Child and Family Services Agency (CFSA)

FY2014 Health Care Oversight and Coordination Plan

June 2013

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INTRODUCTION

The Child and Family Services Agency (CFSA or Agency) provides quality health-related service delivery to children and families through oversight and coordination of health services, educational support, and innovative family teaming. CFSA's Health Services Administration (HSA) has primary responsibility for these services, including assessing, coordinating, and maintaining the health and well-being of children[1] in foster care. HSA also manages CFSA's Healthy Horizons Assessment Center (HHAC), an onsite 24-hour, 7-days-a-week clinic staffed with five nurse practitioners and five medical assistants. In addition, CFSA has established a nurse care manager (NCM) program under the auspices of HSA. The NCM program is staffed with 15 registered nurses who collaborate with ongoing social workers to develop comprehensive health plans for those children requiring more tailored health-related services. Training is also provided to the NCMs and the social workers for assessing a child's emotional trauma experience, as well as the history of their treatment for trauma issues, and the necessary treatment going forward. Lastly, there are two assigned nurses dedicated to the Agency's Child Protective Services (CPS) administration. These nurses provide consultative support to CPS investigative social workers and to the nurses who are available on general assignment to HSA.

Collectively, HSA and HHAC, along with the NCMs and CPS nurses, directly administer and coordinate well-being services for children to ensure timely, comprehensive, and effective medical, dental, and mental health care and related services. HSA also provides supportive resource and consultative services for social workers, foster families, and biological families. Additionally, CFSA partners with various sister agencies in the District, such as the Departments of Health, Mental Health, Health Care Finance, Developmental Disability Services, and the Office of the State Superintendent of Education (OSSE). These partnerships guarantee that the most comprehensive and appropriate array of services to children and families are readily available.

CFSA's fiscal year (FY) 2014 Health Care Oversight and Coordination Plan (HOCP) has been designed to reflect the Agency's latest practices and efforts to meet the service needs cited above. As a living document, HOCP will be updated whenever new strategies are implemented to address the changing and evolving needs of CFSA's foster care population. Finally, as is required by *the Fostering Connections to Success and Increasing Adoptions Act of 2008*, HOCP addresses the following health care plan components:

- Scheduling for initial and follow-up health screenings that also 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

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

INITIAL EVALUATIONS OF CHILDREN'S HEALTH

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

According to CFSA policy (*Initial Evaluation of Children's Health*), best practice standards must be upheld for initial health screenings for all children entering out-of-home care. Through these screenings and timely, comprehensive health assessments for children, all health needs can be identified and appropriately met. Toward that end, CFSA also adheres to all applicable federal and District of Columbia laws and regulations, as well as national best practice principles* for the delivery of every health care service. CFSA specifically 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. It promotes healthy child development and ameliorates conditions that disable children. EPSDT further ensures that all Medicaid-enrolled children under age 21 have access to medical, dental and mental health services.

** As defined and recommended by the American Academy of Pediatrics and the Child Welfare League of America .*

Initial Medical Screenings

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

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 youth as appropriate) regarding the screening.
3. The CPS or assigned social worker receives two copies of the initial screening documentation from HHAC and places one copy into the child's case file. In addition, HHAC provides a "Cleared for Placement" form that includes a summary of the pertinent findings, diagnosis, 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 status are kept strictly confidential and forwarded by the nurse practitioner to the CFSA medical director.
4. To the extent possible, initial screenings shall 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
    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)
5. The HHAC medical assistant schedules appointments for the child's comprehensive health assessment and 30-day dental screening.

Overview of the Comprehensive Health Assessment

DC HealthCheck requires periodic health screenings in addition to the early, comprehensive medical health assessment. As stated above, the comprehensive health assessment shall take place within 30 days of the child's initial 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. Age-appropriate screening tests, including identification of risks and conditions
    e. Preventative services, such as immunizations, health education, and reproductive education (as appropriate)
    f. Development of a current and previous diagnosis list
    g. Development of a treatment plan consisting of treatment objectives and methods, interventions, services that address the child's individual needs, array of health care practitioners, etc.
2. For youth placed in residential facilities (i.e., group homes, shelters, emergency care facilities), a comprehensive medical and dental examination is conducted by a licensed 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 2 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 caregiver 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 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 for the best interest of the child or youth.
6. For follow-up visits and referrals, the resource provider schedules appointments and accompanies the child accordingly. The assigned social worker and the resource provider (if a co-parenting relationship has been established) both encourage the birth parent(s) 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 parent(s).

b. Results of all visits are documented by the assigned social worker in FACES.NET, the District's child welfare information system. The social worker also places copies of any related documents in the official case record. If there are any questions or concerns, the social worker consults HSA.

