

Working Together

HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

NYS Office of Children and Family Services

Appendix B

Selected Health-Related Policies

Administrative Directives

- 09-OCFS-ADM-15 Medicaid Coverage for Final-Discharged Youth 18 to 21 Years of Age 3
- 08-OCFS-ADM-01 Changes associated with CONNECTIONS Build 18-9 Health, Education, and Permanency Hearing Report Modules 19
- 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure 50
- 91 ADM-36 Foster Care and Adoption: HIV-Related Issues and Responsibilities 93
- 90 ADM-21 Foster Care: Medical Services for Children in Foster Care..... 124

Informational Letters

- 09-OCFS-INF-01 Health Care Coordination for Children in Foster Care: Approaches and Benefits 140
- 08-OCFS-INF-02 The Use of Psychiatric Medications for Children and Youth in Placement – Authority to Consent to Medical Care..... 165
- 04-OCFS-INF-05 Smoking in Foster Home 186

Local Commissioners Memorandum

- 04-OCFS-LCM-04 Referrals of Young Children in Indicated CPS Cases to Early Intervention Services 189

General Information System Messages (Department of Health)

- GIS 08 OLTC/001 Bridges to Health Waivers (B2H) for Children in Foster Care 191
- GIS 05 MA/041 Categorical Eligibility for Children in Foster Care 193

Working Together

HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

NYS Office of Children and Family Services



David A. Paterson
Governor

NEW YORK STATE
OFFICE OF CHILDREN & FAMILY SERVICES
52 WASHINGTON STREET
RENSSELAER, NY 12144

Gladys Carrión, Esq.
Commissioner

Administrative Directive

Transmittal:	09-OCFS-ADM-15
To:	Commissioners of Social Services Executive Directors of Voluntary Authorized Agencies
Issuing Division/Office:	Strategic Planning and Policy Development
Date:	August 4, 2009
Subject:	Medicaid Coverage for Final-Discharged Youth 18 to 21 Years of Age
Suggested Distribution:	Directors of Service Child Welfare Supervisors
Contact Person(s):	Any questions concerning this release should be directed to the appropriate Regional Office. Buffalo Regional Office – Mary Miller (716) 847-3145 Mary.Miller@ocfs.state.ny.us Rochester Regional Office – Linda Kurtz (585) 238-8201 Linda.Kurtz@ocfs.state.ny.us Syracuse Regional Office – Jack Klump (315) 423-1200 Jack.Klump@ocfs.state.ny.us Albany Regional Office – Kerri Barber (518) 486-7078 Kerri.Barber@ocfs.state.ny.us Spring Valley Regional Office – Pat Sheehy (845) 708-2498 Patricia.Sheehy@ocfs.state.ny.us NYC Regional Office – Patricia Beresford (212) 383-1788, ext. 4708 Patricia.Beresford@ocfs.state.ny.us Native American Services – Kim Thomas (716) 847-3123 Kim.Thomas@ocfs.state.ny.us
Attachments:	yes
Attachment Available Online:	Will be available as part of the Working Together, Health Services for Children in Foster Care manual (expected to be posted by 8/14)

Filing References:

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
08 OHIP/INF-1 08 OHIP/LCM-1 09OHIP/ADM-1 GIS #09-001 GIS #09-12			ChafeeAct (FCIA) Of 1999(P.L. 106-169) NYS SSL 366(1)(a)(3-a)		

I. Purpose

The purpose of this Administrative Directive (ADM) is to make standardized letters available to Local Departments of Social Services (LDSS) and voluntary authorized agencies. The standardized letters (Attachments 1, 2, 1A, and 2A) provide youth discharged from foster care with information about Medicaid provisions under the federal Chafee Act and New York law.

A recent amendment to New York State law requires Medicaid services be made available for youth until the end of the month of their twenty-first birthday, when 18 years of age or older at the time of discharge from foster care. The letters must be distributed to such youth upon their discharge from custody (final discharge) of the Commissioner of LDSS or the Commissioner of the Office of Children and Family Services (OCFS).

This ADM also highlights the responsibility of the case manager/planner/child's caseworker and an identified contact person to provide assistance in obtaining documents related to a youth's eligibility for Medicaid. Both the case manager/planner/child's caseworker and the identified contact person must also provide resources for the youth for identified service needs as part of a transition plan.

II. Background

The federal Foster Care Independence Act of 1999 was enacted in December 1999. The John H. Chafee Foster Care Independence Program (Chafee program) offers assistance to help current and former foster care youth achieve self-sufficiency. The Chafee program provides individual states with the option of allowing these young people to remain eligible for Medicaid up to age 21.

New York State law was amended by Chapter 58 of the Laws of 2008 (Chafee Amendment) to add a new subparagraph 366(1)(a)(3-a) of the Social Services Law (SSL). This provision is effective January 1, 2009 and provides Medicaid coverage to youth under age 21 who were in foster care on or after their eighteenth birthday, without

an income or resource test. This change makes Medicaid available to such youth discharged from foster care in New York State until their twenty-first birthday if eligibility otherwise is maintained.

The letters and processes in this ADM serve as a follow-up to the State Department of Health directive, ADM-09-OHIP-01 “Chafee Amendment – Medicaid Coverage for Youth 18 to 21 years old final-discharged from foster care,” which provided information regarding procedures to authorize and renew Medicaid coverage.

http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/09adm-1.pdf

III. Program Implications

In accordance with SSL 366(1)(a)(3-a), a youth in the custody of the Commissioner of LDSS or the Commissioner of OCFS, on or after his/her eighteenth birthday, will continue to receive Medicaid up to age 21, whether the youth remains in care or is final discharged. The youth must be a United States citizen or national, Native American, or have satisfactory immigration status, and have residency in New York State to have his/her Medicaid continued.

Youth discharged from care often face obstacles surrounding planned housing, employment, ongoing education, and health insurance. The standardized letters, the directions to provide assistance in obtaining Medicaid coverage, and the identification of service providers are an effort to assist youth in securing Medicaid coverage, which is imperative to their health and well-being.

IV. Required Action

The case manager/planner/child’s caseworker must give the attached letter to an eligible youth who is final discharged on or after his/her eighteenth birthday and up to age 21. The appropriate letter must be sent by the LDSS to the discharge address, if known, in the event of an unplanned final discharge.

There are two versions of the standardized letter that are translated into Spanish. Agencies must reproduce the appropriate letter on their agency letterhead with the content unchanged from the attached letters. They are:

- New York City Version
- Upstate Version (LDSS)

Youth discharged to an address in New York City must be given the NYC version of the letter. Youth discharged to an address in an upstate district must be given the Upstate (LDSS) version of the letter. Each letter includes a detachable section that lists a contact person in the event that the youth needs assistance in obtaining Medicaid services. The identified contact person must be responsible for assisting youth in obtaining the necessary documents and Medicaid services. The contact information must include a name, telephone number, and an address and e-mail address.

The discharged youth's Medicaid case record must contain documentation to continue Medicaid services upon discharge. This includes identity, citizenship and/or immigration status, and residency. A youth must be informed verbally before discharge that whenever he or she moves to a new address, the youth should notify the Medicaid unit within LDSS/HRA. This will avoid any disruption of the Medicaid coverage.

In advance of any discharge and as part of transition planning, the case manager/planner/child's caseworker must obtain any of the following documents that are not available and notify the Medicaid worker of the discharge address:

- **Proof of Citizenship.** Certified copy of Birth Certificate (must have a raised seal) may be obtained via the Bureau of Vital Statistics. See the following link for forms and instructions:

http://www.health.state.ny.us/vital_records/

- **Immigration Status.** Status can be obtained from Form I-485 Application to Register Permanent Residence or Adjust Status, which is available on the U.S. Citizen and Immigration Services website. See the following link for the form and instructions:

<http://www.uscis.gov/files/form/i-485.pdf>

- **Social Security Number.** Although the youth may remember his/her Social Security number, it is preferable to have a Social Security card. A card can be obtained by using Form SS-5 Application for a Social Security Card, which is available on the Social Security Administration website. See the following link for the form and instructions:

<http://www.ssa.gov/online/ss-5.pdf>

Eligible youth must be informed that if they are pregnant or parenting they should contact the Medicaid Department under LDSS/HRA to obtain Medicaid benefits for their unborn or minor children.

Youth Released from OCFS Custody

The youth's OCFS case manager/planner/caseworker must provide the youth the standardized letters, as indicated above, upon final discharge. The contact person identified in the letters shall be from the LDSS to which the youth is returning. The youth's OCFS case manager/planner/caseworker also must take all required actions as set forth in this section, including obtaining any of the listed documents related to eligibility for Medicaid that are not available and informing the youth of the need to keep his/her address current.

- Upstate

The OCFS Federal Resource Unit (FRU) will notify the LDSS designated contact person when an eligible youth is no longer in the custody of the Commissioner of OCFS. A completed and signed Medicaid application (LDSS-2921) must be submitted to the LDSS designated contact person if the youth is not currently in receipt of Medicaid.

- New York City – Youth Discharged from OCFS Facilities

The OCFS Federal Resource Unit (FRU) will notify the HRA designated contact person when a youth is no longer in the custody of OCFS. A completed and signed Medicaid application (LDSS-2921) must be submitted to the LDSS designated contact person if the youth is not currently in receipt of Medicaid. Form LDSS-2921 is available at:

<http://www.otda.state.ny.us/main/apps/2921.pdf>

- New York City – Youth Discharged from Voluntary Authorized Agencies

The OCFS Federal Resource Unit (FRU) will notify the Administration for Children Services' (ACS) designated contact when a youth is no longer in the custody of the Commissioner of OCFS. Medicaid must be authorized until the end of the month in which the youth turns 21 so long as he/she continues to live in New York State.

- For All Youth Released from OCFS Custody

The FRU will notify the local district if the youth is covered by the Chafee Amendment and will include the youth's discharge address.

V. Systems Implications

The New York State Department of Health has developed system support that will identify youth who meet the eligibility requirements of the Chafee program. OCFS GIS-#09-12 (Attachment 3) provides detailed instructions for the Department of Health system supports and can be located at:

All Public Folders/dfa.state.ny.us/OCFS/TSU/ ***Services systems Reference Documents/ GIS (system change notices)

For more information about these system changes, please see WMS/CNS Coordinator Letter dated May 29, 2009, attachment II, Sect X:

<http://health.state.nyenet/rev2009coord.htm>

Future system updates from the Department of Health are forthcoming.

VI. Effective Date

This law went into effect January 1, 2009.

/s/ Nancy Martinez

Issued By:

Name: Nancy Martinez

Title: Director

Division/Office: Strategic Planning and Policy Development

Attachment 3

GIS # 09-12

TO: Directors of Services

FROM: Paul Gavry

SUGGESTED

DISTRIBUTION: Directors of Services, Foster Care Supervisors, Directors of Medicaid

SUBJECT: WMS System Instructions - Chafee Amendment

EFFECTIVE DATE: June 22, 2009

CONTACT: OCFS-IT Customer Support at 1-800-342-3727

The purpose of the General Information System (GIS) message is to provide local departments of social services (LDSS) with an explanation of the WMS enhancement, affecting youth covered by the Chafee Amendment, which became operational on Upstate WMS on June 22, 2009.

Effective January 1, 2009, the Chafee Amendment provides that a youth who was in the custody of the Commissioner of the local department of social services or the Commissioner of the Office of Children and Family Services on or after his or her 18th birthday will receive Medicaid until the youth's 21st birthday without regard to income or resources. The youth must still meet Medicaid citizenship/immigration status requirements and be a resident of NYS.

To support this change, a new Special Population (SP) Field indicator has been added to Screen 4 for both inquiry and update. Youth covered by the Chafee Amendment will be identified with a "C" in this field. This new Special Population Field will appear on the clearance report in the upper right hand corner next to the MCR (Medicare Indicator) Field. The Special Population Field, with a heading of "SP", will also appear on the Application Turnaround Documents and next to the CSD on the MA Coverage History Screen. The Continuous Save Date (CSD) will be set to the last day of the month in which the youth turns 21.

At the next undercare/recertification transaction, the Chafee Indicator - "C" must be manually entered in the SP Field when a youth is at least 18 but not yet 21 years of age and has any of the following foster care Individual Category Codes (ICC) – 32, 77, 78, 79, 80 or 81.

If the Chafee Indicator has not already been manually entered, the SP Field will be automatically populated by a monthly file that contains a record of any youth reported to CCRS as discharged from foster care during the previous month who, at the time of discharge, was at least 18 but not yet 21 years of age. A report of youth successfully updated by the automated file will be supplied to the LDSS. The report will also include youth that failed update. Records that failed update will need to be manually reviewed by LDSS staff.

For further information regarding these system changes, please see WMS/CNS Coordinator

Letter dated May 29, 2009 (attachment II, Sect X): <http://health.state.ny.net/rev2009coord.htm>

For systems questions, please contact OCFS-IT Customer Support at 1-800-342-3727.

GIS messages are available in public folders:

*All Public Folders/dfa.state.ny.us/OCFS/TSU/ ***Services systems Reference Documents/ GIS
(system change notices)*

Attachment 1

Standardized Letter, NYC Version

Date:

Name:

Address:

Dear _____,

This letter has important information for you regarding your right to continue to receive Medicaid. Medicaid is help for people who cannot pay for their medical care. Under the New York State Chafee Foster Care Independence Program, because you were in foster care on your eighteenth (18th) birthday, you are eligible for Medicaid until the end of the month in which you turn twenty-one (21). This is true regardless of your income and/or resources as long as you continue to live in New York State.

In order to receive Medicaid you must be a United States citizen or national, Native American, or have satisfactory immigration status. The Human Resource Administration (HRA) may ask you to submit papers that prove you meet this requirement. They may also request your Social Security Number. It is very important that you submit this information if it is requested. If you do not, you may lose your Medicaid coverage.

You will need a Benefit (Medicaid) Card in order to receive Medicaid services. You will give this card to the doctor, pharmacist, or other medical provider. Your bills will be sent to the State to be paid. If you do not have a Benefit (Medicaid) card, you should contact HRA to request a new Benefit (Medicaid) Card. The HRA Info Line phone number is 1-877-472-8411. If you need assistance, you can also contact the person listed on the slip below.

It is very important that you let HRA know if you change your address. You risk losing your Medicaid coverage if your current address is not on file. Every year HRA will send you a form that you will need to complete and return. **If the Post Office returns this form undeliverable, you may lose your Medicaid coverage.**

Many counties have a Medicaid Managed Care program. When you join a Managed Care health plan, you use the providers and hospitals that are in your plan. You choose your own doctor who will keep track of all of your health care. This person is called a Primary Care Provider. Your Primary Care Provider will send you to a specialist if you need one. HRA may send you a letter asking that you choose a Managed Care program. If you do not choose a Managed Care program, one may be chosen for you. Once you have a Managed Care program, the program will send you an insurance card. This Health Insurance card, along with your Benefit (Medicaid) Card, must be used to access medical services.

If you are receiving any other health insurance benefits, possibly from an employer or

parent, you must tell HRA. HRA may be able to help pay for the cost of this health insurance. You will not lose your Medicaid coverage if you have other health insurance, but you must notify your medical providers of your coverage so they can bill your health insurance before they bill Medicaid.

Keep this letter for your records and remove the contact slip below to keep with you. If you need help getting Medicaid services or have any questions regarding this letter, you should call the contact person at the number listed.

Sincerely,

As a Medicaid eligible youth age 18 to 21, keep this slip for your records.

