needs through screenings, and to determine how these needs will be treated
- Procedures for updating and for appropriately sharing medical information
- Continuity of health care services
- Oversight of prescription medicines
- Consultations with physicians and other appropriate medical or non-medical professionals for assessing children's health and well-being, and for determining appropriate medical treatment

INITIAL EVALUATIONS OF CHILDREN'S HEALTH

CFSA recognizes that children in out-of-home care require a tailored range of health care services to promote their physical, dental (or oral), emotional, developmental, and educational well-being. This section of CFSA's HCOCP outlines the detailed processes that CFSA adheres to while assessing a child's health care needs upon entry into the foster care system.

[4] Child and Family Services Agency Four Pillars Performance Report 2021

According to CFSA policy (*Initial Evaluation of Children's Health*), best practice standards must be upheld for initial health screenings for all children entering or re-entering out-of-home care. Through these screenings and timely comprehensive health assessments for children, all health needs can be identified and appropriately met. CFSA adheres to all applicable federal and District of Columbia laws and regulations for the delivery of every health care service, as well as national best practice principles as defined by the American Academy of Pediatrics and the Child Welfare League of America. CFSA also adheres to the requirements of the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services program (known in the District of Columbia as *DC HealthCheck*). EPSDT is the basic framework for guiding CFSA's health care practice for children. In addition to promoting healthy child development and ameliorating conditions that disable children, EPSDT further ensures that all Medicaid-enrolled children under age 21 have access to medical, dental, and mental health services.

Initial Medical Screenings

Initial medical screenings identify a child's immediate health care needs while simultaneously helping the nurse practitioner to gather information that assists with placement of the child in the most appropriate setting. The following requirements are incorporated into CFSA's screenings for nurturing the child's safety, permanency, and well-being needs:

1. Every child receives a medical screening prior to an initial entry or re-entry into care, or a change in placement.
2. Pre-placement and re-placement screenings take place on-site at HHAC. A nurse practitioner consults with the social worker and child (as appropriate) regarding the screening.
3. The CPS or assigned social worker receives two copies of the *Cleared for Placement* form from HHAC and places one copy into the child's case file. HHAC also provides the resource parent with a *Cleared for Placement* form that includes a summary of the pertinent findings, diagnosis, current and newly-prescribed medication, medical equipment (if applicable), and any other care instructions. These documents are included in the placement folder that accompanies the child to their foster care placement. If applicable, all references to a child's HIV/AIDS[5] status are kept strictly confidential and forwarded by the nurse practitioner to the HSA administrator.
4. To the extent possible, initial screenings assess prevalence of any of the following conditions:
    a. Signs of abuse or neglect
    b. Active medical or psychiatric problems, including obvious illnesses or disabilities
    c. Current use of medication (if any) or immediate need for medication

[5] Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome

d. Allergies to food, medication, or environmental elements (e.g., pets and pollen)
e. Upcoming medical appointments
f. Need for eyewear, hearing aids, or other durable medical equipment (e.g., prosthetic devices)
g. Sexually transmitted infections (STI)
h. Substance use
i. Overdue immunizations[6] (implemented January 2019)
j. COVID-19 Screening (implemented March 16, 2020)

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As of July 2022, the rapid COVID 19 test kits are no longer available for distribution.

The HHAC certified medical assistant schedules appointments for the child's 30-day comprehensive health assessment; social workers or resource parents schedule 30-day dental examinations. HHAC follows up to ensure dental evaluations occur.

Overview of the Comprehensive Health Assessment

As noted, DC HealthCheck requires periodic health screenings in addition to the early, comprehensive medical health assessment (i.e., within 30 days of the child's initial entry/re-entry into out-of-home care). This assessment builds on the information and outcomes obtained from the initial medical screening.

1. The following components of CFSA's comprehensive health assessment are consistent with the requirements of the DC HealthCheck program:
    a. Child's medical history (based on information and outcomes from the initial screening)
    b. Child's developmental history
    c. Physical examination by a qualified health care practitioner
    d. Child screenings for COVID-19
    e. Age-appropriate screening tests, including identification of risks and conditions
    f. Preventative services, such as immunizations, health education, and reproductive education (as appropriate)
    g. Development of a current and previous diagnosis list

[6] The HHAC nurse practitioner gives immunizations to all children who are not up-to-date with their vaccinations, based on the current Centers for Disease Control (CDC) child and youth immunization schedule. Children receive their HHAC immunizations at the 30-day comprehensive assessment for entries and re-entries and then later for children on a case-by-case basis at any change in placement screening.

h. Development of a treatment plan consisting of objectives and methods, interventions, and services that address the child's individual needs, array of health care practitioners, etc.

2. For youth placed in congregate care facilities (i.e., group homes, shelters, emergency care facilities), a comprehensive medical and dental examination is conducted by a licensed health care practitioner or physician within 14 calendar days of admission.
3. A comprehensive health assessment is also completed under the following circumstances:
    a. Within 30 days of a child re-entering care
    b. Within 30 days of a child being absent for more than two weeks without permission from a foster care placement (i.e., abscondence)
4. In an effort to provide support for the completion and follow-up to the health assessment, HSA ensures the following provisions:
    a. Scheduling of examinations for the child or assistance to the caregivers for scheduling within required timeframes.
    b. The social worker provides the child's available medical history to the HHAC nurse practitioner at the time of the exam or as soon as possible thereafter.
    c. The HHAC nurse practitioner ensures that the assessment is completed and that all appropriate actions are taken, including the filling of prescriptions.
5. With the support of an HSA nurse, the social worker ensures that the child receives appropriate health care during placement. It is also important for the resource provider[7] to cooperate with a child's medical, dental, and mental health care practitioners and to follow any instructions related to the child's health care. Ongoing social workers also reinforce the importance of this teaming relationship in the best interest of the child.
6. For follow-up visits and referrals, the resource provider schedules appointments and accompanies the child accordingly. Both the assigned social worker and the resource provider are expected to encourage the birth parents (if a co-parenting relationship has been established) to attend the appointment whenever appropriate. The assigned social worker may also attend the appointment.
    a. If the resource provider is unable to accompany the child, the resource provider notifies the assigned social worker who shall then accompany the child, preferably with the birth parents.
    b. Results of all visits are documented by the assigned social worker in FACES.NET, the District's web-based child welfare information system. The social worker also

[7] For purposes of this document, the terms "resource provider" and "resource parent" are interchangeable and include kinship, adoptive, and traditional foster parents.

places copies of any related documents in the official case record. If there are any questions or concerns, the social worker consults HSA.

FY 2021 Update

While the Healthy Horizons Assessment Center is not a COVID-19 test site, CFSA screens children and youth for COVID-19 at every initial, re-entry, change in placement screening and 30-day comprehensive examination. Children and youth and the accompanying adult are asked several COVID-19 symptom-related questions. Responses and the clinical presentation during the medical examination determine the need to test for COVID-19. If a child and youth need to be tested for COVID-19, the Healthy Horizons Assessment Center provides instructions to the social worker and foster parent on where to receive a test.

Initial Dental Examination

DC HealthCheck guidelines require dental screenings for children as early as six months of age. Accordingly, CFSA refers infants in care to a dentist after the first tooth erupts (around six months) or by 12 months of age (whichever comes first). For children first entering foster care, a DC Medicaid dental provider or HHAC nurse practitioner (infants only) conducts the initial dental examination within 30 days of a child's placement (or 14 calendar days if placed in a residential facility). In FY 2018, 61 percent of children received a dental evaluation within 30 days of entry into foster care. At the end of FY 2018-Q2, 55 percent received a dental evaluation within 30 days. After placement and enrollment of Medicaid, a dental provider is assigned. Dental examinations must occur every six months.

FY 2023 APSR Update

In prior years, CFSA measured dental evaluations at 30, 60, and 90-day intervals. In 2021, the Agency simplified the measure based on a minimal performance difference between evaluations completed at 60 days and 90 days. As a result, CFSA eliminated both the 30-day and 90-day benchmarks (25 percent and 85 percent respectively) while increasing the performance target for the 60-day benchmark from 50 percent to 75 percent.

Between January and June 2021, there was a monthly range of 33-82 percent for children receiving a full dental evaluation within 60 days of entering care. Between July and December 2021, there was a monthly range of 42-64 percent for children who received full dental examinations within 60 days.[8]

[8] Child and Family Services Agency Four Pillars Performance Report 2021

FY2024 APSR Update

CFSA worked closely with the court monitor and plaintiff to create 44 meaningful metrics as a final step for the Agency to exit the *LaShawn vs. Bowser* lawsuit. Many of the measures were part of the Four Pillars Performance Framework in 2021, while some were part of earlier *LaShawn vs. Bowser* court agreements, and others are new. Some of the older measures now include changes in methodology, which include the receipt of full dental evaluations within 60 days of entering care. Instead of tracking monthly compliance, due to the low number of applicable children entering or re-entering care, CFSA is now tracking this measure twice a year with a cumulative count. CFSA is also now publishing performance for the fiscal year versus the calendar year. During this transition of reporting years, CFSA's data covered the January to September 2022 timeframe; the December 2021 report covered the October to December of FY 2022 data.

During January-September 2022, 76 percent (n=93/122) of children received a full dental evaluation within 60 days of entering care. Although no performance target has been set at this time, the Agency will use a rational target setting methodology to do so for the future, i.e., examining and combining past performance data with current data to set a realistic target for analysis of practice performance.

Initial Mental and Behavioral Health Screening

In addition to the early and periodic health screenings, DC HealthCheck guidelines also require mental and behavioral development assessments for all Medicaid-eligible children. These assessments identify needs, as well as mental health-related issues, problems, or risk associated with the child's situation. Psychiatric and psychological services are also made available according to the child's needs.

In 2018, the Agency conducted an internal examination of the delivery of mental health services. As such, the Agency identified a gap in the ability to provide clinically appropriate and timely mental health services through DBH. These barriers impacted placement stability and permanency outcomes for children and families. Therefore, in October 2018, CFSA began providing mental health services in-house, which enables CFSA to provide emergency and short-term therapeutic services to children within the Agency. This implementation will address the critical service gaps and improve timely and appropriate access to quality mental health services.