Initial Dental Examination

An initial dental examination is performed by an HHAC nurse practitioner within 30 days of a child's placement (or 14 calendar days if placed in a residential facility). It should be noted that DC HealthCheck guidelines require dental screenings for children as early as 6 months of age. Accordingly, infants in care are referred to a dentist after the first tooth erupts (around 6 months) or by 12 months of age (whichever comes first). Once a "dental home" is established, it is recommended that every child be enrolled in Medicaid so that dental examinations can occur every 6 months.

Initial Mental and Behavioral Health Screening

In addition to early and periodic health screenings, DC HealthCheck guidelines require mental and behavioral development assessments for all Medicaid-eligible children to 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.

As with the other screenings, the initial mental and behavioral health screening must occur within 30 days of entry into care. All children ages 1 year and older receive a standardized mental health screening administered by the Department of Mental Health (DMH) specialist who is co-located at CFSA. Depending on the age of the child, participation by the birth parent(s) or legal guardian is required. The social worker may also be asked to assist in engaging birth parent(s) or legal guardian in this critical evaluation.

Mental health screenings utilize the following age-specific tools:

- Infant Toddler Social Emotional Assessment (ITSEA) for children ages 12 months to 35 months
- Trauma Symptom Checklist for Young Children (TSC-YC) ages 3-12 years
- Trauma Symptom Checklist for Children (TSCC) for ages 8-16 years
- Mental Status Examination (MSE) for youth ages 17 years and older

Note: The TSC-YC and the TSCC are most useful for evaluating children who have experienced trauma, such as physical and sexual abuse, sexual assault, major losses, etc. These checklists measure various clinical symptoms (e.g., anxiety, depression, anger, post-traumatic stress, dissociation, and sexual concerns).

The mental health specialist discusses the results of the screenings with the social worker and NCM (if applicable). Subsequently, a copy of the results is placed in the child's medical record. As applicable, HSA makes the referral to DMH for further assessment and determination as to whether services are needed. The social worker 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 assessments in accordance with DC HealthCheck guidelines. For all children aged 6 and under, an initial developmental screening is conducted as part of their comprehensive evaluation. Children under the age of 36 months (3 years old) are subsequently referred through HSA to OSSE for a more detailed developmental assessment. All other children are referred through HSA to DC Public Schools (DCPS) Early Stages program for additional screening and assessment. If it is determined that the child has developmental or educational delays, DCPS will provide specialized services as needed.

PREVENTATIVE AND ONGOING HEALTH CARE

This section of the CFSA Health Care Oversight and Coordination Plan describes protocols and procedures that ensure that children in foster care receive preventative as well as ongoing primary medical, dental, mental and behavioral health care. It also contains directives regarding periodic assessments of a child's health, development, and emotional status. CFSA further takes steps to determine any changes in a child's status and need for additional services and interventions.

According to the American Academy of Pediatrics (AAP), children entering foster care are often in poor health and have higher rates of serious emotional and behavioral problems, in addition to increased numbers of chronic physical disabilities, birth defects, developmental delays and poor school achievement. 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 (i.e., when a child has the cognitive and emotional capacity to understand the conversation and is able to offer thoughtful opinions on his or her own health care), his or her birth parents, resource parents,[2] social worker, nurse care manager, and medical and mental health care practitioners. All members of the child's health care team 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 ongoing optimum preventative health care, every child and youth entering CFSA's care have 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. These 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 plan along with appointment dates for the recommended well-child visits. Together the assigned social worker and resource provider work collaboratively to schedule these visits. Although it is the expectation that the resource provider will be the primary person to accompany the child to the visit, the social worker may also attend these visits. In the event that a resource provider is unable to accompany a child and the visit cannot be rescheduled, the social worker will always accompany the child.

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 provider 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).