Name _____

CIN _____

Contact Person:

Name _____

Address _____

Phone _____

Attachment 1A

Standardized Letter in Spanish, NYC Version

Date:

Name:

Address:

Estimado(a) _____,

Esta carta contiene información importante para usted con respecto a su derecho de continuar recibiendo beneficios de Medicaid. Medicaid provee ayuda a las personas que no pueden cubrir el costo de su cuidado médico. Bajo el Programa Independiente de Cuidado de Crianza Chafee del Estado de Nueva York (*New York State Chafee Foster Care Independence Program*), y debido a que usted estaba bajo cuidado de crianza (o cuidado sustituto) cuando cumplió 18 años de edad, usted es elegible para recibir beneficios de Medicaid hasta el final del mes en el que cumpla 21 años de edad. Estos beneficios no toman en cuenta su ingreso y/o recursos, siempre y cuando usted continúe viviendo en el Estado de Nueva York.

Para recibir cobertura de Medicaid, usted debe ser un ciudadano de los Estados Unidos de Norteamérica (EE.UU.), un indígena o nativo de Norteamérica o debe tener un estado inmigratorio satisfactorio. Puede ser que la Administración de Recursos Humanos (*Human Resource Administration—HRA*) le pida pruebas para documentar que usted satisface este requisito, incluyendo su número de Seguro Social (*Social Security Number*). Es muy importante que usted presente esta información si se la solicita. Si usted no provee esta información, es probable que usted pierda la cobertura de Medicaid.

Usted necesitará una Tarjeta de Beneficios de Medicaid (*Benefit Medicaid Card*) para recibir servicios de Medicaid. Usted le entregará esta tarjeta a su médico, farmacéutico u otra persona de la cual requiere ayuda. Sus facturas serán enviadas al estado para ser pagadas. Si usted no tiene la Tarjeta de Beneficios de Medicaid, usted debe contactar a HRA. La Línea de Información de HRA es 1-(877)-472-8411. HRA le enviará a usted una nueva Tarjeta de Beneficios de Medicaid. Si necesita ayuda, usted también puede contactar a la persona cuyo nombre aparece en el recorte de la siguiente página.

Es muy importante que usted notifique a HRA si usted cambia de dirección. Usted corre el riesgo de perder la cobertura de Medicaid si su dirección actual no está en los registros apropiados. Cada año, HRA le enviará un formulario que deberá completar y devolver. **Si este formulario es devuelto por la oficina de correos debido a que no pudo ser entregado, es posible que usted pierda la cobertura de Medicaid.**

Muchos condados tienen un programa de Cuidado Administrado de Medicaid (*Medicaid Managed Care*). Cuando usted se une al plan de Cuidado Administrado, usted utiliza proveedores y hospitales que están en su plan. Usted escoge su propio médico, quien seguirá el cuidado de su salud. A esta persona se la llama Proveedor(a) de Cuidado Primario (*Primary Care*

Provider). Su Proveedor(a) de Cuidado Primario le referirá a un especialista si su condición lo requiere. Es posible que HRA le envíe una carta pidiéndole que escoja un programa de Cuidado Administrado. Si usted no selecciona un programa de Cuidado Administrado, es posible que se le escoja uno. Una vez que usted participe en un programa de Cuidado Administrado, se le enviará una Tarjeta de Seguro de Salud. Esta Tarjeta de Seguro de Salud, junto con su Tarjeta de Beneficios de Medicaid, debe ser usada para obtener servicios médicos.

Si usted está recibiendo cualquier otro beneficio de salud, ya sea de un empleador(a) o bajo el seguro de su padre/madre, usted debe notificar a HRA. Es posible que HRA pueda ayudar en pagar el costo de este seguro de salud. Usted no perderá su cobertura de Medicaid si usted tiene otro seguro de salud, pero usted debe notificar a los proveedores de salud médica acerca de su cobertura de manera que éstos puedan enviar sus facturas a su seguro médico antes de enviárselas a Medicaid.

Por favor **guarde esta carta en su archivo de documentos importantes y recorte la información de contacto que aparece abajo para guardarla**. Si usted necesita ayuda en obtener servicios de Medicaid o tiene alguna pregunta respecto a esta carta, usted debería llamar a la persona de contacto cuyo número se provee abajo.

Atentamente,

Como joven elegible para Medicaid de 18 a 21 años de edad, guarde esta información con sus documentos importantes.

Nombre _____

CIN o Número de Identificación del Cliente _____

Persona de contacto:

Nombre _____

Dirección _____

Teléfono _____

Attachment 2

Standardized Letter, Upstate/LDSS version

Date

Name:

Address:

Dear _____,

This letter has important information for you regarding your right to continue to receive Medicaid. Medicaid is help for people who cannot pay for their medical care. Under the New York State Chafee Foster Care Independence Program, because you were in foster care on your eighteenth (18th) birthday, you are eligible for Medicaid until the end of the month in which you turn twenty-one (21). This is true regardless of your income and/or resources as long as you continue to live in New York State.

In order to receive Medicaid you must be a United States citizen or national, Native American, or have satisfactory immigration status. The local Department of Social Services (LDSS) may ask you to submit papers that prove you meet this requirement. They may also request your Social Security Number. It is very important that you submit this information if it is requested. If you do not, you may lose your Medicaid coverage.

You will need a Benefit (Medicaid) Card in order to receive Medicaid services. You will give this card to the doctor, pharmacist, or other medical provider. Your bills will be sent to the State to be paid. If you do not have a Benefit (Medicaid) card, you should contact LDSS. They will send you a new Benefit (Medicaid) Card. If you need assistance, you can also contact the person listed on the slip below.

It is very important that you let LDSS know if you change your address. You risk losing your Medicaid coverage if your current address is not on file. Every year LDSS will send you a form that you will need to complete and return. **If the Post Office returns this form undeliverable, you may lose your Medicaid coverage.**

Many counties have a Medicaid Managed Care program. When you join a Managed Care health plan, you use the providers and hospitals that are in your plan. You choose your own doctor who will keep track of all of your health care. This person is called a Primary Care Provider. Your Primary Care Provider will send you to a specialist if you need one. LDSS may send you a letter asking that you choose a Managed Care program. If you do not choose a Managed Care program, one may be chosen for you. Once you have a Managed Care program, the program will send you an insurance card. This Health Insurance card, along with your Benefit (Medicaid) Card, must be used to access medical services.

If you are receiving any other health insurance benefits, possibly from an employer or parent, you must tell LDSS. LDSS may be able to help pay for the cost of this health insurance.

You will not lose your Medicaid coverage if you have other health insurance, but you must notify your medical providers of your coverage so they can bill your health insurance before they bill Medicaid.

Keep this letter for your records and remove the contact slip below to keep with you. If you need help getting Medicaid services or have any questions regarding this letter, you should call the contact person at the number listed.

Sincerely,

As a Medicaid eligible youth age 18 to 21, keep this slip for your records.

Name _____

CIN _____

Contact Person:

Name _____

Address _____

Phone _____

Attachment 2A

Standardized Letter in Spanish, Upstate/LDSS version

Date:

Name:

Address:

Estimado(a) _____,

Esta carta contiene información importante para usted con respecto a su derecho de continuar recibiendo beneficios de Medicaid. Medicaid provee ayuda a las personas que no pueden cubrir el costo de su cuidado médico. Bajo el Programa Independiente de Cuidado de Crianza Chafee del Estado de Nueva York (*New York State Chafee Foster Care Independence Program*), y debido a que usted estaba bajo cuidado de crianza (o cuidado sustituto) cuando cumplió 18 años de edad, usted es elegible para recibir beneficios de Medicaid hasta el final del mes en el que cumpla 21 años de edad. Estos beneficios no toman en cuenta su ingreso y/o recursos, siempre y cuando usted continúe viviendo en el Estado de Nueva York.

Para recibir cobertura de Medicaid, usted debe ser un ciudadano de los Estados Unidos de Norteamérica (EE.UU.), un indígena o nativo de Norteamérica o debe tener un estado inmigratorio satisfactorio. Puede ser que el Departamento de Servicios Sociales Local (*Local Department of Social Services—LDSS*) le pida pruebas para documentar que usted satisface este requisito, incluyendo su número de Seguro Social (*Social Security Number*). Es muy importante que usted presente esta información si se la solicita. Si usted no provee esta información, es probable que usted pierda la cobertura de Medicaid.

Usted necesitará una Tarjeta de Beneficios de Medicaid (*Benefit Medicaid Card*) para recibir servicios de Medicaid. Usted le entregará esta tarjeta a su médico, farmacéutico u otra persona de la cual requiere ayuda. Sus facturas serán enviadas al estado para ser pagadas. Si usted no tiene la Tarjeta de Beneficios de Medicaid, usted debe contactar al LDSS. Este le enviará a usted una nueva Tarjeta de Beneficios de Medicaid. Si necesita ayuda, usted también puede contactar a la persona cuyo nombre aparece en el recorte de la siguiente página.

Es muy importante que usted notifique al LDSS si usted cambia de dirección. Usted corre el riesgo de perder la cobertura de Medicaid si su dirección actual no está en los registros apropiados. Cada año, el LDSS le enviará un formulario que deberá completar y devolver. **Si este formulario es devuelto por la oficina de correos debido a que no pudo ser entregado, es posible que usted pierda la cobertura de Medicaid.**

Muchos condados tienen un programa de Cuidado Administrado de Medicaid (*Medicaid Managed Care*). Cuando usted se une al plan de Cuidado Administrado, usted utiliza proveedores y hospitales que están en su plan. Usted escoge su propio médico, quien seguirá el cuidado de su salud. A esta persona se la llama Proveedor(a) de Cuidado Primario (*Primary Care Provider*). Su Proveedor(a) de Cuidado Primario le referirá a un especialista si su condición lo requiere. Es posible que el LDSS le envíe una carta pidiéndole que escoja un programa de

Cuidado Administrado. Si usted no selecciona un programa de Cuidado Administrado, es posible que se le escoja uno. Una vez que usted participe en un programa de Cuidado Administrado, se le enviará una Tarjeta de Seguro de Salud. Esta Tarjeta de Seguro de Salud, junto con su Tarjeta de Beneficios de Medicaid, debe ser usada para obtener servicios médicos.

Si usted está recibiendo cualquier otro beneficio de salud, ya sea de un empleador(a) o bajo el seguro de su padre/madre, usted debe notificar al LDSS. Es posible que el LDSS pueda ayudar en pagar el costo de este seguro de salud. Usted no perderá su cobertura de Medicaid si usted tiene otro seguro de salud, pero usted debe notificar a los proveedores de salud médica acerca de su cobertura de manera que éstos puedan enviar sus facturas a su seguro médico antes de enviárselas a Medicaid.

Por favor **guarde esta carta en su archivo de documentos importantes y recorte la información de contacto que aparece abajo para guardarla**. Si usted necesita ayuda en obtener servicios de Medicaid o tiene alguna pregunta respecto a esta carta, usted debería llamar a la persona de contacto cuyo número se provee abajo.

Atentamente,

Como joven elegible para Medicaid de 18 a 21 años de edad, guarde esta información con sus documentos importantes.

Nombre _____

CIN o Número de Identificación del Cliente _____

Persona de contacto:

Nombre _____

Dirección _____

Teléfono _____



Eliot Spitzer
Governor

NEW YORK STATE
OFFICE OF CHILDREN & FAMILY SERVICES
52 WASHINGTON STREET
RENSSELAER, NY 12144

Gladys Carrión, Esq.
Commissioner

Administrative Directive

Transmittal:	08-OCFS-ADM-01
To:	Commissioners of Social Services Executive Directors of Voluntary Authorized Agencies
Issuing Division/Office:	Strategic Planning and Policy Development
Date:	February 13, 2008
Subject:	Changes associated with CONNECTIONS Build 18.9: Health, Education and Permanency Hearing Report Modules
Suggested Distribution:	Directors of Services Child Protective Services Supervisors Child Welfare Supervisors Legal Staff Staff Development Coordinators CONNECTIONS Implementation Coordinators Voluntary Agency Program Directors
Contact Person(s):	Questions concerning this release should be directed to your Regional Office, Division of Child Welfare and Community Services: Buffalo Regional Office – Mary Miller (716) 847 – 3145 Mary.Miller@ocfs.state.ny.us Rochester Regional Office – Linda Kurtz (716) 238 – 8200 Linda.Kurtz@ocfs.state.ny.us Syracuse Regional Office – Jack Klump (585) 423 – 1200 Jack.Klump@ocfs.state.ny.us Albany Regional Office – Glenn Humphreys (518) 486-7078 Glenn.Humphreys@ocfs.state.ny.us Yonkers Regional Office – Patricia Sheehy (914) 377 – 2080 Patricia.Sheehy@dfa.state.ny.us New York City Regional Office – Patricia Beresford (212) 383-1788 Patricia.Beresford@ocfs.state.ny.us Native American Services – Kim Thomas (716) 847 – 3123 Kim.Thomas@ocfs.state.ny.us
Attachments:	Yes
Attachment Available Online:	Yes Attachment A: “ Build 18.9 Business Functions”

Attachment B: List and Link to JOB Aids
<http://ocfs.state.nyenet/connect/security/Build%2018%209%20BF%20%2001-25-07.pdf>

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
05 OCFS ADM-02 04-OCFS-LCM-04 97 ADM-15		18 NYCRR Parts 357, 428, 432, 441, 466 and 508; 18 NYCRR 360.8.1 and 463.2	SSL §§ 373- a,409, 422, and 446 FCA Articles 3, 7, 10 FCA §1089 Public Health Law Articles 17 and 27-F MHL §22.11 MHL §33.21	NYS OCFS Manual, “Working Together: Health Services for Children in Foster Care.”	SSA § 475(l)(C) 42 U.S.C. 675 EPSDT 5123.2 Public Law 107- 133

I. Purpose

In March 2007, the Office of Children and Family Services (OCFS) implemented Build 18.9 in CONNECTIONS. Included in Build 18.9 were discrete modules that supported the documentation of currently required health and education information for children served through the child welfare system; the incorporation of the Permanency Hearing Report (PHR), the Notice of Permanency Hearing and the Statement to the Court of the Permanency Hearing Report and Notice Sent; as well as additional functional improvements that provide ease of use for workers and aid in system responsiveness.

At the time of the implementation of Build 18.9 in CONNECTIONS, OCFS provided local Departments of Social Services (LDSS) with the option to implement an incremental approach to full compliance with the documentation requirements of health and education in CONNECTIONS. This ADM will serve as official notification of what health and education data must now be included in CONNECTIONS for all children in foster care, including children placed in certified or approved foster homes, and all children in the custody of LDSS or OCFS placed in congregate care settings in Voluntary Authorized Foster Care Agencies (VA).

In addition, this ADM will identify significant changes and enhancements in CONNECTIONS Build 18.9 designed to capture essential data elements required to support New York State compliance with the federal Adoption and Foster Care Analysis Reporting System (AFCARS).

II. Background

The documentation of health and education information for children and families served through the child welfare system has been an essential requirement identified in both federal and state laws and regulations for some time. The documentation of this information in CONNECTIONS in discrete data fields is a new method of documenting critical case information. The new modules provide an organized, central location for staff to enter and view essential health and education information for all children they are responsible for serving through the child welfare system. The new modules also support the collection of essential health care and education data for children in foster care that is required by the federal government in the AFCARS data report that is submitted twice each year.

Section 446 of the Social Services Law (SSL) authorizes the creation of the state's single statewide automated child welfare system.

OCFS regulation 18 NYCRR 466.3 states that upon issuance of an administrative directive by OCFS indicating that information regarding a child welfare service or services must be entered into the CONNECTIONS system, each social services district or public or private agency providing such service that has access to the CONNECTIONS system must use the CONNECTIONS system or record the information in the form and manner prescribed by OCFS to satisfy the data requirements for the particular service.