As with the other screenings, the initial mental and behavioral health screening must occur within 30 days of entry into care. Currently, internal CFSA full-time clinical staff is tasked with conducting mental health screenings that are typically conducted onsite at HHAC but can be

conducted at the child's school, or at any other location where both the caregivers and child may feel safe. Once the mental health screening and initial evaluation are conducted, CFSA clinical staff provide the assessment results and treatment recommendations to the social worker. After receiving the results, the social worker conducts a review of the findings, and either makes a referral to the in-house therapy team for services or to a Core Service Agency or other treatment provider for mental health services. The social worker also develops the case plan to ensure that appropriate services are coordinated. If applicable, the case plan and the NCM plan of care are developed in collaboration with the NCM.

Initial Developmental Screening and Assessment

CFSA conducts initial developmental screenings in accordance with DC HealthCheck guidelines. For all children aged six and under, an initial developmental screening is conducted as part of their comprehensive evaluation. Children under the age of 36 months (three years old) are subsequently referred through HSA to OSSE for a more detailed developmental assessment. The OSSE assessment also involves physical, occupational, and speech therapies. HSA refers all other children to the DC Public Schools (DCPS) Early Stages program for additional screening and assessment. If it is determined that the child has developmental or educational delays, OSSE and DCPS will provide specialized services as needed.

FY 2023 APSR Update

The Agency's benchmark is 90 percent for the number of children aged birth to five years old who receive a developmental screening within 30 days of entering foster care. In FY 2021, 90 percent of children in foster care (ages birth to five years old) received developmental screenings. In FY 2022-Q2, 92 percent of this same age group received developmental screenings.[9]

FY 2024 APSR Update

The Agency's benchmark is 90 percent. During FY 2022 Q3-Q4, 100 percent of the children aged birth to 5 years old received developmental screenings within 30 days of entering foster care.

PREVENTATIVE AND ONGOING HEALTH CARE

This section of the HCOCP describes protocols and procedures to ensure that children in foster care receive preventative and ongoing primary medical, dental, mental, and behavioral health care. It also contains directives regarding periodic assessments of a child's health, development,

[9] CFSA Mayors Performance Plan FY 2021, FY 2022 Q1-Q2

and emotional status to determine any changes and subsequent need for additional services and interventions.

According to the American Academy of Pediatrics (AAP), children entering foster care often experience poor physical health, e.g., chronic disabilities, birth defects, and developmental delays. In addition, children in foster care have higher rates of serious emotional and behavioral problems, and often poor school achievement associated with trauma, i.e., the initial abuse and neglect along with the trauma of removal and entry into foster care. For these reasons, CFSA especially reinforces the importance of a child's health care team working in concert to optimize the child's well-being throughout his or her stay in foster care. As with a child's permanency or case planning team, the team involved with health care contains a cross-section of professionals. In general, a child's health care team includes the age-appropriate child,[10] his or her birth parents, resource parents, social worker, NCM (if assigned), and medical and mental health care practitioners. All members of the child's health care team are expected to consistently and collaboratively partner together with the age-appropriate child to make the best medical and mental health decisions possible.

Overview of Routine Preventative Health Care

To help achieve optimum preventative health care, every child entering CFSA's care has periodic comprehensive medical assessments, also known as well-child visits. These assessments begin at the time of removal when the social worker and HSA nurse obtain the child's critical medical and medication information. The assessments continually inform the child's plan for ongoing health care.

To ensure that a child's preventative health care plan has the greatest possibility for success, the assigned social worker provides the child's resource provider with a copy of the health care plan along with appointment dates for the recommended well-child visits. The social worker and resource provider then work collaboratively to schedule these visits. Although it is the expectation that the resource provider (and when appropriate, a birth parent) will be the primary person to accompany the child to the visit, the social worker (or assigned NCM) may also attend these visits. In the event that a resource provider or birth parent is unable to accompany a child and the visit cannot be rescheduled, the social worker will always accompany the child.

[10] "Age appropriate" is defined as a child with the cognitive and emotional capacity to understand the conversation and the ability to offer his or her thoughtful opinions on their own health care.

In consultation with the HSA nursing staff, the social worker encourages resource parents, as well as the birth parents (as appropriate) to get to know the child's health care practitioner and to discuss or explain any health care issues with the age-appropriate child. Additionally, as part of the teaming process, the resource parent and social worker provide one another with all available information regarding the outcome of a visit as well as any other information related to follow-up activities. Again, and most importantly, birth parents are encouraged to be a part of this teaming process and to participate throughout their child's medical treatment and follow-up (as appropriate).

If a child does not have a currently assigned physician, the following options are available for resource (and birth) parents to select a pediatrician or health care practitioner: (1) opt for a private pediatrician, (2) select a qualified DC HealthCheck practitioner, or (3) choose a pediatrician or health care practitioner identified through the District of Columbia Medicaid provider network. The pediatrician or health care practitioner must accept DC Medicaid as a form of reimbursement.

Once the practitioner is identified, the social worker informs the practitioner that all documentation related to the child's health care must be forwarded to HSA. The social worker ensures compliance with these procedures by engaging the health care practitioner with the support of the child's NCM and resource provider. Lastly, the social worker enters all gathered information into FACES.NET. The social worker places any related documents into the child's official case record.

Well-Child Visits

Following the comprehensive medical evaluation, the assigned social worker coordinates with the NCM, resource provider, and birth parents (whenever appropriate) to ensure adherence to the following AAP guidelines:

1. Initial visits occur once a month after birth for the first six months and then every three months thereafter up until two years of age.
2. Annual visits occur from age two until age 18 which include age-appropriate screenings and assessments.
3. Visits also occur at times of significant changes in placement (such as transfers, reunifications, etc.).
4. Additional visits occur according to current standards for the primary care of specific conditions (if present), e.g., cystic fibrosis, epilepsy, fetal-alcohol syndrome, and HIV.

CFSA's MOA with the District's DHCF (cited above) is anticipated to be operational by the fourth quarter of FY 2019. Meanwhile, CFSA is working on the implementation timeline, including the following components of the well-child visits:

1. Clinical examinations by a pediatrician, pediatric nurse practitioner, or other health care practitioner qualified to provide EPSDT services
   Status: Complete
2. Immunizations consistent with current AAP recommendations for age, including special immunization recommendations for specific conditions that may be present
   Status: Complete
3. Periodic screening tests that are consistent with the current AAP well-child visit schedule, as well as the current professional standards set by DC Health for age and specific conditions
   Status: Complete
4. Health education and anticipatory guidance (e.g., long-term guidance for chronic health care issues) consistent with current AAP recommendations for age
   Status: Complete
5. Updates to the medical condition list and treatment plan at each well-child visit
   Status: Partially Complete

FY 2022 APSR Update

CFSA's Memorandum of Agreement (MOA) with the District's Department of Health Care Finance (DHCF) is anticipated to be in effect through the end of FY 2021. Data sharing meetings with DHCF are held to share child specific medical information about youth in care but were on hold due to DHCF resource issues followed by COVID-19, therefore no data was shared during this time. Data sharing meetings resumed in April 2021 with DHCF concerning well-child visits, dentals, and psychotropic medications. The MOA will be renewed as it expires September 30, 2021.

FY 2023 APSR Update

The MOA is pending final approval. Currently, CFSA assigns an NCM to provide psychotropic medication oversight for children with high-level medical and mental health needs. Social workers can contact HSA if they determine children on their caseload need increased medical or mental health supports.

FY 2024 APSR Update

The MOA remains outstanding. Therefore, CFSA is integrating psychotropic medications into its new electronic health record (EHR) for management.

Currently, the psychotropic medication management program remains in the implementation phase, as it is integrating into the Agency's EHR application, scheduled to launch June 1, 2023. This electronic platform provides an effective way to independently manage and monitor psychotropic medications for children and youth in care (without DHCF data). Protocols for this program align with psychotropic medication standards that include diagnosis, treatment plan, parental consent, and ongoing monitoring associated with mental health improvements, such as stabilized placements, academic growth and decreased usage of psychiatric residential treatment facilities.

The assigned social worker and the resource provider are expected to ensure that the child attends all follow-up appointments. As noted earlier with initial visits, the resource provider, birth parents, or the social worker will accompany the child to each follow-up appointment. The social worker also contacts the health care practitioner regarding referrals, any missed appointments, or other important information. In addition, the social worker provides all updates to the caregivers.

After each well-child visit, the following tasks are completed by the social worker and NCM (if assigned):

1. Review of the child's medical examination record form to determine whether further treatment is recommended, including referrals and medications
2. Contact with the health care practitioner, if necessary, to obtain information on follow-up care and treatment
3. Offer of assistance to the resource parent with follow-up care

Dental Care Services

Comprehensive dental care for children in foster care includes ongoing dental examinations, restorative care, preventative services, and other treatments recommended by the dentist. Follow-up care is required for all conditions identified in the initial dental assessment, which occurs within 30 days of a child entering foster care. The social worker and NCM (if assigned) ensure that the child receives ongoing dental care as prescribed in the District of Columbia Dental Periodicity Schedule. As with other appointments, the social worker, birth parents, or resource provider accompanies the child to all dental appointments, including follow-up care.

The following components are included in preventative dental care visits:

1. Fluoride varnish[11] on newly-erupted teeth to help prevent or stop tooth decay
2. If deemed necessary by the dentist, preventative service sealants on permanent molar teeth at the time of entry into care, and sealants on newly-erupted molars at the preventative visit
3. Timely access to restorative care to promptly address the following dental issues:
    a. Fillings
    b. Root canals
    c. Replacement of missing and damaged teeth
    d. Periodontal care for gum disease
4. Immediate access to the dentist or oral surgeon when acute dental pain or trauma exists
5. Immediate access to medication to relieve dental pain
6. Orthodontics based on medical necessity as deemed by DC Medicaid for severely handicapping dental conditions

The assigned social worker and the resource parent are responsible for ensuring that the child maintains all follow-up appointments, and for accompanying the child to all follow-up appointments. The assigned social worker is also responsible for contacting the dentist regarding follow-up appointments, referrals, missed appointments, or other important information. In addition, the social worker provides all updates to the resource provider.

Mental and Behavioral Health Services

Children in foster care deserve timely and individualized professional diagnoses, treatments, and services for any mental or behavioral health needs identified either in the initial mental health screening or during subsequent assessments. Currently, following initial screenings, the Office of Well Being's (OWB) clinical unit can provide an array of evidence-based mental health services, including assessments, consultations, and linkages to mental health providers and resources. For more intensive behavioral and mental health needs, OWB conducts inpatient referrals for acute care and residential treatment. In addition, OWB provides mental and behavioral health services for biological parents and families and resource providers.