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[2] The terms "resource parent" and "resource provider" are interchangeable in this document with "foster parent".

The following options are available for resource providers to select a pediatrician or health care practitioner: (1) private pediatrician, (2) qualified DC HealthCheck practitioner, or (3) 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 and places any related documents into the child's official case record.

Well-Child Visits

Following the comprehensive medical evaluation, periodic well-child visits occur according to the current AAP guidelines. The assigned social worker coordinates with the NCM, resource provider, and birth parents (whenever appropriate) to ensure adherence to the following guidelines:

1. Initial visits shall occur once a month after birth for the first 6 months and then every 3 months thereafter up until 2 years of age.
2. Semi-annual visits shall occur from ages 2 through adolescence.
3. Well-child 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.

Currently, CFSA is developing a Memorandum of Agreement with the District's Department of Health Care Finance (DHCF) to share information and to develop a system for tracking and monitoring well-child visits. The following components of the well-child visits will be included:

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

The assigned social worker and the resource provider ensure that the child attends all follow-up appointments. As noted earlier with initial visits, the resource provider, birth parents, and/or the social worker will accompany the child to all follow-up appointments. 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 caregiver.

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 for all conditions identified in the initial dental assessment, which occurs within 30 days of a child entering foster care, is required. 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 parent, and/or resource provider accompany the child to all dental appointments, including follow-up care.

The following components are included in preventative care visits:

1. 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
2. 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
3. Immediate access to the dentist or oral surgeon when acute dental pain or trauma exists
4. Immediate access to medication to relieve dental pain
5. Orthodontics based on medical necessity as deemed by DC Medicaid for severe 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, 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 a timely and individualized professional diagnosis, treatment, and service for any mental or behavioral health needs identified either in the initial mental health screening or during subsequent assessments. All psychiatric, psychological, or other essential services are available as appropriate to the child's needs. In addition, CFSA provides mental and behavioral health services for families and resource providers. These types of services are coordinated by the assigned social worker and the mental health specialist co-located at HSA.

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/or 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 many of the circumstances just described.

Pursuant to the Child Abuse Prevention and Treatment Act (CAPTA), CFSA requires all children under 3 years of age who are involved in a substantiated case of child maltreatment to be screened for developmental delays. Children older than 3 years of age receive age-appropriate developmental assessments at routine medical visits. As noted earlier in this document, children between the ages of 3 and 5 years receive further evaluation by the DCPS Early Stages Program, which is designed to identify, evaluate, and provide services for children in this age category who have special needs.

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

1. Each well-child visit shall include 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 partner to 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.

Management of Medical Conditions

Children and youth 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, alternative treatments, and any risks or benefits. To ensure success of the plan, the assigned social worker encourages the birth parent(s) to participate directly in the implementation of the plan. Information on any condition(s) and treatment(s) for the child is also shared with the resource provider. Final decisions for care, however, are the responsibility of the birth parent(s), primary health care practitioner, and CFSA.
2. The ongoing social worker and the NCM (if assigned) ensure that the resource provider and the birth parent 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. At a minimum, HSA assists the assigned social worker in ensuring that children and youth who are experiencing an acute illness or injury receive timely access to appropriate professional health services, accessible after hours advice and care and prompt access to prescribed medications, to include 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 parent(s) 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 life threatening circumstances, the following is prescribed for accessing emergency care:
   a. When, in a resource parent's judgment, there is a potentially life-threatening circumstance, the resource parent shall immediately call *911* and follow the operator's instructions. The resource parent shall at first opportunity (no later than 30 minutes) notify the CFSA Hotline.
   b. After the resource parent has given the information to the Hotline on the life-threatening incident, the resource parent should contact the assigned social worker.
   c. The Hotline worker shall follow the notification procedures outlined in the *Critical Events policy*, including notifying the HSA administrator.
   d. The assigned social worker shall meet 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 parent or legal guardian.

HSA staff teams with the assigned social worker, the resource parent, and the birth parent 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 parent 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 a parent or legal guardian is required for any minor to be admitted for inpatient mental health services. Further, consent of a parent or legal guardian, 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 required to 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) is a 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 (e.g., if the social worker is not making the initial call to ChAMPS).