Section 373-a of the SSL requires that to the extent medical histories are available, the medical histories of a child legally freed for adoption or of a child to be placed in foster care and of his or her biological parents, with information identifying such parents eliminated, must be provided by an authorized agency to such child's prospective adoptive parent or foster parent and upon request to the adoptive parent or foster parent when such child has been adopted or placed in foster care. In addition, to the extent available, the medical histories of a child in foster care and of his or her biological parents must be provided by an authorized agency to such child when discharged to his or her own care and upon request to any adopted former foster child; provided, however, medical histories of biological parents shall be provided to an adoptee with information identifying such biological parents eliminated. Such medical histories shall include all available information setting forth conditions or diseases believed to be hereditary, any drugs or medication taken during pregnancy by the child's natural mother and any other information, including any psychological information in the case of a child legally freed for adoption or when such child has been adopted, or in the case of a child to be

placed in foster care or placed in foster care which may be a factor influencing the child's present or future health. See also OCFS regulations 18 NYCRR 357.3 and 428.8.

OCFS regulations also require every authorized agency to maintain current case records for each child in its care, which must include medical histories of a child and his or her biological family, and a continuing medical record and dental history for each child [18 NYCRR 428.3(b)(2)(ii) and 441.7(a)(1)].

OCFS regulations also require every authorized agency to maintain educational information about foster children and, to the extent available, provide a copy of a foster child's education record at no cost to the child when such foster child is discharged to his or her own care. The education record of a foster child includes the names and addresses of the child's educational providers; the child's grade level performance; assurances that the child's placement in foster care took into account proximity to the school in which the child was enrolled at the time of placement; and any other relevant education information concerning the child [18 NYCRR 357.3 (j)].

Federal law, [section 475(l)(C) of the Social Security Act (SSA)], requires the collection of case plans that include the most recent information available regarding the health records and educational status and services provided to foster children. Federal law also requires the state to collect and report certain data elements to AFCARS for children in foster care and who have been adopted.

The federal and state statutory and regulatory standards pertaining to medical consents, confidentiality of health-related information (including confidential HIV-related information), and acquisition and dissemination of medical history information and educational information will remain the same with the implementation of CONNECTIONS Build 18.9. A description of the effects of the Health Insurance Portability and Accountability Act (HIPAA) on access to health-related information and disclosure of health-related information can be found in 05-OCFS-ADM-02.

Chapter 3 of the Laws of 2005, also known as the Governor's Permanency Law, affects the Family Court, social services districts and voluntary authorized agencies and provides that a PHR be provided to the Family Court and certain other persons in regard to abused, neglected, voluntarily placed and completely freed foster children. The provisions of Chapter 3 of the Laws of 2005 that relate to the PHR were effective December 21, 2005.

The PHR provides the Family Court with the information needed to make decisions regarding the safety and well-being of the child, the family's progress, the plan for achieving timely permanency for the child, and the reasonable efforts to finalize that plan. The requirements for the PHR are detailed in section 1089 of the Family Court Act (FCA). OCFS, in

collaboration with the Office of Court Administration (OCA) and with input from a number of local districts, developed a series of templates for the required PHR to be used statewide by LDSS and VA child welfare caseworkers. These templates, as well as the associated Notice of Permanency Hearing and the Statement to the Court of the Permanency Hearing Report and Notice Sent, have been promulgated as OCA forms. Build 18.9 has incorporated these templates and associated forms directly into the CONNECTIONS application, and certain health and education information and information from the most recent Family Assessment and Service Plan (FASP), at worker choice, may be pre-filled into the PHR.

Please note: With regard to any records kept (including those outside of CONNECTIONS), the records of a non-adopted child in foster care must be retained for 30 years following the discharge of the child from foster care. Records of the child receiving preventive services alone must be retained for six years after the 18th birthday of the youngest child in the family. [See 18 NYCRR 428.10(a)(5)(ii)]. Records of child protective services must be retained in accordance with sections 422(5), 422(6) and 422(8) of the SSL and 18 NYCRR 432.9(f). Records of an adopted child must be sealed and permanently retained. [See 18 NYCRR 428.10(a)(5) and 05-OCFS-ADM-02.]

III. Program Implications

A. Health Services Module

The CONNECTIONS Health Services Module has been designed to provide a systematic and organized presentation of the general health history and other critical health information pertinent to a child being served through the child welfare system.

This module fulfills several purposes.

- Primarily, it allows the child's case manager, case planner, associated caseworker, agency nurse, or health care coordinator easy access to the most critical health information for the child.
- The module also provides an overview of the status of required health activities, such as routine health evaluations and HIV risk assessments.
- Information from the health services module may be pre-filled into the PHR.
- Certain diagnoses recorded in the module are captured by the OCFS Data Warehouse for mandated federal AFCARS reports. Non-compliance with these reporting requirements may have a negative fiscal impact on child welfare operations in NYS.
- Data from the health services module can inform LDSS, VAs and OCFS of important trends and issues related to the health of children in foster care.

The Health Services Module is available for every child who is identified in CONNECTIONS as a “tracked” child. Information in Health Services is discretely entered for each individual child and can only be maintained and/or viewed by persons with an appropriate role in a case and those with access to their workload, or through special security business functions.

The Health Services Module is not intended to be a comprehensive health record or a substitute for the medical records maintained by the social services district, authorized agency, or the child’s medical provider. As is required now, there must still be external documentation maintained that includes:

- copies of lab tests,
- physician forms,
- immunization records,
- medical consent forms,
- psychiatric evaluations,
- copies of referrals to medical providers, and so on.

Because it is not necessary to enter all of the child’s medical appointments or services into CONNECTIONS, the external medical file will be the more complete record. The child’s medical providers will have the most comprehensive record of all and, as such, will likely be timelier than what the district or agency possesses.

Information that must be entered into the Health Module is listed in the **Requirements** section below.

Legal Authority/ Regulations for the Provision of Health Services

All children in foster care must be provided certain health services. The required activities for the provision of health services are outlined in 18 NYCRR 441.15, 441.22, and 442.21; as well as in the NYS OCFS Manual **Working Together: Health Services for Children in Foster Care**; and the Title XIX (Medicaid) Early Periodic Diagnostic, Screening and Treatment (EPSDT) guidance available on the NYS Department of Health website.

This section of the Administrative Directive provides social services districts and voluntary authorized agencies with information on the current requirements for the provision of health services. The above referenced regulations did not change with the implementation of Build 18.9.

According to 18 NYCRR 441.22, each authorized agency is responsible for providing comprehensive medical and health services for every foster child in its care. This care must be provided by qualified persons. Social services districts and voluntary authorized agencies that provide foster care are also responsible for providing appropriate psychiatric, psychological and other essential services appropriate to the needs of the children in care (18 NYCRR 441.15).

Basis for Elements in Health Services Module

Working Together sets forth a five-assessment protocol that comprises the initial comprehensive health evaluation for each child entering foster care. Regulations or rationale for each assessment is as follows:

- Physical/Medical – 18 NYCRR 441.22(c)(2)
- Developmental – 18 NYCRR 441.22(c)(2); EPSDT 5123.2(A)(1)
- Dental – 18 NYCRR 441.22(c)(2)(vii)
- Mental Health – 18 NYCRR 441.15; EPSDT 5123.2(A)
- Substance Abuse – 18 NYCRR 508.8(b)(4)(iii)

In addition to the comprehensive evaluation, there are specific health services and information that are recorded in CONNECTIONS. The authority for these activities is as follows:

- HIV risk assessment for children in foster care – 18 NYCRR 441.22(b)
- Referral to the Early Intervention Program - 04-OCFS-LCM-04;
- Biological family health history – SSL§ 373-a, 18 NYCRR 357.3(b)

Documentation of Health Information

According to OCFS regulation 18 NYCRR 428.1, social services districts must provide a thorough family assessment and an account of all family and children's services delivered to children and their families through case records maintained in the form and manner and at such times as required by OCFS for the following:

- all children placed in social services district custody, or considered for such placement, which includes all children placed by a court directly in the custody of a relative or other suitable person pursuant to Article 10 of the FCA;
- all children in receipt of mandated and non-mandated preventive services (as defined in section 409-a of the SSL);
- all children legally freed for adoption; and
- all children named in an indicated report of child abuse or maltreatment (as defined under 18 NYCRR 432.1).

In addition to the general requirement for case documentation above, OCFS regulation 18 NYCRR 428.3(b)(2)(ii) lists additional information and documents that must be included in the uniform case record for children in foster care. These include:

- all reports of medical or clinical examinations or consultations, including
 - medical examinations and laboratory tests,
 - psychiatric or psychological examinations or consultations (either court-ordered or voluntary),

- dental examinations;
- medical consent forms signed by the parent or guardian, by the commissioner of the social services district, or by the child if the child has capacity to consent, as applicable, regarding medical treatment for any child in foster care placement;
- documentation that the child has been assessed for risk factors related to HIV infection in accordance with 18 NYCRR 441.22(b), and, if one or more risk factors have been identified, a description of the procedures that were followed to arrange for appropriate HIV-related testing, including obtaining the necessary written informed consent for such testing.

Historically, some of this information may have been documented in progress notes, the service plan, an external medical record, or the medical record component of the official case record. The form, manner and method of documenting specific health-related information and activities for children has changed in that now certain information must be entered into CONNECTIONS Health Services Module. However, the services and the need to document them have not changed.

Components of the Health Services Module

The Health Services Module provides functionality to designate health responsibility for each child in foster care to the social services district or authorized agency with whom the child is placed. In addition to the “Designate Health Responsibility” window, there are six tabs in the module.

Child Health Info tab serves as an electronic face-sheet that provides a health “snapshot” for the child. This tab records allergies, durable medical equipment, medications, hospitalizations, after-hours contact, and primary care/medical home. The Child Health Info tab must be kept updated with current information.

Clinical Appointments tab captures the details of specific appointments. Included are the date, medical provider, domain, appointment type, diagnosis, and treatment recommendations. The tab also contains a check-box to indicate whether a child’s immunizations are up-to-date at the conclusion of the medical appointment. Certain diagnoses will be captured from this tab for federal AFCARS reports.

The five domains (physical/medical, developmental, dental, mental health, substance abuse) mirror the multi-assessment protocol put forth in the manual *Working Together: Health Services for Children in Foster Care*. Refer to this manual at http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp for additional information on the requirements and recommended best practices for each assessment, and the comprehensive health evaluation. More than one domain may be selected for an appointment, as the clinician may address multiple aspects of the child’s well-being. For example, pediatricians

routinely assess developmental as well as physical health in the course of an infant's well child appointment.

Early Intervention tab records the date that a child is referred to the Early Intervention Program (EIP), evaluation date, and information on the services and program provider. In accordance with 04-OCFS-LCM-04, LDSS must inform parents of children under the age of three who are subjects in an indicated report of child abuse or maltreatment of the Early Intervention Program, and refer them to their county's EIP. Unlike the other tabs in the health services module, access to the Early Intervention tab is available to any staff with a role in the case.

Bio Family Health Info tab records hereditary conditions of the child's biological family, information on the mother's pregnancy, and the biological parents' cause of death, if applicable. Information on the biological parents' HIV status *must not* be recorded on this tab or anywhere else in the CONNECTIONS system. The CONNECTIONS system does not have a built in system capability to limit access to confidential HIV-related information to only those persons authorized by statute to have access. Therefore, it is incumbent on the social services district or voluntary authorized agency to administer the system in a compliant manner.

HIV Risk Assessment tab is a dynamic window that asks a series of questions on the mandated HIV risk assessment process for children in foster care. Results of HIV tests and Newborn Screening are recorded. The HIV risk assessment tab is completed for children in foster care *only*.

Health Narrative tab is available to document sensitive health information that is not to be included in progress notes, such as HIV-related information, family planning, and information on reproductive rights or sexually transmitted diseases of the child.

Additionally, information in the Health Services Module may be efficiently pre-filled onto the PHR that is now supported in CONNECTIONS. There are several questions in the PHR directly related to the child's diagnoses, specific treatment(s), and medication(s) the child is taking, etc. This information is mapped directly from the Health Services Module into the PHR if the pre-fill option is selected in the PHR window. Using this efficiency, once the information is entered into the Health Services Module, there is no need for duplicate direct data entry by the worker into the PHR. The new PHR may be modified by the worker so that the health information is presented cohesively to the court.

Any changes to specific health information must be completed in CONNECTIONS to provide consistent access to the most current and accurate information related to the health needs of the child for all persons involved with the child who are legally permitted to view or maintain this information.

It is critical for staff to carefully review the newly generated PHR to protect the confidentiality of certain health information. Information may not be inappropriately shared with persons who, while having a legal right to receive a copy of the PHR, do not have a right to certain health information. For example, OCFS has taken specific steps to safeguard against the mapping or inclusion of confidential HIV-related information in the PHR.

Confidentiality

The legal standards relating to the collection, maintenance, and disclosure of client identifiable child protective services, preventive services, foster care and adoption records remain unchanged by the implementation of CONNECTIONS Build 18.9. See 18 NYCRR 466.4 and 466.5 for further information on the confidentiality and security requirements for the CONNECTIONS system.

In general, health information received from a medical provider pursuant to an authorized request may be entered into the Health Services Module without obtaining additional consent from the protected individual. However, there are some circumstances that require special consideration.

HIV Information

A child with capacity to consent to an HIV test may choose to take a confidential test arranged by the social services district or VA, an anonymous test, or refuse a test. If the child agrees to a confidential test, consent is to be obtained for the agency to receive the test results. A model form for this purpose can be found in 97 ADM-15, Appendix D. Test results from anonymous tests cannot be verified, as the patient's name is not associated to the test result.

- If the child consents to a confidential test, the test results are recorded in the HIV Risk Assessment tab.
- If the child agrees to an anonymous test, the results are not available from the provider that performed the test, and therefore cannot be entered into the system.
- If the child confides the results of an anonymous HIV test, encourage the child to agree to a confidential test so that the results can be confirmed and documented, and appropriate services arranged.

If a child is diagnosed with HIV infection, this diagnosis must be entered into the Clinical Appointments tab. The diagnosis will not automatically pre-fill into the PHR. ***Carefully review the PHR to determine if it contains information, such as medications for HIV infection, that recipients of the PHR do not have the right to know and edit accordingly.***

A positive HIV result on the Newborn Screening is not a diagnosis of HIV infection. Rather, it indicates that the child was exposed to HIV in utero. The health provider must adhere to current medical protocols for further testing

and follow-up of an HIV-exposed infant. Subsequent HIV tests for the infant are recorded as a routine HIV risk assessment (not Newborn Screening) in the HIV Risk Assessment tab. Health providers may refer to the following web link:

<http://www.hivguidelines.org/GuideLine.aspx?pageID=258&guideLineID=25>

Notes regarding HIV must be entered into the Health Narrative and *not* in Progress Notes. When it contains confidential HIV-related information, a Health Summary may only be shared with persons who have the right to access confidential HIV-related information. In such a situation, one option is to produce a Child Health History Report by manually selecting each tab to print, omitting the HIV Risk Assessment tab.

Confidential HIV-related information on anyone other than a foster child must not be entered into CONNECTIONS. The CONNECTIONS system does not have a built-in system capability to limit access to confidential HIV-related information to only those persons authorized by statute to have access. Therefore, it is incumbent on the social services district or voluntary authorized agency to administer the system in a compliant manner. If a parent has HIV/AIDS, reference may be made in the case record to the parent's serious chronic illness without naming the diagnosis.