[11] "Fluoride varnish provides extra protection against tooth decay when used in addition to brushing. Fluoride varnish is a pale, yellow gel that sets quickly when applied to children's teeth using a soft brush. The varnish sets quickly, has a pleasant taste and a fruity smell. Scientific studies have shown that fluoride varnish gives added protection to teeth against decay when used in addition to brushing teeth regularly with fluoride toothpaste." Retrieved in June 2016; http://www.child-smile.org.uk/parents-and-carers/fluoride-varnishing.aspx

As stated earlier, the Agency conducted an internal examination of the delivery of mental health services to both in-home and out-of-home families, particularly as it relates to the accessibility, timeliness, and continuity of needed supports. After considering several improvement strategies, the Agency elected to bring mental health services in-house. The in-house services enable CFSA to provide emergency and short-term therapeutic services to children within the Agency. CFSA identified and filled new positions to support the redesign, increased internal capacity to connect children to services in a timely manner, and developed a strategic communications and implementation plan around the redesign that engage key stakeholders.

Mental Health Services

In-House Supports

As part of the FY 2022 updates, the mental health status exam named throughout this document is now named the "initial screening." The diagnostic intake assessment is now named the "mental health evaluation."

During CFSA's 2016 Child and Family Service Review (CFSR) the indicator titled, "Mental/Behavioral Health of the Child," was rated as an overall "Area Needing Improvement". In general, it was found that initial assessments were adequate to identify mental/behavioral health needs of children, but some cases did not have follow-up or ongoing assessments to determine the need for continued services or to determine if there were any changes in the child's needs. In addition, there were cases where services were not provided due to insurance problems, or therapists/providers either quit or were changed.

In FY 2018, CFSA initiated the Agency's Mental Health Redesign, a plan to improve initial access to mental health treatment for children in foster care, including medication management. The redesign included hiring three licensed therapists (clinical social workers, licensed professional counselors, and psychologists) to screen, assess, diagnose, and treat all children entering care. A psychiatric nurse practitioner will join the team in FY 2020 to complete psychiatric evaluation and provide medication management. Already a practice for children entering foster care, CFSA will continue to conduct mental health and trauma screenings.[12] In addition, every child entering care receives a mental health status exam as one component of clearing them for placement.

[12] Screening tools include Ages and Stages Questionnaire Social- Emotional (ASQ-SE), Strengths and Difficulties Questionnaire (SDQ), Global Appraisal of Individual Needs- Short Screener (GAINS-SS), and Trauma Symptoms Checklist for Children and Younger Children.

The goal of the OWB's Mental Health Redesign is to decrease the length of waiting time for children and families to access clinical and therapeutic interventions that support strong mental health and wellness. Children who are receiving mental health services in the community will continue to receive services from the community provider.

Children who are not connected to but demonstrate a need for mental health services are quickly linked to one of the Agency's four internal therapists for short-term treatment of up to 12 months (as needed). As of the date of this report, 47 children are being served by CFSA therapists. The internal mental health unit is trained and able to provide the following therapy interventions:

- Trauma Systems Therapy (TST)
- Family Therapy
- Child-Centered Play Therapy
- Grief and Loss Therapy
- Cognitive Behavioral Therapy (CBT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Traditional Integrative Approach

In December 2019, a new position was added and an HHAC Psychiatric Mental Health Nurse Practitioner (PMHNP) joined the OWB team. Implementation of the PMHNP position provides the opportunity for a licensed professional to conduct initial screenings, mental health evaluations, and initial treatment plans. The PMHNP also allows for the engagement of youth in therapy services in a short time frame.

For children entering care, the PMHNP completes the Initial Risk Screening and Mental Status Exam (MSE). From the initial screening, the PMHNP determines the following needs for the child:

- Immediately safe for placement
- Psychiatric hospitalization needed based on acute psychiatric symptoms
- Behavioral health evaluation needed, including scheduling and submission of an initial screening form to program support staff

Based on information from the initial screening and risk assessment, the licensed clinical therapist will conduct a diagnostic intake/mental health evaluation to determine a diagnosis for a child within 30 days of the child entering care. Every child who is determined to need the

diagnostic intake assessment will receive one regardless of whether they are entering care with a diagnosis or with an assessment completed elsewhere.

CFSA's licensed clinical therapists conduct ongoing therapy for these children as deemed necessary. Therapists create and update the child's treatment plan every 90 days. In addition, for those children who need medication, the psychiatric nurse practitioner will prescribe medication and provide medication management at least every 30 days for children.

FY 2024 APSR Update

CFSA is in the process of hiring two therapists to provide community- and home-based therapy, in addition to the traditional office-based therapy provided for Out-of-Home and In Home cases.

CFSA continues to provide in-house therapists who are available to all children in foster care. The CFSA Office of Well-Being's (OWB) in-house therapy team includes one supervisor, four clinical therapists, and one psychiatric mental health nurse practitioner. Two of the therapists are bilingual (Spanish). In FY 2022, CFSA expanded the availability of its in-house therapists to include the ability to serve In-Home clients. Additionally, CFSA is seeking to provide community and home-based therapy to clients when it is clinically indicated to do so. This is an expansion of service delivery. Up until FY 2023, CFSA provided in-house services in the office setting or virtually. Children who are not connected to mental health services and have a need to receive mental health services are linked to one of the Agency's four in-house therapists for short-term treatment of up to 12 months (as needed).

From April 2022 to March 2023, the average length of time between receiving a mental health evaluation and beginning therapy was 17 days. From April 2022 to March 2023, the OWB in-house therapists served 41 children. As of March 31, 2023, OWB in-house therapists were actively serving 40 children and youth.

The CFSA process for mental health evaluations will continue through FY 2024. Any new practitioners hired during FY 2023 will be fully trained in the assessment process as part of their onboarding plan. In addition to internal training, the OWB therapy team has access to virtual training on diagnostic assessment. For those children who need medication, the licensed psychiatric mental health nurse practitioner (PMHNP) will prescribe psychotropic medication and management at least every 30 days. Between April 2022 and March 2023, the PMHNP prescribed medication to four children.

Between April 2022 and March 2023, the PMHNP and the clinical therapists conducted 32 mental health evaluations within the required 30 days to determine clinical diagnosis. OWB conducted another 12 evaluations after 30 days.

Long-Term Supports

In FY 2020, CFSA began contracting with a local core service agency, MBI Health Services, to provide long-term therapeutic support to youth and families. This contract allows CFSA to ensure a seamless transition for youth and families in need of long-term mental health support. In addition, youth and families are referred to MBI if the clinical teams identify the need for community-based wraparound services at the onset.

MBI Health Services began accepting referrals in January 2020. At the time of this report, CFSA has referred a total of 12 children. Five of the children are currently being served while seven have been discharged due to completing treatment. MBI provides the following specialized mental health interventions:

- Diagnostic assessments
- Psychiatric evaluations
- Medication management
- Individual and family therapy
- Community support services
- Specialized therapies

FY2024 APSR Update

As of March 30, 2023, CFSA continues to contract with MBI Health Services, LLC (MBI) as the CFSA long-term mental health provider. The services offered (see above list) continue. Between October 2021 and September 2022, CFSA referred nine children to MBI. Between October 2021 and February 2023, CFSA referred a total of 21 children to MBI. Between October 2022 and March 2023, CFSA referred 12 children. Of these referrals, MBI currently continues to serve 12 children internally. Under the MBI contract, an additional four youth are receiving dialectical behavioral therapy (DBT) via a specialized DBT provider. MBI discharged the remaining nine children either for successful completion of treatment, lack of engagement, lack of response to outreach efforts, or refusal to participate in the specific treatment being offered.

For children case-managed by CFSA's contracted partner in Maryland, the National Center for Children and Families (NCCF), mental health treatment referrals go through NCCF's contract with Maryland Family Resources.

Quality Assurance for Preventing Inappropriate Diagnoses

The licensed CFSA clinical therapists work closely with the psychiatric nurse practitioner to ensure that appropriate diagnoses, medication management and ongoing treatment needs are met. In addition, the therapists receive regular supervision and oversight from their direct supervisor and program manager, who are also licensed clinicians. During supervision, there is a review of any diagnosis, case notes and any progress made by the child. The supervisors and therapists also discuss the current treatment modality and any other modalities that might improve the child's condition.

Developmental Services

Children entering out-of-home care most often come from families that have experienced chronic poverty, homelessness, poor education, unemployment, substance abuse, mental illness, and domestic violence. Some of these children experience problems in physical growth and cognitive, social, or emotional development resulting from abuse and neglect, premature birth, or poor prenatal and infant health care. The effects of these experiences are then compounded by the separation, losses, and uncertainty accompanying out-of-home placements. Developmental services for children in foster care are designed to address the circumstances just described.

Pursuant to the *Child Abuse Prevention and Treatment Act* (CAPTA), CFSA requires all children under three years of age who are involved in a substantiated case of child maltreatment to be screened for developmental delays. Children older than three years of age receive age-appropriate developmental assessments at routine medical visits. As noted earlier in this document, children between the ages of three and five years receive further evaluation by DCPS Early Stages, which is designed to identify, evaluate, and provide services for children who have special needs in this age category.

To ensure timely access to services, the assigned social worker partners with the resource parents, birth parents (when appropriate), and HSA to facilitate the process for referrals. The following guidelines reinforce the importance of every child's developmental progress:

1. Each well-child visit includes an assessment of the child's developmental, educational, and emotional status based on an interview with the resource provider, standardized tests of development, and a review of school progress (when applicable). For all children, the assigned social worker and HSA ensure that children are assessed as prescribed by the EPSDT Periodicity Schedule.
2. Children at risk for developmental delays are provided formal developmental assessments at regular intervals (as determined by the EPSDT Periodicity Schedule). In this manner, the potential delays are identified as early as possible, particularly for

those who were born prematurely or born to mothers with alcohol or substance abuse problems. All HIV-infected children are included in the schedule.

3. Developmental services include the diagnosis and treatment of all identified developmental delays and deficits, in addition to developmental treatment services such as speech and language therapy, occupational therapy, physical therapy, behavioral services, and services for the hearing and visually-impaired.

FY 2024 APSR Update

Between June 2022 and February 2023, 100 percent of children entering care, aged birth to 5 years old, received development assessments.

Management of Medical Conditions

Children in foster care may experience serious or chronic medical conditions that need ongoing treatment and monitoring (e.g., asthma, seizures, vision and hearing impairments, or chronic infectious diseases). Ongoing primary and specialized health care includes the management of such conditions.