The assigned social worker notifies the supervisor, the parent or legal guardian, CFSA's medical director or designee, and the assigned assistant attorney general (AAG). If prior consent has been provided by the parent or legal guardian for mental health treatment, a copy of the written consent is provided to the AAG and CFSA's medical director or designee. When the parent or legal guardian is not available to provide consent (and reasonable efforts have been made to locate the parent or legal guardian and/or 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 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 parent or legal guardian's written consent have been made but the parent or legal guardian 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 a parent or legal guardian refuses consent, or is cognitively unable to provide consent, or is unable to be located to grant consent, CFSA considers filing an appropriate motion with the Family Court for an order authorizing such 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 a Family Court order for treatment. If there is a need for medication, it must be addressed with the AAG on a case-by-case basis.

CONTINUITY OF SERVICES AND MEDICAL RECORDS MANAGEMENT

The careful maintenance of medical records is critical to the safety and well-being of the children in CFSA's care. It is essential to maintain these records in an organized format, and to have them easily accessible to the assigned social workers, their supervisors, the Health Services Administration (including the Healthy Horizons Assessment Center), and others deemed necessary. 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 policy of CFSA to maintain the medical records of children in its care according to prescribed Agency standards that ensures (in the event of staff turnover, case transfer, placement change or disruption, or other potential case changes) that there is minimal impact in the timing and effectiveness of health care services provided to a foster child. 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 medical records – both the physical record and the information recorded in FACES.NET – reflect the following information:

1. A diligent standard of maintenance that will allow for ease of access to critical health data
2. A system that has standardized processes yet is flexible enough to account for the unique health situations for each child
3. A comprehensive health history and health plan for each child, reflecting thoughtful information management
4. 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

Standards, Responsibilities, and Activities of Records Maintenance

The primary responsibility of maintaining the child's medical records shall be that of the assigned social worker and the HSA. The assigned social worker and the HSA shall be responsible for the following case record standards:

1. Notes that reflect current and past health and medical information and activities.
2. Current and past child health and medical information, documents and records.
3. Records shall contain all forms and documentation pertaining to medical consent.
4. Records 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 Child Protective Services (CPS) social worker, in collaboration with HSA, shall complete the following tasks:

1. Compile 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. Obtain signed consent forms from the child's parent or legal guardian for the release of past medical records and medical history, if applicable.
3. Obtain in writing health records from any known previous and current health care providers.
4. Verify health and medical activities of the child through DHCF, Medicaid, public health records, and private providers.
5. Record all medical-related activities, including the initial medical screening information, into the child's case record and into the medical screens in FACES.NET.

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

Child's Health History

All known information and documentation regarding the child's health and medical history is contained in the appropriate medical section of 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

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. Review the medical status of the child with the assigned social worker and ensure that the information is documented in the appropriate FACES.NET screens.
2. Review case files for compliance with Agency standards.
3. Request the social worker to gather additional health information where deemed necessary.
4. Seek consultation from HSA or request 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 health care provider (PCP) name and contact information
    h. Insurance carrier and number
    i. Medicaid card (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/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

2. Information on the child's medication history, provided by the child's health care provider, shall contain the following details (as applicable):
    a. Current medications (including psychotropic medications), dosage, and frequency
    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 shall include the following information:
    a. Medical assessments
    b. Immunizations
    c. Dental assessments
    d. Mental/behavioral health screening and applicable assessments
    e. Developmental screening and applicable assessments
    f. Vision and hearing screening and applicable assessments
    g. Substance abuse assessments, if applicable
    h. Past medical records
    i. Laboratory and/or radiology reports
4. Pre-placement screening medical records (with the exception of the results of the HIV screening).
5. All applicable consent forms (from the parents and/or child).
6. Other Agency forms and medical notices.

Confidentiality and Health Information

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

1. HIPAA forms, signed by parent or legal guardian
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

All HIV or AIDS-related documents must be kept strictly confidential within the CFSA case record. HIV-related medical information (e.g., HIV risk assessment materials, test results, treatment reports) should be maintained in a sealed manila envelope in the medical section of the case record. The envelope must be clearly labeled "Confidential" and instructions should 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. As well, 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 will be 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 HSA nurse, as well as parents and legal guardians, have access unless the 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 or youth who is of an 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. It can be given to alleviate symptoms or manage medical and/or mental health conditions. Foster parents, staff of residential facilities, guardians, and other caregivers (collectively referred to in this section as "caregivers") and 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 caregiver is expected to administer medications in accordance with the instructions of the health care provider.