Reproductive Health

Minors also have the right to consent for reproductive health services and family planning services. However, a child in foster care may not need to assert that right, given the exercise of the right to consent from another source, such as a parent/ guardian or a local district. The child's ability to consent to services does not necessarily mean that the agency must request the child's permission to receive documentation of the service and enter it into the system.

The following scenarios provide further instruction on the confidentiality of reproductive health services. These apply to children in foster care.

1. Child receives routine reproductive health service (e.g., a pelvic exam) pursuant to an authorized consent signed by the parent for routine medical treatment. Information may be obtained from the provider and entered into the Health Services Module without further consent.
2. Child is prescribed contraceptives.
 - Because of possible side effects and interactions with other medications, this information, if obtained from the provider, must be included in the child's medical record irrespective of consent.
 - If this medication was prescribed pursuant to an authorized consent for routine medical treatment, the information may be obtained from the provider and entered into the Health Services Module without further consent.

- If the child independently sought and obtained the medication from a provider, the child's consent is required for the provider to disclose the information to the agency. If the child provides written consent, information may be obtained from the provider and entered into the system if the consent form allows redisclosure to any person who may access the information through the system. Carefully review the PHR and edit as necessary.
3. Child is treated for a sexually transmitted disease (STD) pursuant to an authorized consent for routine medical treatment (e.g., child was exposed to an STD as a result of sexual abuse). Information may be obtained from the provider and entered into the Health Services module without further consent.
 4. Child independently seeks treatment for an STD or termination of a pregnancy. Child consents to the treatment and confides the information to agency staff or a foster parent.
 - The information must not be shared with the child's parent/guardian without the child's express consent (see section 17 of the Public Health Law).
 - Child should be counseled on the need to share this information within the agency because of the implications for the child's overall health. If the child agrees and signs a written release, information may be obtained from the provider and entered into the system if the consent form allows redisclosure to any person who may access the information through the system.
 - If the child does not agree to share information, do not enter it into the system. The individual to whom the child has disclosed should balance the child's right to confidentiality against the agency's responsibility to protect the child's best interests in regard to safety, permanency and well-being. If it would be detrimental to the child's health if others in the agency were unaware of this information, a notation may be made in the medical record. Rather than entering the information in the clinical appointments tab, a note may be placed in the Health Narrative referring the reader to the agency medical record for further information.
 - Carefully review the PHR and edit as necessary.
 5. In accordance with 18 NYCRR 357.3, the child's medical history must be released to the parent when the child is discharged to the parent. In general, when a minor consents to her own reproductive health care, she may determine who is authorized to receive information about that care. Review the information and consents on file regarding the child's reproductive health services to determine if information may be released to the parent.

Mental Health

Routine mental health services, including initial assessments and ongoing therapy, are provided to children in foster care pursuant to an authorized consent for routine medical treatment. Information may be obtained from the provider and entered into the Health Services Module without further consent. Diagnoses and psychiatric medications should be entered into the Clinical Appointments and Child Health Info tabs respectively. If direct quotes from a mental health evaluation report or licensed clinician's treatment notes are entered into the system, they must be put into the Health Narrative rather than Progress Notes.

A child may obtain mental health services absent parental consent in limited situations (see section 33.21 of Mental Hygiene Law [MHL]). The provider may require the consent of the child or a court order to release the records to the agency. Once obtained, this information may be entered into the system without further consent. Carefully review the PHR and edit as necessary.

Substance Abuse Services

Substance abuse services, including initial assessments and ongoing treatment, are provided to children in foster care pursuant to an authorized consent for routine medical treatment. Information may be obtained from the provider and entered into the Health Services Module without further consent. Diagnoses of substance related disorders or dependencies should be entered into the Clinical Appointments tab. If direct quotes from a substance abuse evaluation report or licensed clinician's treatment notes are entered into the system, they must be put into the Health Narrative rather than Progress Notes.

A child may obtain treatment for chemical dependence absent parental consent in limited situations (see section 22.11 of the MHL). The provider may require the consent of the child or a court order to release the records to the agency. Once obtained, this information may be entered into the system without further consent. Carefully review the PHR and edit as necessary.

Security for the Health Services Module

Due to the confidentiality and sensitive nature of the information contained in the Health Services tab, security for this function is necessarily more restrictive. This extra layer of security enhances protection for the confidentiality and privacy of the child and his or her family.

Access to the Health Services Module is granted based on:

- the worker's role in the stage,
- status of the stage,
- the designation of an agency with health responsibility for each child,
- user's access to a workload, and
- the assignment of two new business functions (BFs) – MAINT (Maintain) HEALTH and VIEW HEALTH.

The MAINT HEALTH BF permits a staff person in a district or designated agency who does not have a specific role in the case, such as a nurse, clinical director or health care coordinator, necessary access to health information based on their need to document critical health activities, track health progress and support follow-up treatment for the children, but limits access to other health information.

For specific details on security and access to the Health Services Module, refer to the **CONNECTIONS System Build 18.9 Job Aid: Health Services** and Online Help within the Health Services Module. Please note the enhanced security does not apply to the Early Intervention tab.

Provision of access to information within a social services district or voluntary agency with which a local district contracts is based upon the principle of persons who have a “need to know” specific information. Social services administrators, program directors and security administrators in social services districts and agencies must make specific decisions regarding who may have access to what records based upon their role in providing services to a child or family member and their unique need to know the information maintained in different parts of the case record. OCFS has disseminated specific guidelines for each BF to aid in this decision-making process. Staff should consult the OCFS Build 18.9 Business Function Guidelines prior to making assignment decisions (see Appendix A).

It is also important for the district/agency to establish a method to monitor and review the proper assignment of the new BFs “VIEW HEALTH” and “MAINT HEALTH” on a periodic basis to provide safeguards for the maintenance and confidentiality of this information.

Required Actions

Entering and updating health-related information in the Health Services Module is *required* for:

- all children in foster care; and
- all children in OCFS custody placed in a Voluntary Agency (also included in the population referred to as “children in foster care”).

Detailed, step-by-step instructions for maintaining data fields in the Health Services Module are contained in the **CONNECTIONS System Build 18.9 Job Aid: Health Services**.

Required elements in the Health Services Module are as follows:

Designate Health Responsibility

Designation of Health Responsibility is required to allow caseworkers with a role in the stage other than that of the Case Manager or Case Planner, and staff with the MAINT HEALTH or VIEW HEALTH business function access to

the Health Services Module. Designation must be completed for each child by the Case Manager or Case Planner upon the child's entry into foster care. Designation is necessary to enable access for a worker with the role of Caseworker, even if the Caseworker is in the same social services district as the Case Manager or Case Planner.

Child Health Info tab

To support the accuracy of critical health information, records from health providers must be in the agency's possession when entering information on an overnight hospitalization. Written documentation in the child's medical record or verification from the prescriber or the prescription itself must be obtained before entering medications into the system. This is particularly critical as many medications have similar spellings. Allergies and durable medical equipment reported by the parent/guardian must be entered into the system pending verification by a health provider. If dates for the onset of allergies, the use of durable medical equipment, and the first prescription of a medication for a chronic condition are unknown, they may be estimated using the protocols described in the Job Aid. This information must be updated whenever it changes.

Required fields on this tab are:

- Current allergies, medications, and durable medical equipment with start and end dates, as applicable;
- All overnight hospitalizations while the child is in foster care;
- To the extent known, overnight hospitalizations prior to foster care which are related to chronic health conditions or conditions that led to the child's removal;
- After Hours Agency Health Contact, as applicable;
- Primary Care/Medical Home provider.

Clinical Appointments tab

To support the accuracy of critical health information, records from health providers must be in the agency's possession when entering data on clinical appointments. If an appointment must be entered, any diagnoses identified by the medical practitioner during that appointment must also be entered.

The following information must be entered into this tab:

- Initial assessments in five domains (physical/medical, dental, developmental, mental health, and substance abuse for children 10 years of age and older) for any child who entered foster care within the 90 days prior to the date the district implements the Health Services Module, and every child who enters foster care thereafter;
- Periodic well-child care (physical/medical domain);
- Periodic preventive care (dental);
- "Immunizations up to date" indicator for initial and well-child physical/medical appointments;

- Discharge exam (use the “Well child” appointment type);
- The initial diagnosis of a chronic health condition. If diagnosed prior to entry into care, use the “Diagnosis at Intake” appointment type;
- All “Emergency Care” and “Crisis Intervention” appointments;
- Provider name and address for all appointments entered.

Early Intervention tab

The Early Intervention (EI) tab must be completed for any child under the age of three in an open Family Services Stage who was involved in an indicated CPS report. Unlike other parts of the Health Services Module, the EI tab is not subject to enhanced security. If the child receives an EI evaluation, record it as a developmental assessment in the Clinical Appointments tab in addition to completing applicable fields in the EI tab.

The following information must be entered into this tab:

- Early Intervention referral date for all children under 3 in an indicated CPS case;
- All other fields as applicable for referred children;
- Information on this tab must be entered prior to the child’s 4th birthday.

Bio Family Health Info tab

Health information on a parent or biological relative should be obtained from the health care provider pursuant to a release signed by the parent or person whose records are requested prior to entering this information into CONNECTIONS. If records cannot be obtained but the information is credible, enter it into the Bio Family Health tab. Put a brief note in the additional information box stating that documentation verifying the diagnosis could not be obtained and why the diagnosis is believed to be credible. Information on the HIV status of a family member should *not* be entered into CONNECTIONS.

The following information must be entered into this tab:

- Hereditary conditions and allergies of the child’s biological family;
- Information on the biological family’s health history that could impact the child’s current or future health;
- Information on the biological mother’s pregnancy for this child;
- Parent’s cause of death, if applicable. If the parent died as a result of HIV/AIDS, record the exact illness (e.g., Pneumonia) if known, or a general term such as Infectious Disease, if unknown.

HIV Risk Assessment

All children in foster care must be assessed for HIV risk, and the results of that assessment must be recorded on the HIV Risk Assessment tab. This tab is used for children in foster care *only*. The CONNECTIONS system does not

have a built-in system capability to limit access to confidential HIV-related information to only those persons authorized by statute to have access. Therefore, it is incumbent on the social services district or voluntary authorized agency to administer the system in a compliant manner. See additional information on HIV in the Confidentiality section above.

The following information must be entered into this tab:

- All risk assessments completed for children in foster care in accordance with OCFS regulation;
- All fields as prompted by system logic;
- Test date and results for Newborn Screening and confidential HIV tests.

Health Narrative

The Health Narrative may be used to record health information that is not appropriate to record in Progress Notes. This includes:

- Any information related to HIV/AIDS services;
- Quotes from the substance abuse provider's reports or notes;
- Quotes from mental health provider's reports or notes;
- Confidential reproductive health services, including STDs.

If the Health Services Module is not utilized for Preventive or open Child Protective cases, any health information (excluding HIV) related to the reason for the delivery of services by the respective child welfare agency *must* be documented in Progress Notes in CONNECTIONS. This information may include service for substance abuse, mental health, Early Intervention, or hospitalizations related to service needs or child protective issues. Given the highly sensitive nature of reproductive health services and STDs, it is recommended that this information *not* be entered into Progress Notes.

Recommended Actions

Maintenance of health-related information in the Health Services Module is *recommended* for:

- all children placed in the direct legal custody of relatives or other suitable persons under Article 10 of the Family Court Act (not in DSS legal custody);
- children served in open, indicated child protective services cases; and
- children served in child preventive services cases.

Health information related to children served through preventive or protective services *may* be maintained in the Health Services Module at the discretion of the social services district. Use of the Health Services Module for children receiving preventive services only through contract preventive agencies is at

the discretion and agreement or contract between a social services district and its contracted agencies. The same safeguards for sensitive information apply to these records.

A referral to the Early Intervention Program and subsequent entry of data into CONNECTIONS is recommended for:

- foster children under the age of three, particularly those whose developmental assessment indicates the possibility of a developmental disability or delay; and
- any child under the age of three receiving child welfare services from a social services district or voluntary agency if there is reason to believe the child may be disabled or developmentally delayed or in danger of becoming developmentally delayed.

B. Education Module

Comparable to the Health Services Module, the Education Module provides an easily accessible location for documenting essential information related to a child's educational status. Documentation of relevant educational information is required for all children in foster care and youth in the custody of OCFS placed in a VA. The module supports easy identification of educational information about children; for example, what school they are in, if they have an Individualized Educational Plan (IEP), what special services they are receiving, surrogate parent information, and so on. In addition, it provides an historical view of the child's educational placements (e.g., how many schools the child was in, any special services provided to the child in previous schools, if the child repeated any grades, if she or he graduated, etc.). Similar to the Health Services Module, certain information entered into the Education Module will pre-fill to the PHR, if the pre-fill option is selected.

While much of a child's educational information must be recorded in the electronic case record, a hard copy of certain documents must still be maintained in the paper record and *must* include the information cited above (see 18 NYCRR 428.3) as well as copies of report cards, standardized test results, complete IEP reports and evaluations. All general information gathered from contacts with the school will continue to be recorded in Progress Notes. There is no narrative area in the Education Module.

Information can be recorded in the education module for children with no age limit, but remains applicable for foster children up to the age of 23. The upper age limit is derived from the federal Educational and Training Voucher (ETV) program funded through appropriations from the federal Promoting Safe and Stable Families Act of 2001 (Public Law 107-133) which makes such vouchers available to foster children and former foster children up to the age of 23.

The Education Module is available to all persons with a role or implied role in the case, and through the unit hierarchy. This ability to access the child's education information provides an opportunity for all persons serving the family to both view current information and, for those with a role in the case, add, modify and update the educational information, as needed. In addition, workers with a role in the current stage can view (but not change) education information that was recorded in a previous stage. Education information recorded in a previous stage is displayed in gray, except for the Child Case Record (CCR). If the child's current record was created in the CWS stage and carried over into the CCR stage, it will display without shading and is modifiable.

Legal Authority/Regulations Affecting Education Information

According to OCFS regulation 18 NYCRR 441.13, agencies providing foster care services are responsible for:

- taking such steps as may be necessary to make certain that all children in care receive education appropriate to their needs and in accordance with the requirements of the Education Law;
- maintaining an active and direct liaison with any school in which a child in its care is enrolled; and
- making certain that each child in its care receives appropriate educational and vocational guidance.

For children in foster care, OCFS regulation 18 NYCRR 428.3(b)(2)(iii) requires that the uniform case record include educational and/or vocational training reports or evaluations indicating the educational goals and needs of each foster child, including school reports and Committee on Special Education (CSE) evaluations and/or recommendations. It is recommended as a best practice that this information be recorded for all children removed under Article 10 of the Family Court Act and placed in the direct custody of a relative or other suitable person. Recording educational information is optional for children in receipt of preventive or protective services who are living at home with a parent or guardian.

Under federal law [section 475(1) of the Social Security Act], a case plan for a foster child must include the following:

- Names and addresses of educational providers;
- Grade level and performance;
- Child's school record;
- Services provided to a child.

For children in foster care or placed into the direct custody of a relative or other suitable person, education information and history has historically been

captured and maintained in the hard copy case file. Certain additional information has also been maintained in Progress Notes, under the Education Planning purpose.

Required Actions

Current educational data must be entered into CONNECTIONS for:

- all children in foster care; and
- all children in OCFS custody placed with a VA (also included in the population referred to as “children in foster care”).

In addition, new school year information is expected to be entered each year by ***October 1*** and any changes to educational information should be entered into the system as close to the actual change as possible.

Information that must be documented includes:

- all applicable fields on the Education Detail window; and
- all applicable fields on the IEP window, including Disability, Service Types, Related Services, and Surrogate Parent.

Detailed, step-by-step instructions for maintaining data fields in the Education Module are contained in the **CONNECTIONS System Build 18.9 Job Aid: Education**.