1. When a child has a chronic illness or condition requiring long-term medical, dental, mental, or behavioral health services, a treatment plan is established by the primary health care practitioner. This plan details the proposed treatment, treatment goals, and any risks or benefits. To ensure success of the plan, the assigned social worker encourages the birth parents to participate directly in the implementation of the plan. Information on any conditions and treatment plans for the child is also shared with the resource provider. Final decisions for care, however, are the responsibility of the birth parents, primary health care practitioner, and CFSA.
2. The ongoing social worker and NCM (if assigned) ensure that the resource providers and the birth parents are provided with appropriate training to manage the day-to-day health care of the child. The HSA nurse also follows up with the health care practitioner to manage the following health care activities:
    a. Coordination of the treatment planning between the primary health care and specialty health care practitioners, if needed
    b. Facilitation of follow-up care as recommended by the primary health care practitioner for any identified conditions
    c. Coordination of a multidisciplinary approach for children with complex chronic medical, mental health, and behavioral problems

Acute Illness and Injury or Emergency Care Procedures

Comprehensive health care includes treatment for acute illness and injury. When needed HSA assists the assigned social worker in ensuring that children who are experiencing an acute illness or injury receive timely access to appropriate professional health care, accessible after-hours advice and care, and prompt access to prescribed medications, including timely administration of the medications by the health care practitioner and monitoring and accountability for proper administration of medications.

In any emergency situation, the assigned social worker makes every effort to notify the birth parents at the first opportunity. If necessary, treatment may proceed as prescribed by the health care practitioner with the consent of CFSA.

1. CFSA recognizes that emergency care is imperative for attending to life-threatening conditions. Emergency room care shall be utilized only in the following situations:
    a. When medically necessary
    b. When no other 24-hour care is available
    c. When injuries indicate the need
    d. When hospitalization is recommended
2. In the event of a life-threatening circumstance, the following steps shall be taken for accessing emergency care:
    a. The resource parent shall immediately call *911* and follow the operator's instructions. At the first opportunity (no later than 30 minutes), the resource parent shall notify the CFSA Hotline.
    b. After the resource parent has given the information to the Hotline on the life-threatening incident, the resource parent contacts the assigned social worker.
    c. The Hotline worker follows the notification procedures outlined in the *Critical Events Policy*, including notification to the HSA administration.
    d. The assigned social worker meets the resource parent and child at the emergency room.
    e. When necessary, CFSA may consent to emergency medical, surgical or dental treatment, or emergency outpatient psychiatric treatment without first obtaining consent from the parents or legal guardians.

FY 2022 APSR Update

1. When necessary, CFSA may consent to emergency diagnostic treatment. Surgical or dental treatments requiring anesthesia, or emergency psychiatric treatments require consent by the parents or legal guardians.

2. If the legal guardian is not available and the diagnosis is life threatening, two physicians can make a determination to provide emergency care.

HSA staff teams with the assigned social worker, the resource parents, and the birth parents to follow up on the prescribed plan of care and discharge planning. The assigned social worker provides the resource parent with assistance to ensure that he or she is fully informed as to the child's ongoing health care needs and that the proper supports are provided. The assigned social worker is also responsible for engaging the child's birth parents in treatment planning and services, including granting permission for treatment and authorizing medications, as appropriate.

Mental Health Services and Supports

Guidelines for Minors (under age 18) Receiving Inpatient Care

Consent of parents or legal guardians is required for any minor to be admitted for inpatient mental health services. Further, consent of parents or legal guardians, or authorization of the Family Court is required before a hospital providing inpatient mental health services may administer a psychotropic drug to a minor. Social workers are responsible for making all efforts to obtain the consent of the biological parent when the biological parent's rights have not been terminated. Social workers will consult with HSA for information on the administration of psychotropic drugs to a minor.

Emergency Mental Health Treatment

When there is a mental health emergency involving a child, the Children and Adolescent Mobile Psychiatric Service (ChAMPS) of Catholic Charities of the Archdiocese of Washington is a 24-hour and 7-day-a-week resource that can and should be contacted immediately by the resource provider, school personnel, the assigned social worker, or other CFSA or private agency staff. Once contacted, ChAMPS is dispatched to the location of the child to attend to the situation and determine the most appropriate course of action. The assigned social worker shall be notified immediately or at the first available opportunity (i.e., if the social worker is not making the initial call to ChAMPS).

The assigned social worker notifies the supervisor, the parents or legal guardians, OWB administrator or designee, and the assigned assistant attorney general (AAG) that ChAMPS has been contacted. If prior consent has been provided by the parents or legal guardians for mental health treatment, a copy of the written consent is provided to the AAG and OWB administrator or designee. When the parents or legal guardians are not available to provide consent (and reasonable efforts have been made to locate the parents or legal guardians to obtain written

consent), the social worker and OWB confer with the assigned AAG to determine the appropriate relief to seek from the Family Court. The AAG also files the appropriate motion with the Family Court.

Non-Emergency Outpatient Psychiatric Treatment

When CFSA has physical custody of a child during the 72-hour period prior to the initial Family Court hearing, CFSA may consent to non-emergency outpatient treatment for a child when reasonable efforts to obtain the parents or legal guardians' written consent have been made but the parents or legal guardians cannot be consulted. Whenever CFSA believes non-emergency outpatient psychiatric treatment (beyond the 72-hour time period outlined above) is necessary for the child's well-being and parents or legal guardians refuse consent or are cognitively unable to provide consent or are unable to be located to grant consent, CFSA will file the appropriate motion with the Family Court to authorize the services.

Non-Emergency Inpatient Psychiatric Treatment at a Substance Abuse Treatment and Detox Program

Before a child can be admitted to a substance abuse treatment and detox program, CFSA must obtain consent from the parents or legal guardian or obtain a Family Court order for treatment. If there is a need for medication, it must be addressed with consent from the parents or legal guardian. If neither is available CFSA will consult the AAG for next steps on a case-by-case basis.

CONTINUITY OF SERVICES AND MEDICAL RECORDS MANAGEMENT

The Agency's policy on *Medical Records Maintenance* outlines conservative Agency standards for the careful maintenance of medical records and to ensure the timing and effectiveness of health care services provided to a foster child. It is essential to maintain these records in an organized format, and to have them easily accessible to the assigned social workers, their supervisors, HSA (including HHAC), and others deemed necessary. This is particularly true in the event of staff turnover, case transfer, placement change or disruption, or other potential case changes. Policy dictates that medical records should be comprehensive, concise, and contain accurate information and documentation of the child's health history. It is also important that the child's medical records are reviewed and monitored on a routine basis to ensure accuracy of vital health care information. Maintenance of the information is the primary responsibility of HSA in consultation with the assigned CFSA or private agency social worker.

It is the FACES.NET case record in general, and the health care information module specifically, that ensures continuity of health care services. The maintenance of both the physical record and the information recorded in FACES.NET reflect the following quality assurance checkpoints:

1. A diligent standard of maintenance allows for ease of access to critical health data.
2. A system of standardized processes is flexible enough to account for the unique health situations for each child.
3. A comprehensive health history and health plan for each child reflects thoughtful information management.
4. There is an accurate accounting of the child's past medical history, current health status, and proposed future plan of treatment.
5. A high standard and respect for individual confidentiality and privacy exists for each child's record.

Standards, Responsibilities, and Activities of Records Maintenance

The primary responsibility for maintaining the child's medical records is that of the assigned social worker and HSA, including the following case record standards:

1. Records include notes that reflect current and past health and medical information and activities.
2. Current and past child health and medical information, and documents are included in records.
3. Records contain all forms and documentation pertaining to medical consent.
4. Records are maintained in an organized format to provide accessible, accurate, and concise health and medical information.

The Initial Medical Record

In the initial health care record, the CPS social worker, in collaboration with HSA, completes the following tasks:

1. Compiles a medical record containing all known past and current health care and medical activities and information, including a copy of the initial screening documentation, and any treatment plans for on-going health care.
2. Obtains signed consent forms from the child's parents or legal guardians for the release of past medical records and medical history, if applicable.
3. Obtains in writing health records from any known previous and current health care providers.
4. Verifies health and medical activities of the child through DHCF, Medicaid, DC Health (formerly DOH) public health records, and private providers.
5. Records include all medical-related activities, including the initial medical screening information, into the child's case record and into the medical screens in FACES.NET.

In consultation with the assigned social worker, HSA is also responsible for ensuring that the health care information accompanies the child to the initial comprehensive medical evaluation visit (i.e., EPSDT).

Child's Health History

All known information and documentation regarding a child's health and medical history is contained in the case file.

1. All collected medical history information, including the child's medical history from all known health care providers and all medical information available from the public health system (including Medicaid), is inserted into the appropriate section of the official hard copy of the case file.
2. The following critical information is included:
    a. Child's birth history
    b. Developmental history
    c. Previous and current health care providers
    d. Previous and current insurance carrier
    e. Previous and current diagnoses
    f. Previous and current major treatment (including previous and current prescription history)
    g. History of hospitalization
    h. Known drug or other allergies
    i. Previous and current mental and behavioral health information

Monitoring of Medical Information in the Official Case Record

The supervisor of the assigned social worker is responsible for monitoring and reviewing the medical information in the child's case record and for completing the following tasks:

1. Reviewing the medical status of the child with the assigned social worker and ensuring that the information is documented in the appropriate FACES.NET screens
2. Reviewing case files for compliance with Agency standards
3. Requesting the social worker to gather additional health information where deemed necessary
4. Seeking consultation from HSA or requesting information where additional information is necessary to ensure prescribed Agency standards

Organization of Medical Records

All medical records shall contain the following categories of information:

1. A summary of all current and historical information on the child's health, including the following information:
    a. Client name
    b. FACES.NET identification number
    c. Assigned social worker
    d. Date of birth (DOB)
    e. Height and weight (and date of most recent measurement)
    f. Gender
    g. Primary care provider (PCP) name and contact information
    h. Insurance carrier and number
    i. Medicaid number (or copy)
    j. Emergency contact and next of kin
    k. Major diagnosis and/or treatment (historical or ongoing), if any
    l. History of hospitalization(s), if any
    m. Notifications and precautions for children with special needs, if any
    n. Consents for release of information including a list to release private health information
    o. Known drug or other allergies
    p. Parents or legal guardian name and phone numbers
2. Information on the child's medication history, provided by the child's health care provider, including the following details (as applicable):
    a. Current medications (including psychotropic medications), dosage, and frequency, and mode of administration (e.g., oral, suppository. inhaler, etc.)
    b. Past medications (including psychotropic medications), dosage, and frequency
    c. Drug allergies
    d. Insurance carrier
    e. Pharmacy
    f. Prescribing physician
    g. Special instructions
    h. Other significant information

3. Documents collected from health care providers, including the following information:
    a. Medical assessments
    b. Immunizations
    c. Dental assessments
    d. Mental and behavioral health screenings and applicable assessments
    e. Developmental screenings and applicable assessments
    f. Vision and hearing screenings and applicable assessments
    a. Substance abuse assessments, if applicable
    b. Past medical records
    c. Laboratory and radiology reports
    d. Pre-placement screening medical records (with the exception of the results of the HIV screening)
    e. All applicable consent forms (from the parents or older youth)
    f. Face-to-face visitation tool
    g. Discharge Form
    h. Other Agency forms and medical notices

Confidentiality and Health Information

The medical section of the case file reflects all privacy or sharing transactions, including the following documentation:

1. HIPAA[13] forms, signed by parents or legal guardians
2. Consent for the release of information
3. Requests for private health information
4. The release, or receipt, of private health information
5. Consent to receive treatment
6. Any other documentation related to private health information

FY 2022 APSR Update

In 2020, CFSA chose to participate in the Chesapeake Regional Information System for Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law,

[13] Health Insurance Portability and Accountability Act

CFSA is able to retrieve health information through this exchange in order to provide faster access to records and better coordination of care, and to assist providers and public health officials in making more informed decisions.