The assigned social worker shall facilitate this process by ensuring that the caregiver has the resources necessary to comply with medical recommendations, particularly as these resources pertain to the administration of medications.

This section of the Health Care Coordination Plan sets forth the instruction for CFSA social workers and caregivers on the specifics of medication administration and management, including instruction on the responsibilities of both the assigned social worker and caregiver. It also delineates who has medication consent authority.

Medical Consents

Prior to the administration of any medication (regular or psychotropic) to a child in the care of CFSA, consent to administer the medication is required, unless it is an emergency situation.

Consents required for regular medication

1. Consents from parents or legal guardians are not required for routine medical care, including the administration of medications. Best practice, however, dictates 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/or mental health evaluations and treatments, based on each occurrence. All efforts regarding consent for non-routine evaluations and treatments shall be 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 a parent or legal guardian 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 providing inpatient mental health services may administer a psychotropic drug to a minor.
2. Consent from the parent or legal guardian is required for the administration of psychotropic medications (wherever the child), unless there has been a termination of parental rights (TPR) or a relinquishment severing the rights of all parents.
   a. When the parent or legal guardian refuses to consent and it is believed that the medication is in the best interest of the child, the social worker and HSA shall confer with the assigned AAG. The AAG will determine whether to file a motion with the Family Court to override the parent or legal guardian's refusal to provide consent.
   b. When the parent or legal guardian is not available to provide consent (and reasonable efforts have been made to locate the parent or legal guardian and/or to obtain written consent), the social worker and HSA shall confer with the assigned AAG to determine the appropriate relief to seek from the Court. The AAG files the appropriate motion with the Family Court.
   c. It should be noted that there may be some health care providers who will only accept the consent of a parent or legal guardian 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 with the minor's consent (and not the consent of a parent or legal guardian) under one or more of the following circumstances:
      i. When the minor's parent or legal guardian is 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. When requiring consent of the minor's parent or legal guardian 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. When the minor's parent or legal guardian refuses 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. Consent from the parent or legal guardian is required for the psychiatric treatment and the administration of psychotropic medications for a child in outpatient care.
   - When the parent or legal guardian will not provide consent or are unable to provide consent, the assigned social worker shall follow the procedures outlined above.
4. If a TPR is in effect for the parent or legal guardian, the following guidelines apply:
   a. CFSA is the legal guardian of the child and may consent until the child is adopted.
   b. CFSA's medical director or designee within HSA is designated to provide consent for routine and non-routine evaluation and treatment, health services, and the administration of psychotropic medications.

Note: Social workers may not be considered as the designee in the above cases, unless specifically authorized by the medical director in writing.

Administration of Medications

When a child has completed the pre-placement or replacement screening at HHAC, the nurse practitioner provides the social worker with any prescribed medications for the child. The social worker obtains from the nurse practitioner clarification on the dosage, frequency, modes of administration, directions for use, refills, expiration date, and possible side effects of all medications. Additionally, the social worker provides this 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.

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 be in compliance 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 to be taken during the regular school day, the prescribing health care practitioner must write a separate prescription for the school administration to follow. Instructions should include the purpose of the medication in addition to 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, should be kept in their original containers and brought to medical appointments, except as allowed below when both the original container and pill organizer should be brought to all medical appointments.

If blood work or other tests have been ordered, the social worker advises the resource provider that all tests should 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 medication supports the therapeutic goal. Birth parents or legal guardians are encouraged to participate in the meeting with the treating child or adolescent psychiatrist.

CFSA has entered into a Memorandum of Agreement (MOA) with DMH and DHCF to form a workgroup known as the Psychotropic Monitoring Group (PMG). PMG's aim is to ensure that psychopharmacologic treatment provided to youth in the District's child welfare system meets (or exceeds) established standards of care. For guidance, the MOA establishes the terms and conditions under which the parties coordinate and share data and information sufficient to identify youth who are enrolled under the Medicaid program and who were 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.