Other information gathered from the schools and related to the child’s educational issues, educational needs or attendance must continue to be documented in Progress Notes. In addition, the federal Safe and Timely Placement of Foster Children of 2006 requires that foster children be given their educational records, to the extent available, (at no cost) when the child is discharged from foster care to their own care. The education record includes, among other things, the names and addresses of the child’s educational providers and the child’s grade level performance. (See 18 NYCRR 357.3(j))

Build 18.9.6 will create a new BF for the Education Module. In Build 18.9.7 this business function will support allowing a worker, primarily an education specialist without a role in the case, to record and view education information.

Recommended Actions

If determined by the LDSS or VA as a best practice, educational information must also be entered for school age or pre-kindergarten children in direct custody of a relative or other suitable person (non-foster care) as certain information from Education can, at worker option, be made to pre-fill portions of the PHR.

The Education Module is optional for Preventive or Child Protective Services cases, but recommended for these service populations as well. VAs should

confer with the social services districts with which they contract about requirements to record education information. Being able to readily identify what school a child is attending and who the contact person is will assist every staff person associated with the case currently and in the future.

In order to provide for timely and accurate data entry, LDSS and VA staff should assess their current business processes regarding:

- whether information on children living at home who are in receipt of preventive and/or protective services will be supported in the Education Module;
- who is responsible for the entry and maintenance of this information;
- who is responsible for loading information on children currently in care;
- if departmental communication flow needs to be altered to allow for Education documentation to be entered into CONNECTIONS;
- if there are new CONNECTIONS users who may be responsible for the entry of Education information;
- if they have an existing system/database that can be replaced by CONNECTIONS;
- if they maintain two systems, how updates to both CONNECTIONS and an internal system/database will be achieved;
- how documents will be shared/passed from one department to another and if this will need to change.

C. Permanency Hearing Report

The Governor's Permanency Law (Chapter 3 of the Laws of 2005) requires that a PHR be created and sent to required parties fourteen days prior to each and every permanency hearing date certain and that the report be filed with the Court. A Notice of Permanency Hearing with the date, time and location of the hearing must also be submitted or mailed to the required parties and a Statement to the Court of the Permanency Hearing Report and Notice Sent must be submitted to the Court, listing all those who received the PHR and/or the Notice. These documents were placed on the OCFS website as stand-alone templates when Chapter 3 went into effect. With the implementation of Build 18.9, the PHR, Notice and Statement are supported in CONNECTIONS.

It should be noted that permanency hearings and PHRs apply to the following children:

- children who have entered foster care as abused or neglected children (FCA Article 10);
- children who have entered foster care through a voluntary placement agreement (SSL §384-a);
- children in foster care who have been surrendered for adoption (SSL §383-c) and are completely legally free;

- children who have been surrendered for adoption (SSL §384);
- foster children determined by a court to be completely legally free for adoption, whether in foster care pursuant to FCA Articles 3 (juvenile delinquent), 7 (PINS), or 10 (abused/neglected), or by voluntary placement or surrender; and
- children placed by the court directly with a relative or other suitable person as an outcome of a FCA Article 10 proceeding.

[Note: While Chapter 3 of the Laws of 2005 does not expressly refer to Unaccompanied Refugee Minors, OCFS's position is that the standards of the new Article 10-A of the FCA relating to permanency hearings apply to such children in part in order to satisfy federal Title IV-E State Plan requirements whereby New York must afford procedural safeguards to all categories of foster children, irrespective of whether they receive Title IV-E funding.]

Chapter 3 of the Laws of 2005 does *not* apply to permanency hearings for persons in need of supervision (PINS) and juvenile delinquents (JD) in foster care who are *not* completely freed for adoption.

Each permanency hearing for children affected by this law will have a date certain established. Petitions for extension of placement and/or permanency hearings are no longer filed as a means to calendar the permanency hearing for this population. The term "date certain" means a specific day set by the court when a permanency hearing will be held. The date certain for the initial permanency hearing is set at the first removal hearing, or the hearing under section 358-a of the SSL approving the voluntary placement agreement or surrender. The date for each subsequent permanency hearing is set at the completion of the previous permanency hearing. The actual timing of the date certain is based on the standards set forth in section 1089 of the FCA:

- Initial Permanency Hearing (Non-freed Child)
Date of removal from home plus 60 days plus 6 months = no later than 8 months;
- Initial Permanency Hearing (Completely Freed Child)
Immediately following an approval of a surrender or termination of parental rights disposition; or no later than 30 days after the court hearing completely freeing the child;
- Subsequent Permanency Hearings (Freed and Non-freed Child)
No later than 6 months following the preceding permanency hearing.

The Family Court has the authority to establish a date certain at an earlier date than the time frames listed above, since the statute requires the permanency hearing date to be set "no later than" each of the specified time frames. It should be noted that the date certain is to be entered in CCRS, as a modifier to the legal activity (Permanency Hearing) that is reported. This date is brought

over to CONNECTIONS. If necessary, it can be changed in CONNECTIONS, although any such change does not feed back to CCRS.

Notice of the Permanency Hearing and the Permanency Hearing Report under Article 10-A of the FCA must be provided to the following:

- the child's parent, including any non-respondent parent (see exception noted below);
- any other person legally responsible for the child;
- the foster parent in whose home the child currently resides, if applicable;
- the child's law guardian;
- the attorney for respondent parent, if applicable;
- the agency supervising the child's care, if applicable;
- any pre-adoptive parent; and
- any relative providing care for the child.

All former foster parents within whose home the child resided for a continuous period of 12 months must be provided *only with Notice of the Permanency Hearing*. This requirement is to be met regardless of whether the foster boarding home remains open or has since closed.

Effective July 26, 2006, Permanency Bill Technical Amendments - Chapter 437 of the Laws of 2006 did the following:

- Amended the notification provisions of section 1089 of the FCA to dispense with notification to the birth parent where the parental rights of the birth parent have been terminated or surrendered; and
- Permits the court to dispense with notification to a former foster parent where the court determines it is in the best interests of the child.

Overview of Permanency Hearing Report Module

CONNECTIONS Build 18.9 provides workers with the ability to complete their obligations regarding the PHR, Notices and Statement, by utilizing functionality in CONNECTIONS. With Build 18.9, the worker's responsibility to fulfill statutory and regulatory requirements associated with date certain time frames as they apply to completion and submission of the PHR remains in effect as detailed in Article 10-A of the FCA. In addition, current models of practice related to contributors to the PHR continue with Build 18.9, as does the capacity for multiple workers with an assigned role in the case to contribute to the PHR. The PHR Module in CONNECTIONS utilizes the same content as the PHR Templates. The PHR templates continue to remain available on the OCFS website. Workers at ACS and voluntary

authorized agencies that contract with ACS will continue to use the Legal Tracking System (LTS) as an adjunct to the Module.

The PHR in CONNECTIONS is generated based on the child's permanency planning goal. It is presented in template format with Microsoft Word-like functionality available. There are three types of Permanency Hearing Reports:

- Individual child report;
- Multiple children in the same case who are not completely legally freed; and
- Individual child who is completely legally freed for adoption (available only in the Child Case Record (CCR)).

The Permanency Hearing Reports are integrated into CONNECTIONS and are accessible and easily navigable from the Permanency window. From that window, selecting a single child will automatically generate the Individual Child Report, unless that child is freed for adoption and in a CCR, in which case the Freed Child Report will be generated. Selecting multiple children in the same placement will automatically produce the Multiple Child Report. It is important to note that more than one PHR can be launched and in process within a stage; however, only one PHR can be in process at any one time per child (or children if PH-2 is being used for multiple children).

Use the Permanency Hearing Report for **Multiple Children (PH-2)** for children who are *not* completely free for adoption when:

- all children in the same family are scheduled to have a Permanency Hearing at the same time; and
- the children have at least one parent in common (but if any confidentiality concerns among parent recipients exist, use the Individual Report); and
- the children are placed together; if placed apart again consider confidentiality.

Responses about each child must be individualized on the Multiple Children Report.

Use the Permanency Hearing Report for **Individual Child (PH-1)** for a child who is *not* completely free for adoption when:

- a child is "partially free" and another child in the family is not free for adoption;
- *any* of the Multiple Children Report conditions are not met; or
- whenever it is equally or more convenient for the caseworker or the Court has directed an Individual Child Permanency Hearing Report be used.

Always use the Permanency Hearing Report for **Freed for Adoption Individual Child (PH-3)** for:

- each child completely legally free for adoption.

No address information about any of the participants in a permanency hearing (including the child's address), nor the child's school address information should be included in any Permanency Hearing Report. Concerning the inclusion of confidential HIV-related information in the Permanency Hearing Report, such information may be included *only* if all the persons with whom you are sharing the report are authorized under the Public Health Law to have access to such information.

Any worker with a role in the case can launch a PHR. He or she will next select either "pre-fill" or "no pre-fill." Demographic information and certain other data will populate the PHR and is not modifiable on the report, whether "pre-fill" or "no pre-fill" is selected. Selecting "pre-fill" will produce a document already populated with information from the Family Services Stage (most recent FASP, Plan Amendment, Removal Update, and the Health and Education modules), however some information will still need to be directly entered into the "pre-filled" PHR (particularly the Freed Child report). All information pre-filled in the template will be modifiable by the users (except for demographic information as noted previously). *If the worker selects the pre-fill option, it is critical that he or she review the information in the answer fields so that it will be appropriate and accurate. Editing will be required in almost every case.*

All contributors with a role in the stage are able to work in the PHR template within the system. The system will maintain a history of all Permanency Hearing Reports generated for each child in a stage.

A PHR may still be e-mailed, after being secured by password protection, to parties outside of CONNECTIONS, such as a LDSS attorney or supervisor. The PHR must be password protected in accordance with the instructions in the Guide for Caseworkers – Permanency Hearing Report, December 2005 and in keeping with "Security Guidelines for using Electronic Communication for Sharing Case Specific Information" located on the CONNECTIONS Intranet Security page. The Guide is accessible at:

<http://www.ocfs.state.ny.us/main/legal/legislation/permanency/Guide%20for%20Caseworkers-Permanency%20Hearing%20December%202005.doc>

In addition to the PHR, the Notices and Statements are also generated by the system. Court information necessary for these notices is entered in CONNECTIONS and the system will note when the document was generated; workers can note when they were mailed. A history is also kept on who they were sent to and when. Furthermore, other participants in the permanency hearing can be added to the Invitee List for the permanency hearing via the

“Add Other Participants” function (from the Stage Composition Options menu).

Build 18.9.7 will add additional functionality to the Permanency Hearing Module such that information about the petitioner can be added to the Court Information window, and that information will be pre-filled on the Notice.

Legally Freed Children

For a child who has been legally freed and in a CCR, the Freed Child Report will be generated. The initial permanency hearing for a freed child must take place within 30 days of the hearing at which the child was legally freed. Many courts conduct the dispositional hearing and upon making the finding that a child is legally freed, move directly to the initial permanency hearing for the freed child. If the Family Court does not conduct the initial permanency hearing immediately following the dispositional hearing determining that a child is freed, there is the potential for a delay in the ability to auto-generate the correct PHR and submit that to the court and other parties within the specified time frames required by law. If the Court establishes the date certain for the initial permanency hearing for a completely freed child at the dispositional hearing, the child’s case is to be progressed to a CCR stage, thus allowing auto-generation of the correct PHR. If the Court does not establish the date certain for the initial permanency hearing after freeing, then the LDSS or VA staff must wait until receipt of notification of the date certain or court order legally freeing the child before they create the CCR.

Detailed, step-by-step instructions for creating and managing the PHR, Notice and Statement in CONNECTIONS are contained in the **CONNECTIONS System Build 18.9 Job Aid: Permanency Hearing Reports**.

Required Actions:

- Once the PHR is launched, before staff take any further steps, they must check the demographics that are presented in the PHR template.
 - Data fields cannot be modified directly in the PHR; therefore, they will have to go to the original data entry source in the FSS and change the information there.
- All social services districts and VAs must confirm and review established guidelines and business processes regarding who will launch the PHR and who will complete what parts, because everyone who has a role in the case can “launch” the PHR, just like the FASP.
- Workers must keep the report in DRAFT until they are confident that material is complete and all required reviews have taken place, in accordance with any district/agency guidelines about PHR review. Social services districts and VAs are asked to review the implications of this for the review and approval process, and to decide who will make the decision that the PHR is complete.
- Each PHR must be reviewed for: cohesion, accuracy, currency, redundancy, and compliance with applicable confidentiality standards.

- Workers must delete any health information from a pre-filled PHR if it would become available to a person who does not have the legal authority to access such information, or if the consent of child is required but has not been granted to share certain information.
- After review is completed, the PHR is to be marked as final, freezing the report.

There may be circumstances where the use of the PHR templates outside of CONNECTIONS may still be needed. One example is a freed minor mom in foster care who has her own child with her. Currently, the CCR can only accommodate a single person, necessitating leaving the minor mom in the CWS, so an expanded payment can be made for the pair. The freed child PHR is only available from the CCR, necessitating use of the stand alone template. There may be other reasons as well.

D. Security Changes

Recommendations:

Management should carefully consider who receives those Business Functions listed in Appendix A and also refer to the **CONNECTIONS System Build 18.9 Job Aid: Health Services**, and Online Help within the Health Services Module for further detail.

Out assignments, in conjunction with Unit Hierarchy Access, should be carefully reviewed to protect the confidentiality of the information in the Health Services tab. Agencies should:

- Review agency assignments of the UNIT SUM ACCESS Business Function;
- Realign agency protocol regarding the assignment of the UNIT SUM ACCESS Business Function if needed;
- Remove the UNIT SUM ACCESS Business Function from those who should not have it;
- End date any staff that are no longer in need of CONNECTIONS access at all.

Persons who do not have a role in the stage and who should be updating health information for all children in a district or voluntary agency, such as a Nurse or other health care professional, should be given the MAINT HEALTH Business Function. The MAINT HEALTH business function, in conjunction with the CASE or CASE/PERS SEARCH Business Function allows users to update/view Health for all children for whom his/her agency has been designated responsible. Persons who need access to agency-wide health information but do not need to update health information should be given the

VIEW HEALTH BF in conjunction with ACCESS ALL AGY/DISTRICT BF. This might include administrators or Directors of Services.

E. AFCARS Data Elements

Several of the required AFCARS elements are part of the Health and Education Modules. Primarily these are diagnoses which establish the child as disabled. It is essential that all such diagnoses be entered in the course of recording Initial Assessment, Reassessment and Well Child medical appointments. Any chronic condition for which credible information exists is to be entered as “diagnosis at intake.”

Modifications and enhancements will be made to CONNECTIONS in Build 18.9.6 that will further support compliance with federal AFCARS reporting requirements. Build 18.9.6, scheduled for implementation in spring of 2008, will contain modifications to include specific data elements related to placement and adoption services, including a new adoption related AFCARS window and additions to other windows for additionally required foster care data. Completion of these data fields will be required in order to meet AFCARS reporting needs for the first quarter of 2008. Most of these specific data elements relate to:

- Date of Removal
- Type of Legal Event Associated with Removal
- Conditions Associated with Child’s Removal

Examples of additional data elements that will be required are:

- Child Ever Adopted
- Has the child been previously adopted?
- Age (of child when previous adoption was recognized)
- How old was the child when the previous adoption was finalized?
- Was the child adopted internationally
- Foster family structure
- Child placed in Congregate Care

Required Actions:

All data elements must be completed effective with the date of implementation of the new functionality available in the CONNECTIONS application.