In regard to HIV or AIDS-related documents, these are all kept strictly confidential within the CFSA case record. HIV-related medical information (e.g., HIV risk assessment materials, test results, treatment reports) are maintained in a sealed manila envelope in the medical section of the case record. The envelope is clearly labeled "Confidential" and instructions appear on the outside of the envelope as to who may have access to the information. The number of personnel who are aware of the child's condition is kept to the minimum to assure proper care and treatment of the child in accordance with CFSA's policy on *Confidentiality*. Some personnel may be privy to such information if knowledge of the HIV test results is relevant and necessary to their decisions and actions relative to the care and treatment of, or permanency planning for the child. Generally, access is limited to the social worker, supervisor, and program manager, or administrator directly responsible for investigating abuse or neglect or for providing or securing care and services for a child or family. The HSA administrator, the HHAC nurse practitioner, NCM (if assigned), and parents and legal guardians have access unless the age-appropriate child has indicated that they do not want the information to be shared with birth parents or legal guardians. Additionally, written consent may be obtained from the child who is of age and mental status to give informed consent, and to share information with others such as medical or dental care providers, for specific purposes.

OVERSIGHT OF PRESCRIPTION MEDICATIONS

The purpose of medication depends on the child's medical or mental condition and needs. Foster parents, staff of residential facilities, guardians, and other caregivers (collectively referred to in this section as "caregivers") and age-appropriate children should be fully informed of the purpose of any prescribed medications.

Caregivers are responsible for understanding and following directions given by the prescribing health care practitioner to ensure compliance with medical recommendations and to avoid medication errors. For medications prescribed during the course of scheduled or emergency medical visits, the caregivers are expected to administer medications in accordance with the instructions of the health care provider. The assigned social worker facilitates this process by ensuring that the caregivers have the resources necessary to comply with medical recommendations, particularly as these resources pertain to the administration of medications.

Pursuant to Agency policy, this section of HCOCP sets forth the responsibilities of both the assigned social worker and the caregivers, in addition to describing the instructions for CFSA

social workers and caregivers to ensure proper medication administration and management. The section also delineates medication consent authority.

Medical Consents

Consents Required for Regular Medication

1. Consents from parents or legal guardians are not required for routine medical care, including the administration of non-psychotropic medications. *Best practices, however, dictate that social workers engage parents or legal guardians to participate in the decision-making process, and to provide consent prior to any routine medical procedures*.
2. Consents from parents and legal guardians are required for non-routine medical and mental health evaluations and treatments, based on each occurrence. All efforts regarding consent for non-routine evaluations and treatments are documented in FACES.NET. A copy of the consent form signed by the parents or legal guardians for non-routine medical care is provided to the child's primary care provider and any other providers treating the child, including the assigned NCM, if applicable.

Consents Required for Psychotropic Medications

1. Consent of parents or legal guardians is required for any minor to be admitted for inpatient mental health services. In addition, consent of a parent or guardian, or authorization of the Family Court is required before a hospital may administer a psychotropic drug to a minor who is receiving inpatient mental health services.
2. Consent from the parents or legal guardians is required for the administration of psychotropic medications (regardless of whether the child is receiving inpatient or outpatient services) unless there has been a termination of parental rights (TPR) or a relinquishment severing the rights of all parents.
    a. If the parents or legal guardians refuse to consent and it is clinically determined that the medication is in the best interest of the child, the social worker and HSA confer with the assigned AAG. The AAG determines whether to file a motion with the Family Court to override the parent or legal guardian's refusal to provide consent.
    b. If the parents or legal guardians are not available to provide consent (and reasonable efforts have been made to locate the parent or legal guardian to obtain written consent), the social worker and HSA confer with the assigned AAG to determine the appropriate relief to seek from the Family Court. The AAG files the appropriate motion with the Family Court.

c. There may be some health care providers who will only accept the consent of parents or legal guardians for administration of psychotropic medication. For a minor who is 16 years of age or older and receiving inpatient treatment, psychotropic medication may be administered solely with the minor's consent under one or more of the following circumstances:

   i. The minor's parents or legal guardians are not reasonably available to make a decision regarding the administration of psychotropic medication and the treating physician determines that the minor has capacity to consent that such medications are clinically appropriate.

   ii. Requiring consent of the minor's parents or legal guardians would have a detrimental effect on the minor, and a determination is made by both the treating physician and a non-treating psychiatrist (who is not an employee of the provider) that the minor has capacity to consent and that psychotropic medications are clinically indicated.

   iii. The minor's parents or legal guardians refuse to give such consent and a determination is made by both the treating physician and a non-treating psychiatrist (who is not an employee of the provider) that the minor has capacity to consent and that such medications are clinically indicated.

3. Parents or legal guardians must consent for the psychiatric treatment and the administration of psychotropic medications for a child in outpatient care. If the parents or legal guardians will not provide consent or are unable to provide consent, the assigned social worker follows the procedures outlined above.
4. If a TPR is in effect for the parents or legal guardians, the following guidelines apply:
   a. CFSA is the legal guardian of the child and may consent until the child is adopted.
   b. The HSA administrator or designee has the authority to provide consent for routine and non-routine evaluation and treatment, health services, and the administration of psychotropic medications.

Note: Social workers are not considered a designee in the above cases, unless specifically authorized in writing by the HSA administrator.

Administration of Medication

When a child has completed the pre-placement or re-placement screening at HHAC, the nurse practitioner provides the social worker with any prescribed medications for the child. The nurse practitioner provides clarification on the dosage, frequency, route of administration, directions for use, refills, expiration date, and possible side effects of all medications. The social worker provides this same information to the resource provider when the child is placed. The resource

provider is expected to request this information from the health care practitioner at all subsequent medical appointments.

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When a child has completed the pre-placement or re-placement screening at HHAC, the nurse practitioner provides the social worker with the prescription for the child. The nurse practitioner provides instruction on the dosage, frequency, route of administration, directions for use, refills, and possible side effects of all medications. The nurse practitioner also provides the social worker with a "cleared for placement" form that includes the same information provided in the child's Placement Passport packet.

For medications prescribed during the course of any medical appointment, the resource provider is expected to administer medications in accordance with the instructions of the health care provider. If the social worker has any knowledge of a resource provider's refusal to comply with the administration of any medication, the social worker reports this information to their supervisor and consults with HSA in order to remedy and ensure compliance with the directives of the health care practitioner.

When medications are taken during the regular school day, the prescribing health care practitioner must write a separate prescription for the school administration to follow. Instructions include the purpose of the medication as well as clear directions on administration. The assigned social worker ensures that the school administration receives the medication instructions along with the medication in the original container dispensed by the pharmacy.

All medications, including over-the-counter items and vitamins, are kept in their original container and brought to medical appointments, except as allowed below when both the original container and pill organizer is brought to all medical appointments.

If blood work or other tests are ordered, the social worker advises the resource provider that all tests need to be completed within the timeframes directed by the health care practitioner.

Administration of Psychotropic Medication

Psychotropic medication can be an integral part of a comprehensive mental health treatment plan. Proper monitoring and administration of the medication is critical to ensuring that the medication supports the child's therapeutic goal. Birth parents or legal guardians are encouraged to participate in the meeting with the treating child or pediatric psychiatrist.

CFSA hired a psychiatric mental health nurse practitioner to develop a psychotropic medication management program based on evidence-based practice methods and trends.

CFSA and DBH are still working through the mechanics of on-going monitoring by DBH. For guidance, the MOA establishes the terms and conditions under which the parties are able to sufficiently coordinate and share data and information to identify children who are enrolled under the Medicaid program, and who have been prescribed psychotropic medication over the past 12 months.

1. Before a child is prescribed psychotropic medication, the following steps must be taken:
    a. The treating psychiatrist performs a clinical assessment that follows the criteria mandated by the American Academy of Child and Adolescent Psychiatry, including necessary lab work.
    b. The social worker requests a diagnosis from the treating psychiatrist and inquires whether there is a need to prescribe psychotropic medication.
2. If psychotropic medication is recommended by the treating psychiatrist, the social worker immediately notifies and informs the birth parents or legal guardians (if they are not present at the appointment) as well as the child's caregivers and NCM (if assigned).
3. The social worker, treating psychiatrist, birth parents or legal guardians, caregivers, and NCM (if assigned) share information regarding the diagnosis and treatment plan, including the effectiveness, progress, and potential side effects of the medication on the diagnosed condition. The following information is shared:
    a. Reasons given by the psychiatrist for prescribing the medication
    b. Type, dosage, and date of medication prescribed
    c. Instructions for administering the medication
    d. Information on expected benefits and possible side effects of the medication
    e. Impact of the medication on the targeted symptoms
    f. Results and outcomes of the medication
    g. Information from appropriate persons who are familiar with the child's overall functioning, e.g., teachers and daycare providers
4. Consent from the parent or legal guardian is required for each individual psychotropic medication and may be required for each change in medication dosage. (See CFSA's *Medical Consents* policy.)
5. For monitoring purposes, the prescribing psychiatrist re-evaluates the child's mental health status and condition on a monthly basis or at the time the medications are scheduled to be refilled (within five days of the prescription expiration) with mutual involvement of the social worker, NCM (if assigned), caregivers, and birth parents or legal guardians, when appropriate.