3. The social worker, treating psychiatrist, birth parents or legal guardians, caregivers, and NCM 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 shall be shared:
   a. The reasons given by the psychiatrist for prescribing the medication
   b. The type, dosage and date of medication prescribed
   c. Instructions on 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 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 5 days of the prescription expiration) with mutual involvement of the social worker, NCM, caregiver, and birth parents or legal guardians, when appropriate.

6. The social worker notifies the primary health care practitioner, NCM, and other members of the child's family team of any new medication or changes in medication.

7. The social worker and NCM confer with the HSA administrator and the DMH co-located staff for referral to the DMH provider when mental health expertise and consultation is needed.

8. The social worker enters the following documentation in FACES.NET:
   a. The drug, dosage, and frequency of the prescribed medication
   b. The 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 and 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.

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 directions to do otherwise 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 "Five Rights" of medication: *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 medication administration and management process. 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 with the prescribing physician or health care practitioner the child's name, name of the drug, date, mode of administration, dosage, frequency, time, directions for use, precautions, refills, and expiration date.

3. The resource provider must inform 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.

4. 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 parent or legal guardian provides consent.
    b. All staff administering or supervising the self-administration of medication shall be 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.

5. 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 assist resource providers to understand the following guidelines for proper administration of medication:

1. Verify the information with the cognitively 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 cognitively age-appropriate child. Also observe closely for potential side effects.
4. Store the medication as directed, e.g., temperature sensitive, safely and securely out of the reach of children.
5. Have a list of the child's medication record readily available at all times.
6. The assigned social worker advises the resource provider to utilize any of the following approaches when a child refuses to take medication:
    a. Talk with the cognitively age-appropriate child to identify the reasons for refusal (e.g., taste, after-taste, or route of administration). 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 and/or HSA to determine the appropriate course of action. 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 should 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 should immediately contact the health care practitioner or pharmacist for advice. Resource providers should also contact the assigned social worker and/or HSA.

Storage, Inventory, Disposal of Medication

Social workers must 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 choose to put medications in a pill organizer to better organize and track the child's use of prescribed medications. This may be especially 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, with controlled substances 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, or no longer prescribed, or unused prescription medications are 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

According to the *District of Columbia HIV/AIDS, Hepatitis, STD and TB Annual Report 2011,* the World Health Organization defines high prevalence epidemics as those where the prevalence of HIV/AIDS is greater than 1 percent. The overall prevalence of HIV is at 2.7 percent among District of Columbia adults and adolescents. Youth aged 13 to 19 account for less than 1 percent of living HIV/AIDS cases in the District. Over 73 percent of pediatric HIV/AIDS cases were youth who were over the age of 13 at the end of 2010, with almost half (44.7 percent) between 13-19 years of age. In addition, increasingly high rates of sexually-transmitted diseases (e.g., chlamydia and gonorrhea) also indicate that sexual behavior among adolescents poses a significant risk of later HIV infection. Adolescents between the ages of 15 to 19 comprise the largest proportion of chlamydia (42 percent) and gonorrhea (35.3 percent) cases. The city's high late-tester rate further reveals that too many District residents living with the HIV virus are not aware that they are HIV positive and are potentially infecting others.

CFSA seeks to address these significant issues related to HIV/AIDS infection among children in the District of Columbia, and to reduce the following challenges it has faced in 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 is in compliance with a health regimen
- The continuance of involvement of adolescents known to be HIV-positive in high risk behaviors, such as multiple pregnancies, sexual promiscuity, lack of medical compliance, etc.
- The 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 who are being served by the Agency and who are known to have AIDS or HIV, or who have signs or symptoms of HIV infection, or who are at high risk for HIV infection, receive appropriate and timely counseling, testing, and/or medical services. The Agency is also committed to the provision of the 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.

Although current laws and statutes define HIV and AIDS as both a "sexually transmitted disease" and a "communicable disease", CFSA takes both definitions into consideration with the goal of optimizing treatment to children in its care without any attached stigma. It should be noted that CFSA is currently a partner with the District of Columbia Department of Health's HIV/AIDS Administration in developing a strategic HIV prevention initiative.

All children who enter foster care are screened for HIV/AIDS 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 placements.

CFSA policy also ensures that all Agency staff, contracted agency staff, age-appropriate children, birth families, and resource providers are 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.