IV. Effective Date:

All requirements outlined in Health and Education are effective immediately. Priority should be given to entry of required fields in the Health Services Module, Clinical Appointments tab. This data must be entered by January 20, 2008 for all children in foster care in the custody of LDSS and OCFS as of December 1, 2007 or later. In relation to children receiving Preventive or Protective services only, all essential health and education information related to the reason for the receipt of child welfare services must be maintained in CONNECTIONS in either the Health or Education modules and/or in Progress notes. All relevant information must be maintained contemporaneously with the event and/or receipt of the information.

/s/ Nancy W. Martinez

Issued By: Nancy W. Martinez
Title: Director
Office of Strategic Planning and Policy Development

Appendix A

NYS OFFICE OF CHILDREN AND FAMILY SERVICES
BUILD 18.9 BUSINESS FUNCTIONS

Business Function	Security Attributes	Recommendations for Assignment	Description	Needed with Role	Needed without Role	Office Type
MAINT APP REG	Maintain App Reg	LDSS staff who are approved within their district to open a WMS Services Case from CONX. Persons, who do not have a role in the stage and who are responsible for documenting/ updating health information and maintaining the medical history for all children in a district or agency; such as a Nurse, other health care professional, or care coordinator. Refer to the Health Services Job Aid for further detail.	Users with this BF will be able to initiate the application registration process in WMS for child welfare cases open in CONX.	Yes, if they are approved to open a WMS Services Case from CONX.	Yes, if they are approved to open a WMS Services Case from CONX.	LDSS
MAINT HEALTH	Maintain Health	Persons who need to access health information on a district or agency wide basis, such as an Administrator or Service Director who do not have a role in the stage, or access via unit summary. The BF must be assigned with the access all in district or agency BF to first gain access to the stage. The View Health BF allows them further access to Health information. Refer to the Health Services Job Aid for further detail.	Users with this BF may update/view Health information for all children for which his/her agency has been designated as having health care responsibility. Must be assigned the Case/Pers Such BF. BF allows access to the Health dialog via the Case Search path. No other dialogs are enabled.	No, not to access a child on their workload.	Yes, see Recommendations for Assignment	LDSS, VA, DRS
VIEW HEALTH	View Health	Persons who need to access health information on a district or agency wide basis, such as an Administrator or Service Director who do not have a role in the stage, or access via unit summary. The BF must be assigned with the access all in district or agency BF to first gain access to the stage. The View Health BF allows them further access to Health information. Refer to the Health Services Job Aid for further detail.	Users with this BF who also have the access all in district or agency BF may view health information for any child in a case where that district or agency has a role in the stage (or had a historical role in the case) and has or had been designated as responsible for updating the health information. For Implied Role. When accessing other FSS stages via Implied Role, the Health tab will only be enabled when the person in common is in any open INT, INV or ARI stage on the user's workload.	No, not to access a child on their workload.	Yes, see Recommendations for Assignment	LDSS, VA, DRS, RO, State

Appendix B

The Job Aids referenced in this ADM and the Job Aid describing other functionality that became available with Build 18.9 are located on the CONNECTIONS intranet website by following the link below:

<http://ocfs.state.nyenet/connect/jobaides/jobaides.asp>

Build 18.9 Job Aids

- [CONNECTIONS System Build 18.9 Job Aid: Health Services](#)
 - **Revisions:** [Health Services Job Aid](#)
- [CONNECTIONS System Build 18.9 Job Aid: Permanency Hearing Reports](#)
 - **Revisions:** [Permanency Hearing Reports Job Aid](#)
- [CONNECTIONS System Build 18.9 Job Aid: Critical Improvements](#) *(dated 4/5/07)*
 - **Revisions:** [Critical Improvement Job Aid](#)
- [CONNECTIONS System Build 18.9 Job Aid: Education](#)
 - **Revisions:** [Education Job Aid](#)

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 97 ADM-15

TO: Commissioners of
 Social Services
 Executive Directors of
 Voluntary Authorized Agencies

DIVISION: Services and
 Community
 Development

DATE: July 24, 1997

SUBJECT: Foster Care: Assessment of Foster Children for Capacity to
 Consent and HIV Risk; Counseling of Adolescents; Legal
 Consent for HIV Testing; Documentation and Disclosure

 SUGGESTED

DISTRIBUTION: | Directors of Services
 | Medical Services Staff
 | AIDS Coordinators
 | Staff Development Coordinators
 | Foster Care Supervisors
 | Legal Staff

CONTACT PERSON: | BRO - Linda Brown (716) 847-3145 USER ID: 89D421
 | RRO - Linda Kurtz (716) 238-8201 USER ID: 0FH010
 | SRO - Jack Klump (315) 423-1200 USER ID: 89W005
 | ARO - William McLaughlin (518) 432-2751 ID: 0FN010
 | MRO - Fred Levitan (212) 383-1788 USER ID: 72W035

ATTACHMENTS: | Listed in Table of Contents where those available on-
 | line are so indicated

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
90 ADM-21	94 LCM-64	18 NYCRR	SSL 20	Standards	
91 ADM-36		Parts 357	34	of	
		428	373-a	Payment	
		441	398	Chap.VIII	
		507	PHL	(B)	
			Article		
			27-F		

D.	<u>Third Step: Obtaining Legal Consent for Testing</u>	15 - 17
	1. Child With Capacity to Consent.....	15
	2. Child Without Capacity to Consent.....	15 - 17
	a. Consent by the parent or legal guardian.....	16 - 17
	b. Consent by the commissioner or designee.....	17
	(1) parental surrender or TPR.....	17
	(2) Article 10 placements.....	17
E.	<u>Fourth Step: HIV Counseling</u>	17 - 20
	1. Counseling Required by Public Health Law.....	17 - 19
	2. Counseling Required by Social Services Policy and Regulations.....	19 - 20
F.	<u>Training, Information and Support for Staff and Families Providing Services</u>	20 - 21
	1. Information and Training for Staff.....	20
	2. Foster Parent Support and Training.....	20 - 21
IV.	<u>REQUIRED ACTION</u>	21 - 32
	A. <u>Designation of Staff Responsible for Assessment</u>	21
	B. <u>Required Timeframes for Assessments</u>	21 - 22
	C. <u>Basis for Assessment of HIV Risk</u>	22 - 23
	D. <u>HIV Risk Factors</u>	23 - 24
	E. <u>Obtaining Legal Consent</u>	24 - 28
	1. Child Lacks Capacity to Consent and Is Article 10	24 - 25
	2. Child Lacks Capacity to Consent and Is Freed.....	25 - 26
	3. Child Lacks Capacity to Consent and Is Placed Voluntarily or Is JD or PINS.....	26
	4. Child Has Capacity to Consent and Right to Make Decision Re: Testing.....	26 - 28

F. <u>HIV Testing of Child</u>	28 - 29
G. <u>Services Required Following HIV Testing</u>	29
H. <u>Documentation Required in Uniform Case Record</u>	29 - 30
I. <u>Confidentiality and Disclosure of HIV-Related Information</u>	30 - 32
1. Persons/Agencies With Direct Access to Information.....	31
2. Persons to Whom Information Must Be Disclosed.....	31
3. Persons Entitled to Information Under Certain Conditions.....	31 - 32
4. Persons With Right to Redisclose.....	32
J. <u>Recruitment of Families to Care for HIV-Infected Children</u>	32
V. <u>REPORTING AND SYSTEMS IMPLICATIONS</u>	32
VI. <u>ADDITIONAL INFORMATION</u>	32
(Appendices A. through M. are attached after VII.)	
VII. <u>EFFECTIVE DATE AND SIGNATURE OF DEPUTY COMMISSIONER</u>	33

APPENDICES

- A. Warning Notice Against Redisclosure..(On-line)
 (Spanish Translation on Reverse)...(On-line)
- B. Model Form: Authorization for Redisclosure of Confidential HIV-Related Information..(On-line)
- C. Model Form: Request for Parental Permission to Test Child Without Capacity to Consent For HIV Infection..(On-line)
- D. Model Form: Decision Regarding Test for HIV Infection by Child With Capacity to Consent..(On-line)
- E. NYS Department of Health Form: Informed Consent to Perform an HIV Test

APPENDICES, Cont.

- F. Hotlines and Information
- G. Anonymous HIV Counseling and Testing
- H. NYS Independent Living Training Network With Information and Resources Available on Adolescent Issues..(On-line)
- I. Adolescent Health Services
- J. HIV Specialized Care Centers
- K. Community Prevention and Primary Care Services
- L. Permanency Planning Service Providers
- M. Legal Services

I. PURPOSE

The purpose of this directive is to provide guidance and set best practice standards for implementing New York State Department of Social Services regulations and policies requiring assessment of risk for human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS) in foster children. Included in this directive are guidelines for determining a foster child's capacity to consent and for obtaining legal consent for HIV testing when risk is identified.

Regulations requiring these actions were adopted and effective on August 23, 1995, amending sections 428.3, 441.22, and 507.2 of Title 18 NYCRR. New York State statutes related to these regulations include Public Health Law, Article 27-F, which establishes criteria for HIV-related testing and confidentiality; Section 373-a of the Social Services Law (SSL) which specifies the persons and entities to whom the medical history of the foster child must be provided; and Section 398(6) of the SSL, which requires local commissioners of social services to provide for expert mental and physical examinations of any foster child reasonably suspected of having a mental or physical disability or disease and to provide necessary medical or surgical care for any child needing such care. In addition, standards of care and treatment applying to residential programs for children must be provided according to SSL, Section 462.

II. BACKGROUND

As the number of HIV/AIDS infection and mortality cases continues to increase nationwide, the number of New York families and children infected and affected by the epidemic also continues to rise. While the highest statistics are reported by New York City, no area of the state is exempt from mounting numbers of cases of HIV infection. No vaccine and no cure for the disease has been developed as of the issuance of this directive. However, continuing research has resulted in development of new treatments and medications being used by the medical community to prolong life and maintain the quality of life for those infected. More effective early treatment makes the identification of children at risk more urgent and has resulted in the determination of the State Department of Social Services to develop this major policy initiative for the benefit of the children in foster care. The regulations emphasize the importance of preventive measures, counseling and education of youth and risk reduction, as well as testing when risk is identified, and medical care as needed.

The 1995 regulations were an important addition to previous requirements set forth in the Department's earlier Administrative Directive (91 ADM-36) issued September 16, 1991: "Foster Care and Adoption: HIV-Related Issues and Responsibilities." That directive focused on confidentiality and disclosure issues, documentation, and required training and information for staff involved in HIV-related issues, HIV counseling and testing.

The addition of the HIV assessment, counseling and testing regulatory requirements discussed in this directive continues the Department's efforts to address a health care crisis affecting families and children of all ages, with particular focus on children in foster care.

Chapter 220 of the Laws of 1996, which became effective February 1, 1997, required that all infants born in hospitals or birthing centers be tested for HIV. No parental consent for this additional component of the prior existing Newborn Screening Program is required. For a discussion of the significance of this testing in relation to an authorized agency's responsibilities, see page 10 of this directive.

III. PROGRAM IMPLICATIONS

The regulatory requirement for assessment of HIV risk for each child placed in foster care, regardless of age, provides a higher standard of awareness and medical services related to the HIV epidemic affecting children and families in New York. Practice and program implications of this mandate will include development of new agency procedures for designation of informed staff to conduct assessments, obtain legal consents, arrange for HIV testing, provide follow-up services and ongoing counseling.

A. DESIGNATION OF STAFF TO MAKE ASSESSMENTS

Designation of staff to make the assessments of capacity to consent and HIV risk is an important internal administrative decision for each authorized agency. Such designations must include serious consideration of staff information and training on HIV/AIDS issues as required by Department regulations, as well as staff experience with particular age groups. Counseling and the ability to discuss prevention and risk reduction are skills needed by designated staff working with older children. When medical staff or a clinical social worker is available within the agency, such persons may be able to undertake the assessments with a minimum of additional preparation and training. Designated staff will need to use flexibility, cultural sensitivity, and their own experience and judgment in implementing assessment procedures, and modify those procedures based on the age, developmental stage and cognitive abilities of the foster child.

Staff designated to make the assessments should take advantage of further training opportunities offered through Department contractors, or through other agency, community or medical training providers, as discussed on page 20 of this directive. (Please also see pages 24 and 25 of 91 ADM-36 for agency requirements to provide HIV-related information and training for staff initially and annually.)

In addition to understanding the basic medical/physical development and impact of the disease, designated staff making the assessments of capacity to consent and HIV risk will need to learn the legal standard for capacity to consent as defined on page 5, as well as the rules regarding HIV-related confidentiality and the penalties for breaking such rules (see page 30 and Appendix A). The ability to relate to children in different stages of development and growth will be important in making the assessments, requiring sensitivity to the developmental and emotional status of each child. Ability to counsel adolescents will be a particularly important skill needed by staff designated to work with this age group.

B. FIRST STEP IN ASSESSMENT: DETERMINATION OF CAPACITY TO CONSENT

Determination of the foster child's capacity to consent is the first step for designated staff to take in meeting the requirements for assessment of HIV risk. No HIV testing, even after identification of risk, may take place unless written consent has been given by a person authorized to give consent according to Public Health Law, Article 27-F. A person with capacity to consent is the only person who may provide the required written informed consent before HIV testing may take place. For a child without such capacity, written consent for HIV testing must be obtained from a person authorized by law to give such consent (see pages 15-17 of this release).

An assessment of a child's capacity to consent is required by Department regulations within five business days of each child's entry into foster care. For each child who entered foster care prior to September 1, 1995, an assessment of capacity to consent was to have been made 60 days prior to the child's next medical examination or to the next service plan review occurring after August 23, 1995, whichever was earlier.

1. Alternatives and definitions

Staff designated to determine the child's capacity to consent are required to consider in their initial five day assessment which of the following two alternatives applies to the child: (1) there is NO POSSIBILITY that the child has the capacity to consent, or (2) there may be A POSSIBILITY that the child has the capacity to consent. In the case of the second category, staff have 30 days to make a final determination regarding the child's capacity to consent. The determination regarding which

category applies to the child must be made without specific regard to the child's age, and the decision must be based on the definition of capacity to consent provided in Article 27 F of the Public Health Law and included in Department regulations at section 441.22 (b) (1) as follows:

+++++

CAPACITY TO CONSENT

Capacity to consent means an individual's ability, determined without regard to the individual's age, to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, or of a proposed disclosure of confidential HIV-related information, as the case may be, and to make an informed decision concerning the service, treatment, procedure or disclosure.

+++++

Decisions regarding capacity to consent are to be made on a case-by-case basis, with consideration given to the developmental stage and cognitive abilities of the child.

"Cognitive abilities" refers to a child's level of perception, memory, judgment, and understanding as these characteristics relate to HIV risk factors, risk behavior reduction, HIV testing, counseling on the nature and consequences of the disease, and the disclosure of HIV-related testing information.

In cases where a designated staff person has difficulty making a satisfactory determination regarding an individual child's capacity to consent, supervisory assistance is recommended. In rare instances when the decision is not resolved with supervisory assistance, consultation with a third professional may be necessary.

2. Assessment Categories

While the definition of capacity to consent prohibits determination based on specific age, the application of the definition to children in foster care requires an assessment based on realistic levels of development and cognitive abilities. The following assessment categories provide best practice guidelines for making the determination:

a. Infants and pre-school children

Infants and pre-school children entering foster care would clearly have NO possibility of capacity to consent, based on the legal definition given above. In such cases,

designated staff are to proceed immediately with the assessment of risk for HIV infection described in Section III. C. beginning on page 7. For those children with NO possibility of capacity to consent, the HIV risk assessment, based on medical or psychosocial information available at the time, must also be completed within the first five business days of entry into care. Children in this category who entered foster care prior to September 1, 1995 were to have an assessment of capacity to consent and HIV risk 60 days prior to their next periodic medical examination or service plan review, whichever came earlier.