6. The social worker notifies the primary health care practitioner, NCM (if assigned), and other members of the child's family team of any new medication or changes in medication.
7. The social worker and NCM (if assigned) confer with the HSA administrator and the co-located DBH staff for referral to the DBH provider when mental health expertise and consultation is needed.
8. The social worker enters the following documentation in FACES.NET:
    a. Drug, dosage, and frequency of the prescribed medication
    b. Child's reaction to the medication
    c. Monthly follow-up reports by the treating psychiatrist
    d. Ongoing lab work required to monitor the prescribed medication
9. For children in psychiatric residential treatment facilities, the residential specialist provides monthly on-site monitoring and clinical assessment of the child's treatment plan and service needs (including monitoring the progress of the child's educational needs). The residential specialist confers with the assigned social worker and together they track the progress of the child towards case plan goals and a positive discharge plan. The social worker also enters all data into FACES.NET.

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CFSA's psychiatric mental health nurse practitioner (PMHNP) implemented the first phase of the psychotropic medication program. This program serves children and youth either case managed by the PMHNP or those with assigned nurse care managers.

Administration of Over-the-Counter Medications

Social workers advise all resource providers to consult with the primary health care provider (during office visits or by telephone), as well as with the HSA nurse practitioner or the pharmacist, to determine which over-the-counter medications (including vitamins) can be administered to children in their care. Over-the-counter medications shall be administered according to the manufacturer's label, unless there are written or verbal contraindications or other directions given by a treating physician, HSA, or a pharmacist.

Administration of Medications in Emergency Situations

In emergency situations, the social worker calls the 24-hour HSA on-call manager and follows any given directions.

Best Practices for Administering Medication

Best practices for administering medication to children in care follow the commonly accepted standard of safety, i.e., the "five rights" of medication administration: *right person*, *right medication*, *right dosage*, *right mode of administration* and *right time*. The five rights serve as reminders to reinforce thoughtful and attentive administration of medication.

The decision regarding who will administer medications is integral to the administration and management of medications. Equally important is the information that needs to be conveyed to those administering the medication. For a child to self-administer medication, factors such as the child's age, ability to prepare and self-administer the medication, and willingness to do so are important considerations. The resource provider is expected to supervise the child who has permission to self-administer medications.

1. Prescription medications are given to a child in care only on the instructions of a physician or other licensed health care practitioner. The resource provider is expected to supervise and administer the exact amount of the medication.
2. The resource provider confirms the following information with the prescribing physician or the health care practitioner:
    a. Child's name
    b. Name of the drug
    c. Date
    d. Mode of administration
    e. Dosage
    f. Frequency
    g. Time
    h. Directions for use
    i. Precautions
    j. Refills
    k. Expiration date

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The Expiration date (letter k above) was removed as this is not confirmed by the health care practitioner but by the pharmacist.

1. The resource provider also informs the assigned social worker within 1 business day if a licensed health care practitioner prescribes any medication, including over the counter medications. The assigned social worker documents this information in FACES.NET.
2. For youth residing in congregate care facilities, a licensed health care professional administers medications, unless a physician has authorized facility staff to administer medications or the youth is authorized to self-administer medications.

a. The birth parents or legal guardians provide consent.
b. All staff administering or supervising the self-administration of medication are adequately and properly trained.
c. When youth are permitted to self-administer medication, facility staff is responsible for providing training concerning administration procedures and for providing oversight to ensure compliance with prescription guidelines.
d. The facility's staff documents the administration of the prescription medication and notifies the health care professional. Staff also records significant changes in the child's behavior or health.
e. Medication is administered in a manner that allows a youth to keep their need for medication confidential.

3. The assigned social worker documents on the FACES.NET medical screen all matters related to administration of medication. The assigned social worker also consults with HSA, when needed.

Social workers are expected to help resource providers understand the following guidelines for proper administration of medication:

1. Verify the information with the age-appropriate child.
2. Ensure that medications are administered under sanitary conditions (e.g., hand washing and wiping down counter tops with anti-bacterial cleaning supplies).
3. Observe the child taking the full dose of medication or receive verbal confirmation from the age-appropriate child. Also observe closely for potential side effects.
4. Store the medication as directed, taking into account room temperature, safety, and secure storage that prevents access by others, particularly children who are not approved for self-medication administration.
5. Have a list of the child's medication record readily available at all times.
6. Advise the resource provider to utilize any of the following approaches when a child refuses to take medication:
    a. Talk with the age-appropriate child to identify the reasons for refusal (e.g., taste, after-taste, route of administration, or side effects). Stress the importance of the medication he or she is refusing to take.
    b. Explain to the child that it is not only their right but it is appropriate for them to share medication-related concerns with the health care provider at the next visit.
    c. If the child has a chronic condition that requires medication (e.g., seizures or asthma), talk to the health care practitioner or HSA to determine the appropriate course of action for maintaining prescription medication compliance. The

resource provider should inform the social worker of the results of the discussion.

Medication Errors

Situations related to medications errors may occasionally arise and require attention. The following examples of medication errors are expected to be addressed by the resource provider as soon as possible:

1. Missed medication
2. Wrong medication
3. Wrong dose of medication
4. Medication given at the wrong time
5. Medication given to the wrong child
6. Medication given via wrong route or method
7. Expired medication administered

In the event that any of the above medication errors occurs, the resource provider is expected to immediately contact the health care practitioner or pharmacist for advice. Resource providers also contact the assigned social worker or HSA.

Storage, Inventory, Disposal of Medication

Social workers advise resource providers of the following guidelines regarding the storage of medications:

1. All medications that require refrigeration are refrigerated.
2. Child safety caps are requested and used for all medications.
3. A cool, dry, dark cupboard is the best storage for most medications unless otherwise directed by the health care practitioner or pharmacist.
4. All medications are kept in a safe place and out of the reach and sight of children who are not allowed to self-administer.
5. All medications are kept in the container in which they were received from the pharmacist. The information on the label is intact, and properly identifies the patient, provider, medication, instructions for use, and date the prescription was dispensed.
6. In consultation with the health care practitioner, a resource provider may put medications in a pill organizer to better organize and track the child's use of prescribed medications. This may be useful for children who take more than one dosage of a medication throughout the day.

7. For children in congregate care facilities, storage, and inventory shall entail the following guidelines:
    a. All medications are stored in a safe, locked, and sanitary area. Controlled substances are kept under separate locked storage.
    b. Refrigerated medications must be kept locked in a refrigerator.
    c. Medications must be kept in the original container and in an area accessible only by designated staff of the facility.
    d. Medication for each child is kept in a separate container, clearly marked with the child's name.
8. Expired, no longer prescribed, or unused prescription medications are brought to the Healthy Horizons Assessment Center by social workers and discarded immediately. In congregate care facilities, health care professionals supervising medication administration discard unused or expired medications and document as appropriate. Other resource providers consult with the health care practitioner or pharmacist on the proper disposal of medications.
9. The assigned social worker ensures adherence to the above-stated guidelines.

HIV/AIDS

The most recently available *District of Columbia Annual Epidemiology and Surveillance Report (2018)* presents a snapshot of the District's HIV, Sexually Transmitted Diseases (STDs), Hepatitis, and Tuberculosis (TB) complex epidemics. This data provides insight from 2013 to 2017 into how the DC Department of Health (DC Health) in partnership with community-based services has continued to make progress for the health of District residents.

In 2017, 13,003 residents of the District of Columbia were living with HIV. In 2017, there were no babies born with HIV which means that 100 percent of the perinatal HIV cases were averted. Perinatal HIV cases are defined as those in which transmission occurs during pregnancy, labor and delivery, or breastfeeding. Since the introduction of recommendations to provide anti-retroviral medication to women during pregnancy, labor and delivery, and to the infant in the neonatal period, there has been a 95 percent reduction in mother to child transmission of HIV nationally. Transmission rates among those who receive recommended treatment during pregnancy, at labor and delivery, and newborn period are as low as 1 percent nationally. From 2016 to 2017, the number of cases of chlamydia increased by 19 percent, and gonorrhea by 36 percent for young people ages 15-19. Per the report, in 2017, there were 368 youth ages 13-24, that were known to be living with HIV. However, in 2017 youth represented 41 percent of new HIV diagnosis, higher than any proportion in the past 10 years.

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The COVID-19 pandemic presented challenges to health care providers and organizations delivering services, including patient eligibility for services, reduced operating hours, and suspended activities. As a result, the *District of Columbia Annual Epidemiology and Surveillance Report (2021)* raised concerns for underreporting and underdiagnosis of HIV cases. DC Health reported a nearly 20 percent decline in the volume of HIV, chlamydia, gonorrhea, syphilis, and laboratory reports received in 2020 compared to 2019. In 2021, lab reporting increased for primary and secondary syphilis (8 percent), chlamydia (13 percent), and gonorrhea (17 percent), but reporting for sexually transmitted infections was still below 2019 levels for chlamydia and syphilis. HIV lab volume decreased further from 2020 to 2021 with a 20 percent decline, and an overall decline from 2019 of 32 percent. Given disruptions to screening services, the potential for underdiagnosis and underreporting is most substantial for those with asymptomatic infections.

In 2021, 1.8 percent (n=11,904) of the District of Columbia population was living with HIV. Zero of those cases included babies (aged birth to 1 year). The number of newly diagnosed HIV cases was 230 in 2021, which was a decrease from 273 in 2019. Of those 230 newly diagnosed HIV cases, gender breakdowns included 3.5 percent (n=9) identifying as male, 22.6 percent identifying as female (n=51), and 73.9 percent (n=170) identifying as transgender. CFSA policy requires appropriate and timely referrals for counseling and medical services to children and youth in foster care diagnosed with AIDS or HIV, or with signs or symptoms of HIV-infection, or at high risk for HIV infection.

Per the 2021 data, the number of new diagnoses increased from 5,956 cases of chlamydia in 2020 to 6,920 in 2021 with one in six diagnoses attributed to youth between 13-19 years old. There was an increase in cases of gonorrhea from 3,593 cases in 2020 to 4,304 of gonorrhea in 2021 with 1.2 percent attributed to those less than 30 years old. There were 178 cases of primary and secondary syphilis cases reported in 2020.