The following section of the Health Care Coordination Plan prescribes protocols and procedures for children in CFSA out-of-home care. For children and their families served by CFSA in their home, the assigned social worker consults with HSA for assistance and guidance in ensuring these families receive all necessary HIV and AIDS-related education, supports, and services.

Screening

1. All children entering foster care are screened for HIV/AIDS as a part of the routine examination during the pre-placement screening.

2. The results of the screening, whether negative or positive, are forwarded to HSA's medical director. All results will be kept confidential.
3. If the screening is positive, the medical director (or designee) and the assigned social worker discuss the next steps with the child (if they have the capacity to consent). If the child does not have the capacity to consent, next steps are discussed with the birth parents or legal guardians.
4. Children with a positive screening have an expedited 14-day comprehensive health screen and appropriate referral for further HIV testing.
5. For children already in care, screening and testing (if applicable) is recommended, at a minimum, on an annual basis during the DC HealthCheck process. Immediate screening occurs for children with presenting risk factors, children who have returned from abscondence, or children who have had a change in placement. Testing is also recommended, with special attention, to adolescents in the following categories:
    a. Showing symptoms of HIV-infection
    b. With a sibling or parent who is infected
    c. With a history of sexual abuse or diagnosis of a sexually-transmitted disease
    d. With a history of illicit substance use or abuse
    e. Known to be sexually active
6. Children may also request to be screened and/or tested on their own.
7. Post-screening counseling is available at the time and location of the screening.

Risk Assessment

It is important to gather information related to HIV-infection and HIV/AIDS risk factors for all children in care.

Children assessed by a social worker or health care provider to have risk factors for HIV/AIDS are referred 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 children. 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 caregiver to assure that the birth parent, resource provider, and/or social worker accompanies the child for testing and counseling. The child may also express a preference for who accompanies him/her for testing.

Placement and Care of Children Known to Have HIV or AIDS

Children with HIV or AIDS require additional resources and specialized services. These children are assigned an NCM to assist in the coordination of service needs. Resource providers must agree to participate in training on how to care for infants, children, and youth diagnosed with HIV or AIDS. CFSA takes responsibility for ensuring they 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.

In order to assure proper care and treatment of an HIV-positive child, (e.g., protecting them against other contagious diseases such as measles and chicken pox), 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. *The child's name, however, should not be 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, may not 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 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 CFSA's medical director within 24 hours of the receipt of the results. If the results are positive, the medical director 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. The consent must be an informed consent.
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. 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/caregiver families express an interest in supportive services (such as group or specialized/individual counseling) the social worker contacts HSA for further guidance.

Declined Consent for Testing

Occasionally, a child or parent or legal guardian 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*), executed by the parent or guardian 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 and/or disclosing confidential information pertinent to HIV/AIDS must comply with applicable federal and local law, as well as Agency policies and procedures as prescribed by professional standards. 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 should be observed:
    a. All caregivers shall sign a Confidentiality Agreement.
    b. All congregate care facilities shall require that the facility's director sign a Confidentiality Agreement regarding the disclosure of a child's HIV-related information. The director shall consult with the child's social worker and HSA to determine which facility staff member should also have this knowledge. Any facility staff member who is required to have this knowledge shall sign a Confidentiality Agreement.
    c. All Confidentiality Agreements shall be submitted to the social worker, who will forward 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. 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. The number of personnel who are aware of the child's condition is kept at the minimum necessary to assure proper care and treatment of the child. In other words, 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 they do not want the information to be shared with birth parents or legal guardians. Written consent 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, for specific purposes.

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 only made on case forms and narrative material or case plans as necessary to address issues of the child's protection and progress toward permanency. 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 a relative (kinship) caregiver, 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 caregiver 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 staff, contracted agency staff, resource parents, and congregate care providers engaged in providing direct services to children and families to be trained in and to use universal infection control precautions on a daily basis. Contract agency staff also abides 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, the law requires CFSA to ensure that during transition planning, which commences at age 15 and continues until permanency has been achieved, CFSA shall complete the following objectives:

- Address the youth's options for health insurance.
- Include information about a health care power of attorney in the youth's transition plan.
- 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.

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 policy *Transition Services for Youth*.

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.