In cases where an infant or pre-school child has already been tested through the Department of Health mandated universal newborn testing program effective February 1, 1997, and the results of such test are made available to the authorized agency, documentation of any known risk and results of the HIV testing at birth are to be included in the child's uniform case record. This information will need to be shared with the child's medical provider at the time of the comprehensive physical examination required within 30 days of the child's entry into foster care.

b. Elementary school children

A foster child in this category would generally have NO possibility of capacity to consent, particularly if the child is in the lower elementary grades. It is unlikely that a child under the age of puberty would be fully able to understand and appreciate the nature of this complex disease or to make an informed decision regarding testing and disclosure. Only in exceptional cases might such a child be considered to have A possibility of capacity to consent. (The fact that a child is assessed to have no capacity to consent does not eliminate consideration of informing and counseling an elementary school child regarding prevention and risk reduction at a level appropriate for the age and development of the child.)

Further, since capacity to consent is to be determined on a case-by-case basis, if there may be A possibility of such capacity, staff may take up to 30 days after the child's entry into care to make a firm decision and to complete the HIV risk assessment. For elementary school children who entered foster care prior to September 1, 1995, determination of capacity to consent and assessment of risk for HIV infection were required no later than 60 days before the child's next periodic medical examination or service plan review, whichever came earlier.

c. Pre-adolescent, early adolescent middle school children

Foster children attending middle school or junior high school are more likely to have the capacity to consent

based on the legal definition. However, the broad range in individual physical, mental and emotional development in children at this stage of growth requires a case-by-case determination of such capacity within the 30 day timeframe allowed by the regulations when there may be A possibility of capacity to consent. In this developmental stage, supervisory review of the determination of capacity is suggested, and where a question remains, consultation with a third party may be necessary.

d. High school and post-high school youth

Young people in these categories will generally have the capacity to consent to HIV testing and disclosure, although there may be exceptions in cases of developmental delay or disability and/or mental or emotional instability. In most cases, through the required information and counseling process within the 30 day timeframe for determination of capacity and assessment of risk, adolescents and young adults will be able to understand and appreciate the nature and consequences of the disease and to make an informed decision regarding the recommended testing when risk is identified.

Unresolved questions regarding capacity to consent in this stage of development should be referred to a supervisor and may suggest the need for consultation with other appropriate professional staff, such as a psychologist or clinical social worker.

When a youth in foster care is determined by staff on the basis of developmental stage and cognitive abilities to have the capacity to consent, that young person has the right to make his or her own decision on whether to be tested for HIV infection.

C. SECOND STEP: RISK ASSESSMENT FOR HIV INFECTION

1. Required timeframes for HIV risk assessment

The second step in the requirements for HIV assessment and testing involving children in foster care is the determination of HIV risk factors in the child's medical and psychosocial history, based on the information available. For children with NO possibility of capacity to consent, the assessment of HIV risk must be completed within the first five business days of entry into care. If agency staff determine that a child may have A possibility of capacity to consent, the timeframe for both the determination of capacity to consent and the HIV risk assessment is extended to 30 days from entry into care.

For each child who entered foster care prior to September 1, 1995, determination of capacity to consent and assessment of HIV risk were to be completed 60 days prior to the child's next

service plan review or next scheduled medical examination, whichever came earlier.

2. HIV risk factors

Three groups of HIV risk factors for use during the assessment process are provided in the Department's regulations (section 441.22(b) of 18 NYCRR) and in Section IV.D. (pages 23-24) of this directive. Developed with the cooperation of the medical community and the AIDS Institute of the Department of Health, the listed factors are to be used by designated staff in reviewing the health/medical and psychosocial history and other written records regarding the child, as well as for guidance in discussions as appropriate with a child, youth or child's parents. The risk factors should never be used as an oral checklist with children, but are intended primarily for internal use by staff in making the assessments.

The first group of risk factors is relevant for an assessment of infants and pre-school children, with the factors related to perinatal transmission from the mother to the infant during pregnancy, at birth or through breast-feeding. The second group, a list of family psychosocial/health factors which also may result in perinatal HIV transmission, is primarily related to infants and pre-school children, but has been identified as a latent source of transmission to some elementary and middle school children as well.

The third group provides a list of factors primarily used for assessment of older children, based on the child's behavior and/or other means of direct transmission. (See further discussion on pages 23-24.) It is this third group which may be helpful in counseling and discussions on prevention and risk reduction with older youth who may be able to understand the serious issues involved in transmission of HIV/AIDS.

3. Assessment of HIV risk through written records

For all age groups, the health/medical and psychosocial family history of the child, to the extent available, is the foundation for the assessment of HIV risk. Therefore, a review of any written information/records concerning the child is essential. Information regarding the child or child's family may be available through the following:

- a. any medical or psychosocial records available at the time of placement or that become available at any time while the child is in foster care;
- b. any relevant information recorded as a result of contacts and discussions with the child's family, foster family, or medical providers;

c. child protective services investigative reports on the Preliminary Assessment of Safety form (DSS 4337) or other written record.

When a child is identified through such available information as having one or more of the HIV risk factors listed on pages 23 and 24 of this directive, the risk factor(s) and basis for the determination are to be documented in the uniform case record of the child. Authorized agencies must keep all HIV-related information in the medical history file of the child which is technically part of the uniform case record, but is often kept in a separate location in order to limit access to specified persons.

When a review of the information available is insufficient to determine whether a child is at risk, staff will need to make a reassessment when new information becomes available. In all cases, staff will need to review any additional relevant information at each service plan review and each periodic medical examination of a child that occurs after the initial assessment of the child pursuant to Section 441.22(b)(6) of Department regulations.

4. Assessment of HIV risk indicating direct, person-to-person discussion/contact

The following guidelines for assessment of HIV risk involving person-to-person contacts, discussion and counseling, as appropriate, are provided in the same four categories as those used above to determine capacity to consent:

a. Infants and pre-school children

Available written records of the child in this category will generally be sufficient to make an assessment of HIV risk. However, if relevant information is lacking, designated staff may wish to make reasonable efforts to contact the parents of the child, other staff, medical or community services providers who are known to have knowledge of the child and/or the child's family.

It is this category of child for whom early intervention and medical treatment have been determined through scientific studies to be extremely important in maintaining the quality of life and prolonging life. The identification and medical care of infants and pre-school children who may be HIV-infected are therefore urgent goals of the Department's assessment and testing policy and regulations. If one or more risk factors are identified for a child in this category, immediate efforts should be

made to obtain necessary legal consent for testing or re-testing as necessary and to arrange for the test so that early treatment and services may be provided if the child tests positive.

+++++

Virtually all children born in the State since February 1, 1997 are tested for HIV antibodies shortly after birth as part of the State's Newborn Screening Program (NSP). The authorized agency should not retest a child under the age of twelve months unless the child tests negative at birth but there are risk factors that are present after birth (i.e., the infant has been breast fed); the authorized agency is unable to obtain the NSP test results; or the child's NSP test was positive necessitating follow-up PCR or viral culture testing discussed below. Additionally, given the availability of the test results, as described below, authorized agencies should seek the test results for all foster children born on or after 2/1/97, up to the age of 12 months, regardless of whether or not there are risk factors present. The test results should be available approximately ten days after the child's birth.

There are two possible methods for obtaining the test results, both of which require obtaining one of the following identifiers: a) the Newborn Screening Program Blood Collection form identification number (available from the birth hospital through the Newborn Screening Designee; however, after a couple weeks following birth may only be available through the hospital's medical records office which, depending upon the hospital, may take too long a period to be made available to be viable); or b) the mother's social security number.

A physician caring for the foster child can access the newborn test results through the NSP's Voice Response System (VRS) at Wadsworth Laboratory, using one of the two identifiers described above. (Note: All physicians must register with the NSP at (518) 473-7552 if they have not used the system before.) If the authorized agency does not find this method of obtaining the test results practicable for a particular child, the agency can instead contact the ACS Pediatric AIDS Unit (212) 266-3304, if the child is in ACS' custody, or Carol Shortsleeves from this Department at (518) 474-9594. If you choose to use the ACS or NYSDSS contact person, it will still be necessary to have one of the two identifiers listed in the preceding paragraph. The ACS and NYSDSS will then contact the State Department of Health (SDOH) Laboratory to obtain the test result. (SDOH will be evaluating the volume of requests it receives for test results from ACS and NYSDSS to determine its ongoing

capacity to provide results for foster children up to the age of 12 months.)

The newborn's antibody test results reflect the HIV status of the mother. A negative result means the mother and newborn are most likely not infected. A positive result means the mother is infected and the newborn may or may not be infected. To determine if the newborn is infected, a child must be retested using a more sophisticated "PCR" test (or viral culture). All infants will need at least two PCR tests. The optimal time for the first PCR is at the first pediatric visit or by one month of age. HIV infection can be reasonably ruled out for infants who have had two negative PCR tests after one month of age, with one test coming after 4-6 months of age. (The SDOH does HIV PCR testing on all HIV positive infants less than 18 months of age for free.) The SDOH requires the birth hospital to notify the physician responsible for the baby's care of the antibody test results. If the result is positive, the physician must administer the follow-up PCR test(s) and provide or arrange for post-test counseling for the infant's mother. Any PCR test required to be administered to an HIV-antibody positive infant up to the age of 12 months born on or after 2/1/97 does not require the obtaining of legal consent.

The SDOH requires birth hospitals to ensure that an infant who tests HIV-antibody positive on the Newborn Screening test is located and has a definitive diagnosis by PCR (or viral culture). The hospital is also required to obtain the results of the PCR test (or viral culture). It is important to determine those infants who are infected so they can receive early care, including drugs to prevent PCP (a serious form of pneumonia to which very young HIV-infected infants are particularly susceptible).

There may be occasions when a child tests HIV-antibody positive, enters foster care shortly after birth, and the birth hospital (or the SDOH, if the hospital asks for assistance) is trying to locate either or both the infant and the mother. In relation to the infant, the authorized agency should provide the following information, upon request, to the birth hospital or the SDOH:

- (1) the location of the infant;
- (2) the name and phone number of the physician/clinic caring for the infant;
- (3) whether a PCR (or viral culture) is scheduled for the infant or has been done; and
- (4) the results of such testing.

If the birth hospital or the SDOH asks for assistance in locating the infant's mother, it is for the purpose of informing her of the test result, providing counseling, and

encouraging her to receive appropriate medical care, especially if she was previously unaware of her HIV positive status. If the case planner knows the whereabouts of the infant's mother or is in contact with her, he/she should tell the infant's mother that they have been asked to inform her that she should contact the birth hospital to obtain important medical information about herself. After making such contact as soon as practicable, the case planner should inform the entity trying to locate the infant's mother that the message was conveyed.

+++++

b. Elementary school children

Written records and reports should serve as the foundation for the assessment of HIV risk in this category of children. Relevant risk factors will be found primarily in the first two groups of factors listed on pages 23 and 24, involving perinatal transmission of HIV.

However, staff should be aware that some items in the third group (e.g., sexual abuse), may also be applicable to elementary school (and pre-school) children. After checking the written records available, a designated staff person with experience and ability in relating to this category of children may wish to initiate a discussion with the child as appropriate about HIV risk behavior and the reasons for the assessment and possible testing.

The approach used in such discussions will depend on the developmental and emotional status of the child and the ability of the child to understand such explanations. For example, a child may be among those children who have already been involved in substance abuse or in sexual activity. If there is any indication of such risk behavior, and if the child appears able to engage in a discussion of prevention issues, the staff should begin such a discussion and provide opportunities to continue on other occasions.

In many cases in this category, designated staff may be able to discuss with the child who has one or more risk factors the importance of the HIV test in order to provide any necessary medical care. It should be explained to the child that the test will probably involve drawing blood, but will be no more painful than, for example, the types of required injections the child has experienced to protect against disease -- the required pre-school vaccinations.

While the older child in this category may be determined to have capacity to consent as defined in section III.C., most of these children will probably not meet the standard. Therefore, if one or more HIV risk factors are identified, and the child is determined not to have the capacity to

consent, staff will need to obtain the necessary legal consent for HIV testing from someone other than the child and arrange for the test according to procedures described in paragraph III.D. below.

c. Pre-adolescent, early adolescent middle school children

Many children in this category may meet the standards of development and cognitive ability leading to a determination of capacity to consent. HIV risk assessments involving children at this level should be made by staff who are well-informed regarding HIV/AIDS issues and have training and experience in working with children in this category.

While a review of written records will again serve as the basis for an initial assessment of risk, staff must initiate a person-to-person discussion with each youth within the first 30 days of entry into foster care in order to complete a determination of capacity to consent and a valid assessment of HIV risk.

Staff should take care to ensure that the initial and subsequent meetings of staff with the child regarding HIV risk be non-confrontational and non-threatening. Again, the risk factors listed in Section IV. D. of this directive should not be used as an oral checklist in assessment and counseling meetings with children and youth. The list is intended as a guide for staff in reviewing records and discussing prevention, risk reduction, and transmission of the disease with children and youth as appropriate for their level of understanding.

Risk factors particularly relevant to this category of child will be those in the third group on page 24 related to direct transmission of HIV through personal contact involving blood or semen, although perinatal transmission has been documented as the risk factor in some cases. Discussion of the third group of factors can form the basis for providing important information and counseling to the child. The initial meeting will be important in helping the child understand the reasons for the required assessment of HIV risk in order to offer support services and medical care if needed. Continuing opportunities for sharing information should be offered. If risk is identified, other issues for discussion will include required information on confidentiality and disclosure as discussed on page 30 of this directive.

d. High school and post-high school youth

As with the middle school category above, the initial meeting with high school youth will be important in helping the youth understand that the required HIV risk assessment

and discussion are meant to offer opportunities for sharing information on prevention and reduction of risk behavior, as well as to provide a recommendation for testing if risk is identified.

As is true for the pre-adolescent children, staff working with this category of youth will need to be sensitive and flexible in providing opportunities for such counseling and discussion and to understand that the young person may be both emotionally and physically exhausted by the events which have led to placement in foster care. At no time should such meetings become threatening, confrontational, or coercive.

The risk factors particularly relevant to high school and post-high school youth are those on page 24 related to direct transmission of HIV from another person, generally through the youth's own behavior, particularly related to sexual activity or drug abuse. Other possible risk factors are sexual abuse and, very rarely today, contaminated blood transfusions. Prior to discussions and counseling sessions with the youth, staff will need to review any information available through CPS, medical history, or other documentation related to possible HIV risk.

If the youth has the capacity to consent and is identified through the HIV risk assessment as having one or more risk factors, staff will recommend testing and discuss with the youth the reasons why such a test is important in order to obtain medical and other services if the result is positive. In addition to a discussion of the identified risk and the recommendation for testing, staff will need to forthrightly discuss the issues of confidentiality and disclosure as they apply to foster children (see page 30), as well as explaining to the youth the two types of testing available -- confidential and anonymous -- and the differences between the two. The youth with capacity to consent then has the absolute right to make his or her own decision regarding whether to undergo HIV testing and, if so, the type of testing.

In confidential testing of children in foster care, the name of the child and the authorized social services agency with responsibility for the child are recorded by the test site, and the results of the test are to be provided to the agency, as well as to others specifically permitted by law to be given such information as discussed on pages 30-32.

Anonymous testing is available in certain locations only to persons with capacity to consent. The person tested is identified only by an ID number. Results of the test can be given only to that person, regardless of foster care

status. However, a recent Department of Health policy change allows the person who chooses the anonymous type of testing to request a conversion from anonymous to confidential status at the time the results are provided. This makes possible the transmission of the results to a medical or social services provider in order to obtain needed treatment or services.