CFSA seeks to address issues related to HIV/AIDS infection among children in the District of Columbia, and to reduce the following challenges when identifying and serving children who may be HIV-positive or diagnosed with an AIDS-related illness:

- Conducting HIV testing on a case-by-case basis only when indicated by a physician that there is a clinical presentation.
- Minimal knowledge regarding HIV-positive adolescents; of those adolescents known to be HIV-positive, very little information exists on where they are going for care or if the adolescent complies with a health regimen.

- Continuance of high-risk behaviors by adolescents known to be HIV-positive (examples include multiple pregnancies, sexual promiscuity, lack of medical compliance, etc.).
- Limited knowledge by CFSA of the universe of HIV testing or HIV-positive tests among the children served by CFSA.

To address the above challenges, CFSA policy ensures that children receive appropriate and timely counseling, testing, and medical services when known to have AIDS or HIV, or who have signs or symptoms of HIV infection, or who are at high risk for HIV infection. The Agency provides or refers appropriate medical care services and supports, as well as HIV/AIDS awareness and education to the children in care, parents and families, foster parents, and staff.

Current laws and statutes define HIV and AIDS as sexually transmitted and communicable diseases. CFSA takes both definitions into consideration with the goal of optimizing treatment to children in its care without any attached stigma.

CFSA continues to finalize plans to offer HIV/AIDS screening at HHAC to children ages 11 up through 20 years old who enter foster care as a part of the routine examination during the pre-placement screening (*see "Screening" section following*). For children already in care, screening and testing (if applicable) is recommended, at a minimum, on an annual basis during the DC HealthCheck process. Testing is immediate for children who present with risk factors, or after they have returned from abscondence, or after they have had a change in placement.

CFSA policy requires that all CFSA and CFSA-contracted staff, age-appropriate children, birth families, and resource providers be informed and educated on all policies, procedures, laws and best practices pertaining to the care of HIV/AIDS-infected children. All social workers have basic knowledge about HIV/AIDS, including its transmission and risk factors for infection.

In all cases involving children with HIV/AIDS-related special needs, social workers make sure that birth parents, foster parents, adoptive parents, and other caregivers receive the necessary information and training regarding care of the child, including medication and other treatment interventions, risk factors for HIV/AIDS, and universal infection-control precautions. Special programs and initiatives are targeted for the adolescent population, including adolescents who are sexually active, or who are substance abusers, have returned from abscondence, or have had a change in placements.

Pursuant to CFSA's HIV/AIDS policy, the following section of HCOCP describes protocols and procedures for children in CFSA out-of-home care. For children and families receiving in-home services, the assigned social worker consults with HSA for assistance and guidance for ensuring that these families receive all necessary HIV and AIDS-related education, supports, and services.

CFSA plans to work with DC Health in the near future to begin discussions for appropriate steps for conducting HIV/AIDS screenings for children in foster care.

Risk Assessment

CFSA gathers information related to HIV-infection and HIV/AIDS risk factors for all children in care. The assigned social worker or health care provider who assesses the child as having HIV/AIDS risk factors refers the child to HSA for access to counseling, testing, or medical services, if applicable. Information gathered during the risk assessment is confidential.

Referrals for Testing and Counseling

HIV/AIDS testing is readily available to all adolescents. Counseling associated with HIV/AIDS testing is provided by a certified medical professional once the test results are received. Such post-test counseling occurs at the site where the testing is conducted. After consultation with HSA for advice on the provision of counseling and testing for the child, the social worker refers the child for any additional counseling, whenever appropriate. The social worker also consults with the child's caregivers to assure that the birth parents, resource providers, or social worker accompanies the child for testing and counseling. The child may also express a preference for any adult or profession accompanying the child for testing.

Placement and Care of Children Known to Have HIV or AIDS

Recognizing that children with HIV or AIDS require additional resources and specialized services, CFSA ensures that resource providers participate in training on how to care for infants, children, and youth diagnosed with HIV or AIDS. CFSA also takes responsibility for ensuring that resource providers are informed about supports that are available to them and to the child. Whenever possible, cases of HIV-positive children are managed by social workers, staff, and resource providers with prior training and demonstrated experience in working with persons infected with HIV or persons who have AIDS. These children are also assigned a NCM to assist in the coordination of service needs.

Social workers provide resource providers (including a foster or kinship parent, third-party provider, or congregate care facility staff) with information (including medication regimen) regarding a child's HIV status prior to placement. In so doing, the Agency can assure proper care and treatment of an HIV-positive child (e.g., protecting them against other contagious diseases such as measles and chicken pox). *The child's name, however, is not disclosed until the placement is confirmed.*

Social workers inform all resource providers that *HIV information is confidential and may be shared only with those who are directly and substantially involved in the care of the child and have a need for the information.* Information about the HIV status of a child in a facility or foster home, including information about that child's parents or other family members, is not to be disclosed to other children residing in the facility or foster home or to their family members.

Disclosure of an HIV Diagnosis to a Child

1. Disclosure of HIV status to children who have been diagnosed takes into consideration age, cognitive ability, developmental stage, and clinical status. The child's understanding of the nature of his or her illness is likely to develop over time. It is important that the adults in the child's life, including social workers, be comfortable in providing accurate answers to the child's questions.
2. Health care practitioners who administer the HIV test forward all test results, whether positive or negative, to the HSA administrator or designee within 24 hours of the receipt of the results. If the results are positive, the HSA administrator or designee immediately (within 24 hours) contacts the child's assigned social worker to decide the course of action regarding notification and scheduling of a meeting between the health care practitioner and the resource provider, birth parents (if appropriate), and the age-appropriate child.
3. The assigned social worker and the health care practitioner explain and advise children during the post-test counseling that any child with the capacity to consent has the right to make certain decisions about the disclosure of information related to an HIV test. Consent is based on the child's thorough understanding of his or her rights and decision-making power.
4. HSA and the assigned social worker jointly ensure that the child receives the necessary treatments for both medical and mental health issues. Further, HSA and the social worker jointly monitor the child's progress. The social worker also ensures that medical follow-up is taking place, that the resource provider adheres to the child's medication schedule, and the child's counseling needs are being met.
5. In the event that birth or foster families express an interest in supportive services (such as group or specialized and individual counseling) the social worker contacts HSA for further guidance.

Declined Consent for Testing

Occasionally, a child or parents or legal guardians of a child may decline or refuse HIV/AIDS testing of the child, despite such testing being medically advised. In each of these cases, the social worker consults with HSA. If it is the child who declines or refuses testing, the social

worker in conjunction with HSA, the health care provider, the birth parents (if appropriate), and the resource provider (if applicable) continue to engage the child to consent to the testing.

If the child continues to decline or refuse testing, HSA notifies either the AAG or the child's guardian *ad litem* to request a Family Court order granting CFSA medical guardianship for the specific purpose of consenting to HIV/AIDS testing. When medical guardianship is granted, the Agency may provide the necessary consent for HIV/AIDS testing. The Agency director (or designee) may also provide consent when parental rights have been judicially terminated or relinquished to CFSA, since this creates a legal guardianship relationship between the child and the Agency. *For children already in care, under no circumstances may a CFSA social worker, a resource provider, congregate care provider, or private agency staff member independently provide consent for HIV/AIDS testing of a child.*

Confidentiality and Disclosure

1. Disclosure of the HIV status of an adult or a child to anyone other than a 24-hour caregiver, a health care practitioner, or the assigned social worker, supervisor, and supervisory managers should be made only with a written authorization (compliant with the federal *Health Insurance Portability and Accountability Act* and CFSA's policy on *Confidentiality*), executed by the parents or guardians of the child, or the age-appropriate child, or by a Family Court order.
2. Protocols specific to CFSA staff and private service providers for obtaining, maintaining, or disclosing confidential information pertinent to HIV/AIDS must comply with applicable federal and local law, as well as Agency policies and procedures as noted above. Any unauthorized disclosure is prohibited by law and may result in criminal penalties.
3. When CFSA has medical guardianship of a child or parental rights have been terminated, the Agency has the authority to consent to the release of medical information.
4. If a resource provider receives knowledge of a child's HIV status while the child is in their care, the resource provider *is required* to immediately notify the assigned social worker.
5. As necessary, CFSA periodically updates, develops, and distributes its HIV/AIDS protocols. Generally, however, the following guidelines are observed:
    a. All caregivers sign a Confidentiality Agreement.
    b. All congregate care facilities require the facility's director to sign a *Confidentiality Agreement* regarding the disclosure of a child's HIV-related information. The director consults with the child's social worker and HSA to determine which facility staff member should have this knowledge. Any facility staff member who is required to have this knowledge also signs a Confidentiality Agreement.

c. All *Confidentiality Agreements* are submitted to the social worker, who forwards the document to HSA.

d. CFSA's statement regarding unlawful re-disclosures and any other information related to confidential HIV/AIDS information is provided to resource providers in the placement packet.

e. All HIV or AIDS-related documents are kept strictly confidential within the CFSA case record.

    i. As noted earlier, HIV-related medical information (e.g., HIV risk assessment materials, test results, treatment reports) are maintained in a sealed manila envelope in the medical section of the case record.

    ii. The envelope is clearly labeled *Confidential* and instructions appear on the outside of the envelope as to who may have access to the information.

    iii. This information is provided only to those individuals in the position to make relevant decisions and actions regarding the care and treatment of, or permanency planning for, the child. Generally, access is limited to the social worker, supervisor, program manager, or administrator directly responsible for investigating abuse or neglect, or for providing or securing care and services for the child or family. The HSA administrator, the HHAC nurse practitioner, the HSA nurses, as well as parents, legal guardians, and those responsible for the child's daily care have access, unless the age-appropriate child has indicated that she or he does not want the information to be shared with birth parents or legal guardians. Written consent for specific purposes may be obtained from the child who is of an age and mental status to give informed consent, and who is able to share information with others such as medical or dental care providers.

    iv. Social workers should use the term "chronic illness" when referring to the condition of the child in all case plans, FACES.NET notes, court reports, Family Team Meeting reports, and all other written documents. Reference to the HIV/AIDS status of a child or adult family member is <u>only</u> made on case forms and narrative material or case plans <u>*as necessary to address issues of the child's protection and progress toward permanency*</u>. The social worker consults with HSA, as necessary.

    v. When it is necessary for the Family Court to be advised of the HIV status of a child or a parent, then the social worker, preferably through the assigned AAG, requests that a parent sign a release of information authorizing disclosure. The age-appropriate child may also be asked to give consent to share information. If consent to disclose information to the Family Court is denied, the AAG may state in the court report and on the record in the court room that CFSA has highly confidential information that is prohibited

by law from being disclosed in public but which is pertinent to the progress of the case. Therefore, the AAG requests a court order to disclose the information. *Whether disclosure is the result of consent or of a court order, it should occur at the bench and not in open court*.

6. Whenever possible, children infected with HIV/AIDS are placed with resource providers who are trained and experienced in working with persons infected with HIV or AIDS. Resource providers are also trained in the use of universal precautions on a daily basis. Resource providers are given information regarding a child's HIV status prior to placement. The child's name, however, should not be disclosed until the placement is confirmed.
7. In the case of relative (kinship) caregivers, information that a child is HIV positive should be given prior to placement but only when the placement is assured and only with the consent of the child's parents since this information may indirectly reveal a parent's HIV positive status. If the parents refuse to give consent, CFSA shall petition the Family Court for authorization to release this information in order to ensure proper care and attention to the child's special needs. The social worker shall inform the relative caregivers that information concerning the child's HIV status and that of any other family members, known or assumed, is confidential.
8. Prospective adoptive parents should be made aware of a child's HIV status, prior to identifying a specific child, as part of making the determination regarding placement. Once the adoption is finalized, the adoptive parents have the same authority to release medical information about the child as would birth parents whose parental rights remain intact.
9. Birth parents are entitled to receive information about the health status of their child except under either of the following circumstances:
    a. Parental rights have been terminated or relinquished or a court of general jurisdiction has ordered otherwise.
    b. The age-appropriate child has given sole consent to the testing and agrees to recommended treatment. If the child refuses treatment, a parent must be informed.
10. Information about a child's HIV status may be given to one parent, except in the situations enumerated above, even when it indirectly reveals the HIV status of the other parent.
11. When a child is being transferred to another jurisdiction, disclosure of HIV status to staff in the new agency should be limited only to those who need to provide or arrange for care. Any necessary medical records should be sealed, marked "Confidential," and sent directly to those individuals.

Universal Infection Control Precautions for Staff

CFSA requires Agency and contracted agency staff, resource parents, and congregate care providers to be engaged in providing direct services to children and families. The Agency also requires caregivers to be trained in and to use universal infection control precautions on a daily basis. Contracted agency staff also abide by policies and procedures of the agency where they are employed.

HEALTH CARE CONSIDERATIONS FOR TRANSITION PLANNING

The Patient Protection and Affordable Care Act of 2010 introduced new requirements of Title IV-E agencies with respect to health care coordination and transition planning for youth who are preparing to age out of the foster care system.

Specifically, CFSA ensures that transition planning, which commences at age 14 and continues until permanency can be achieved through the following health related objectives:

- Address the youth's options for health insurance.
- Include information about a health care power of attorney in the youth's transition plan (as applicable).
- Include information about the value and importance of establishing a health care proxy, or other similar document recognized under District law.
- Provide the child with the option to execute such a document.
- Provide youth transition services for a connection to adult human service support agencies and community service providers to assist the youth with health and family planning.
- Provide youth exiting care with consultation to promote continuity of health insurance following transition from care into their state of residence.
- Provide youth exiting care with original versions or official copies of their birth certificate, social security card, District identification card, Medicaid card, immunization records, school records, health care records, immigration documents, and a signed Ward letter indicating that the youth had previously been in foster care.

In order to comply with this requirement, CFSA addresses the above important health care considerations as part of the transition planning process, outlined in CFSA's *Older Youth Services* policy. The CFSA social worker ensures that the youth on his or her caseload understands the information and is able to make an informed decision regarding the establishment and enactment of health care power of attorney or health care proxy.

Transition planning includes language acknowledging that this important information was discussed with the youth, is signed by the youth accordingly, and documented in FACES.NET by the assigned social worker.

ASSESSMENT & DIAGNOSIS

Procedures to Prevent Inappropriate Diagnoses

Whenever a child enters care, the child receives a mental health screening and risk assessment by in-house clinical staff. The results from the screening and assessment are used to determine if further assessment is needed for the child.

If further assessment is needed, CFSA's in-house clinical staff conducts a mental health evaluation and provide treatment recommendations to the social work team based on the evaluation. Treatment recommendations may include a recommendation for therapy via the in-house clinical therapy team or via a DBH-approved core service agency. Additional traditional and non-traditional treatment recommendations may be made as well. If a child is recommended for therapy with in-house clinical staff, treatment begins in 5-7 days. CFSA employs mental health professionals (licensed clinical social workers, licensed professional counselors, and psychologists) to complete assessments and provide diagnosis and mental health treatment recommendations.

If a child is referred to a core service agency (CSA), the DBH co-located staff will enroll the child with the chosen. DBH notifies the social worker when the CSA is identified so that the social worker can schedule the intake and diagnostic assessment for the child. The CSA employs mental health professionals (licensed professional counselors, licensed clinical social workers, licensed graduate social workers, psychiatrists, and psychologists) to complete assessments and provide the mental health diagnosis along with a recommendation for treatment for each child in need of services. Sometimes, a child's primary care physician provides a diagnosis, such as attention deficit hyperactivity disorder (ADHD).

Social workers receive information about a child's diagnosis via results of the DBH or HHAC assessments, or via a pre-existing mental health record, court-ordered evaluation, family members, etc. Once a child receives a diagnosis, the frequency and duration of mental health treatment is dependent on the child's treatment plan. In most cases, children are seen by the mental health provider weekly, while community support services can vary from one to two times a week. In general, medication management is monthly with the treating psychiatrist.

CFSA expects that social workers are in regular communication with the treating mental health provider and that social workers are documenting these contacts in FACES.NET. CFSA's practice also requires social workers to request and maintain treatment plans and assessments in the child's case file. If a child has an NCM assigned, the NCM will monitor medication management and document treatment progress in FACES.NET. Monitoring medication includes whether or not the child is compliant in taking medication, attending medication management appointments as indicated by the psychiatrist, completing lab work as ordered by the physician, and experiencing positive medication impacts. Positive medication impacts include whether the intended outcome of the medication is being achieved. Negative effects might include drowsiness, weight gain, or difficulty concentrating. Sometimes, the child refuses to take the medication because of the negative impacts, so the NCM will assist with communicating that need. The NCM can also assist with scheduling medication management appointments as needed and educating and supporting the child regarding their mental health diagnosis and the benefits of treatment.

FY2024 APSR Update

Documentation of medication monitoring occurs in FACES.NET. After implementing the relevant module, documentation will transition to DC's new comprehensive child welfare information system database, called STAAND (Stronger Together Against Abuse and Neglect in DC).

Procedures to Ensure Children are Placed in a Psychiatric Residential Treatment Facility Only as Needed

CFSA always seeks to place children in a foster home or group home prior to consideration of placing a child in a psychiatric residential treatment facility (PRTF). The following considerations occur prior to placement in a PRTF:

- The child's team (social worker, supervisor, guardian ad litem, biological family, resource family, child if age appropriate) considers the strengths and needs of the child and the family in order to determine what supports and services would most thoroughly meet the needs of the child.
- After multiple meetings and attempts at community-based services (such as therapy, community-based interventions, intensive wrap around services, etc.), the team tries to come to a thoughtful consensus. If the team agrees that a PRTF would best meet the needs of child, the social worker completes a PRTF referral form and submits it to a dedicated email address for the CFSA Internal PRTF Review Committee. The referral includes documentation that the child's team collectively made every effort to maintain the child safely in the community. If there is an urgent need for a PRTF placement, the referring

social worker will note the circumstances of the urgent need and provide justification in the transmittal.

- CFSA's Clinical Services Unit first reviews the PRTF referral and schedules a meeting with the social work team (social worker, supervisory social worker, and program manager) and members of the CFSA Internal PRTF Review Committee. The CFSA Internal PRTF Review Committee reviews the referrals on a bi-weekly basis unless there is an urgent request or need for the referral to be reviewed prior to the scheduled bi-weekly meeting.
- At the conclusion of the meeting, the CFSA Internal PRTF Review Committee renders one of two outcomes:
    a. The committee submits additional recommendations or services to maintain the child in the community, whereby a follow-up meeting is held within 30-45 days to discuss the outcome and status of the recommendations.
    b. The committee supports the submission of the PRTF referral to DBH for placement, whereby the social worker re-submits the referral form and all supporting documentation electronically to prtf.reviewcommittee@dc.gov for the DBH PRTF Committee or HSCSN to make a medical necessity determination. In addition, the DBH PRTF review coordinator provides a case summary to the DBH PRTF Review Committee.
- Unless additional information is required to make a determination, the DBH PRTF Committee will review the case and make a necessity determination based on federal regulations (§441.152 - Certification of Need For Services).
- Within one-to-two business days of the determination, the DBH PRTF coordinator will provide the written determination to the referring party with any additional recommendations made by the review committee.
- Once the review committee provides an approval for the placement, CFSA's PRTF coordinator sends the child's packet to the various DC Medicaid residential programs that fit the clinical needs of the child.
- Once a PRTF is agreed upon, the social worker must submit an ICPC[14] packet to the ICPC Unit by the social worker.
- Once the ICPC Unit indicates approval of the packet, travel arrangements can be finalized by the social worker.
- After a child is placed in a PRTF, the assigned social worker (with the support of CFSA's PRTF coordinator) will monitor the case by participating in monthly treatment meetings,

[14] If there are no PRTFs within the District of Columbia, the ICPC (Interstate Compact on the Placement of Children) packet provides access to a PRTF out of the jurisdiction.

completing child site visits,[15] and monitoring the child after discharge for six months to ensure that appropriate and supportive clinical services are in place. Monthly treatment meetings include the child's team and the PRTF clinical staff. These meetings continue for the six months after discharge. During community placement, if there are immediate concerns regarding treatment and safety of the child between monitoring meetings, the social worker contacts the clinical staff member assigned to the unit and the PRTF coordinator to schedule an immediate staffing to develop a plan to maintain the child in the community.

FY2024 APSR Update

Beginning in FY 2023, CFSA has been conducting internal reviews of each case where a child aged 12 or less was admitted to a PRTF or similar residential treatment setting for more than 30 days. CFSA's Performance Accountability and Quality Improvement Administration (PAQIA) conducted the reviews in partnership with OWB staff and the child's assigned ongoing social worker. The reviews determine whether admission to the residential program was necessary as well as whether the admission remained necessary for the duration of the review period. To date, the review concluded that 100 percent (n=3/3) of the cases involved necessary admissions due to the mental health challenges being experienced by the child.

[15] For children placed more than 100 miles outside of the District, social workers must visit every six months; for children placed less than 100 miles, social workers must visit once a month.