As in all categories, documentation in the case record will be necessary on the assessment of capacity to consent, assessment of HIV risk, counseling provided, and in the case of youth with capacity to consent, the decision regarding testing and arrangements made for the test if consent is obtained.

D. THIRD STEP: OBTAINING LEGAL CONSENT FOR TESTING

When HIV risk has been identified, designated staff will need to obtain legal written consent from an individual with legal authority to consent before the child can be tested.

1. Child with capacity to consent

As indicated on the preceding page, the child or youth who has been determined to have capacity to consent is the only person who can make a decision regarding testing and provide legal written consent for his or her HIV test.

If the youth agrees to be tested, he or she will be asked to sign a brief dated statement of consent (see model form in Appendix D) to be retained in the case file. (Please note that this brief statement is for the social services agency record; at the testing site, the youth will be asked to sign the Department of Health official informed consent form (see Appendix E for official form).) Staff will then proceed to make arrangements for the test within the next 30 days.

2. Child without capacity to consent

When a foster child does not have capacity to consent, there are three possible sources, all with specific limitations, for the necessary legal consent for the HIV testing of the child:

0 - the parent or legal guardian of the child; or

0 - the local social services commissioner or designated representative on an administrative level; or

0 - a court order in cases of urgent medical necessity as defined on page 16-17.

+++++

FOSTER PARENTS OR PROSPECTIVE ADOPTIVE PARENTS MAY NEVER PROVIDE LEGAL CONSENT FOR TESTING OF A FOSTER CHILD. CASEWORKERS MAY NEVER PROVIDE LEGAL CONSENT FOR TESTING OF A FOSTER CHILD.

+++++

a. Consent by the parent or legal guardian of the child

(1) When HIV risk has been identified for a child without capacity to consent, and the child has been taken into custody under Article 10 as an abused or maltreated child, or has been taken into or kept in protective custody or removed from the place where the child was residing pursuant to section 417 of the SSL or section 1022, 1024, or 1027 of the FCA, it is necessary to discuss with the parent or guardian the child's risk and the need for testing. Staff need to ask the parent/guardian for permission to test the child and to ask for a written response within 10 days of the request. If the parent agrees to provide legal consent for the test and is able to be present at the test site with the child to sign the required Department of Health pre-test consent form, staff should schedule the appointment and make other arrangements, including transportation as necessary.

If the parent refuses or is unable to provide written permission for testing the child identified as being at risk for HIV after reasonable efforts have been made to contact and discuss the importance of testing, it will be the responsibility of the commissioner or designated representative to provide the legal consent for testing in Article 10 cases.

(2) When HIV risk has been identified for a child without capacity to consent, and the child has been placed in foster care voluntarily by the parent/guardian, or has been placed in foster care as a Person in Need of Supervision (PINS) or as a Juvenile Delinquent (JD), written parental consent is required in order to test the child. If the parent refuses to provide such consent, staff are encouraged to meet with the parent to discuss the importance of early treatment and care for children who may be HIV-infected. If the parent continues to refuse, the authorized agency's only alternative in such cases is to determine whether to ask for a court order, pursuant to FCA 233, based on urgent medical necessity as defined below.

+++++

Urgent medical necessity, for the purpose of this directive, means a determination that:

- (1) a child entering care has previously tested positive and/or has symptoms related to HIV infection requiring immediate medical attention; or
- (2) the infant or pre-school child has been abandoned; or
- (3) the child's parent has HIV/AIDS or has died from HIV/ AIDS.

+++++

b. Consent by the local social services commissioner or designated representative.

+++++

"Designated representative" refers to designation by the local social services commissioner of specific staff on an administrative level within the agency or in a contract agency to provide written consent on behalf of the commissioner in appropriate cases; for example, a deputy commissioner, director of services, or the executive director of a voluntary child caring agency.

+++++

(1) When HIV risk has been identified for a child without capacity to consent, and the parents of the child have surrendered guardianship and custody of the child or parental rights have been terminated, the local social services commissioner or designated representative must provide the necessary written consent for testing the child. Designated staff will need to obtain the signed consent and make arrangements for the test.

(2) When HIV risk has been identified for a child without capacity to consent, and the child has been taken into or kept in protective custody pursuant to Article 10 of the FCA or section 417 of the SSL, and the parents are unavailable or have refused to provide consent for the child to be tested, the local social services commissioner or designated representative will provide the necessary written consent, as explained in a. above.

E. FOURTH STEP: HIV COUNSELING

1. Counseling required by Public Health Law

Article 27-F of the Public Health Law requires that the person who provides written consent for the HIV test must receive pre- and post-test counseling and information regarding the test at the test site. This rule is applicable to the child with capacity to consent and to the parent or guardian who accompanies the child without capacity to consent to the test site.

However, such a rule would not be applicable to a physician who provides consent in an emergency situation, nor to the social services commissioner with custody of the child, nor to the commissioner's designated representative with the legal right to sign the required consent form prior to an HIV test for foster children without capacity to consent. Again, caseworkers or foster parents who accompany a child to a test site may not sign consent for the child's testing, but should carry with them the required consent form signed by the appropriate person. They may be asked by site personnel to receive such pre- and post-test counseling as is appropriate.

Counseling and information provided at the test site are governed by the requirements of the New York State Department of Health, and will include an overview of the following as appropriate for the child to be tested and/or the adults present:

- a. the HIV test, including its purpose, the meaning of the results, and the benefits of early diagnosis and medical intervention;
- b. the procedures to be followed, including that the test is voluntary for persons with capacity to consent; that consent may be withdrawn at any time by a person with capacity to consent; and that anonymous testing is available for persons with capacity to consent;
- c. the persons entitled to disclosure of HIV-related information according to Public Health Law;

+++++

(Please note that this information may be confusing unless the foster child, parent or guardian, foster parent, or caseworker present at the testing site has been previously informed regarding confidentiality and disclosure issues under Social Services Law and regulations, which differ from and add to the basic requirements in Public Health Law.)

+++++

- d. the nature of AIDS and HIV-related illness, information about discrimination problems and the legal protections against such discrimination, and information about risk behavior for transmission/contraction of HIV infection;
- e. referral to an anonymous testing site upon request of a child with capacity to consent.

These Public Health Law requirements in no way replace the responsibility for authorized agencies providing foster care to

meet the assessment and counseling requirements set forth in Department regulations and this directive.

2. Counseling required by social services policy and regulations

Social services agency staff need to ensure that foster children and youth, parents or legal guardian, foster and prospective adoptive parents, as applicable, are prepared and informed prior to the child's testing site visit. When the test is conducted in-house, qualified and licensed medical employees of the authorized agency may be designated by the administration to provide the information and counseling needed to meet both Public Health Law and social services requirements. However, if the testing site is external to the agency, the staff there will provide standard information as required, but may have no familiarity with the child's background or medical history and no reason to develop a continuing relationship with the child. Therefore, the PHL counseling procedure will not negate the foster care agency's responsibility to maintain a counseling relationship with the child, especially with adolescents.

One of the most difficult and critical challenges of the HIV assessment and testing policy is the need for staff to provide information and counseling to pre-adolescent and adolescent foster youth on HIV prevention and risk reduction as required by section 441.22(b)(4)(i)(h) of Department regulations and this directive. Department-contracted training for staff on "Adolescents and AIDS" is available to prepare staff for this responsibility, as are a variety of materials from the Department of Health and community organizations. Any combination of individual and group discussions, booklets, pamphlets and other print materials, videos, peer support groups, peer theater productions or other means of communication, as well as directed counseling, may be useful in gaining the young person's attention regarding the importance of HIV prevention and risk reduction. Medical centers and youth-serving organizations in urban areas are often resources for this essential service.

In all cases, the youth with capacity to consent must be informed by designated staff of any risk factors identified for him or her, and the importance of being tested in order to receive medical care and services if HIV-infected. In addition to being offered the choice of confidential or anonymous testing as described on pages 14 and 15, the youth should be fully informed as to the confidentiality and disclosure rules required by Social Services Law; for example, the requirement that agencies inform the child's foster or prospective adoptive parents of all known medical issues, including HIV-related information concerning the child, as discussed on pages 31 and 32.

Along with discussion of the risk assessment and information regarding an HIV test, designated staff working with children

who have any possibility of capacity to consent should ensure that they have ongoing opportunities for access to further information and discussion.

F. TRAINING, INFORMATION AND SUPPORT FOR STAFF AND FAMILIES PROVIDING SERVICES RELATED TO HIV ASSESSMENT, TESTING AND CARE OF AT RISK FOSTER CHILDREN

Every authorized agency will need to develop a plan to provide or arrange for the training, information and support necessary for all persons involved in the HIV-related assessment, testing and care of at risk foster children.

1. Information and training for staff

All staff who are given access to confidential HIV-related information will need information and training within 45 days of employment on basic medical, legal and service issues related to the HIV risk assessment and testing of foster and adoptive children. In addition, annual updates on such issues will ensure that information is provided on continuing changes in medical care and legal procedures. Such information may be provided through any combination of formal training, informal discussion and informative materials, so long as all topics required by Section 431.7(c) of Department regulations are covered.

Basic and advanced AIDS training for agency staff is provided by the Department under contract with qualified organizations. In addition, other state agencies, including the Department of Health, as well as many urban medical centers and community service providers, offer conferences, forums, and classes related to HIV/AIDS issues.

+++++

Please refer to Administrative Directive 91 ADM-36, "Foster Care and Adoption: HIV-Related Issues and Responsibilities," pages 16, 24-25 for more detailed discussion of training issues. For additional resources, see Appendices attached to this directive for possible contacts, consult your agency's staff development coordinator, or contact your Regional Office for further information on available training.

+++++

Some agencies working with HIV-affected children and families have found that support groups for staff have been effective in helping them cope with the emotional stress involved in providing services to this population. In many communities, networks of HIV/AIDS service providers offer mutual support activities. Appendices attached to this directive suggest contacts.

2. Foster parent support and training

Foster parents caring for HIV-infected children should also be

encouraged to take advantage of any educational opportunities provided by the agency or through the wider community to develop greater understanding of this complex disease and the skills necessary to support such children. Basic and advanced AIDS training for foster parents is provided by Department contractors.

If the child is designated as a "special" case, the foster parents must meet an annual training requirement of four hours in order to receive an enhanced (special) maintenance payment. If the child is designated as an "exceptional" case requiring a high level of care, foster parents must meet an annual training requirement of five hours in order to receive an exceptional maintenance payment. (See section 427.6 of Department regulations or the Standards of Payment Manual, Chapter VIII (B).)

IV. REQUIRED ACTION

Authorized agencies are required to take the following actions related to HIV risk assessment of all foster children and to HIV testing when appropriate:

A. DESIGNATION OF STAFF RESPONSIBLE FOR ASSESSMENTS OF CAPACITY TO CONSENT AND RISK OF HIV INFECTION

1. Each authorized agency must designate staff with appropriate background, training and experience to make the required assessment of each foster child's capacity to consent and risk of HIV infection. Such staff persons may be caseworkers, supervisors, clinical social workers, or medical personnel.

2. Qualifications of staff designated to make HIV risk assessments must include:

- a. participation in HIV-related training; or
- b. knowledge of HIV confidentiality requirements.

B. REQUIRED TIMEFRAMES FOR ASSESSMENTS OF CAPACITY TO CONSENT AND HIV RISK

1. Within five days of entering foster care, each child, regardless of age, must be assessed for capacity to consent as defined in Public Health Law and on page 5 of this directive.

A determination must be made and documented by designated staff within each authorized agency as to whether there is no possibility that the child has the capacity to consent or whether it is possible that the child may have the capacity to consent to HIV-related testing.

2. If a child is determined to have no possibility of capacity to consent, an assessment of risk for HIV infection must also be

determined within the first five days of entering care and documented as described beginning on page 7.

3. If it is determined that it is possible that a child may have the capacity to consent, an informed decision must be made and documented within 30 days of the child's entry into care regarding such capacity, and an assessment of risk for HIV infection must also be determined within the 30 day timeframe as described beginning on page 7.

4. For children entering care prior to September 1, 1995, all such children were required to be assessed for capacity to consent and risk of HIV infection at least 60 business days prior to the children's next scheduled periodic medical examination, as indicated in section 421.22 of Department regulations, or at least 60 business days prior to the children's next required service plan review, whichever occurred first.

C. BASIS FOR ASSESSMENT OF HIV RISK

1. For the child determined within five days of entry into foster care to have no capacity to consent, the child must, within the same five day period, immediately be assessed for risk of HIV infection based on the available medical and psychosocial history of the child, whether documented in a Child Protective Services (CPS) report, preventive services or other records, or provided orally by the child, parent, caseworker, or medical provider.

2. When it is determined within five days of entry into care that a child may have capacity to consent, such determination of capacity to consent must be made within 30 days. The child also must be assessed for risk of HIV infection within that 30 day timeframe, using available medical and psychosocial history of the child as documented in reports and records, and through oral discussions with the child or medical provider as appropriate.

Oral assessments and counseling of the child must be conducted as appropriate for the age and development of the child, as discussed in Section III of this directive. Such discussions with the child must never be confrontational or threatening in any way. The second group of risk factors involving family members should not be used as an oral checklist with a child.

3. Assessments must be based on the risk factors listed on pages 23 and 24.

4. Results of the assessment must be documented in the child's medical record section of the uniform case record, with any risk factors identified. If no risk factors are identified, documentation in the uniform case record must specify that an assessment has been completed as required and must record the

date of the assessment. If the risk assessment for infants or very young children cannot be completed within required timeframes because of an emergency placement with no medical or social history of the child available, dated documentation in the case record must state that fact, along with a plan for obtaining such history. However, please note in the risk factors in section IV. D that abandonment is a valid risk factor, and also, as stated in C.1 above, a review of a CPS report or preventive services record may establish risk.

D. HIV RISK FACTORS

There are three groups of risk factors that must be used as the basis for determining whether the foster child or youth is at risk for HIV infection. The first two groups are primarily applicable to infants or young children who may have been infected at birth. The third group is primarily applicable based on the personal behavior of older children and adolescents, although there are important exceptions, such as sexual abuse. These risk factors include:

1. Risk factors associated with direct perinatal transmission of HIV infection from the mother during pregnancy, at birth, or through breast-feeding:

- a. the child had a positive drug toxicology or drug withdrawal at birth;
- b. the child had a positive test for syphilis at birth;
- c. the child has symptoms consistent with HIV infection;
- d. a sibling has a diagnosis of HIV infection, initially tested positive for HIV infection but later seroreverted to negative, or died due to an HIV-related illness or AIDS;
- e. the child was abandoned at birth and no risk history is available.

2. Risk factors related to the medical and psychosocial history of the child's mother or father, or a sexual partner of the child's mother or father, generally relevant only to an infant or young child through perinatal transmission:

- a. the individual has a diagnosis of HIV infection, or symptoms consistent with HIV infection, or death due to HIV-related illness or AIDS;
- b. the individual has or had a male sexual partner who has had sex with another man;
- c. the individual has a history of sexually transmitted diseases, such as syphilis, gonorrhea, hepatitis B, or genital herpes;
- d. the individual is known or reported to have had multiple sex partners or engaged in the exchange of sex for money, drugs, food, housing, or other things of value prior to the child's birth;
- e. the individual has a history of tuberculosis;
- f. the individual is known or reported to inject illegal drugs or share needles, syringes, or other equipment

- involved in drug use or body piercing;
- g. the individual is known to use non-injection illegal drugs, such as crack cocaine;
- h. the individual had a transfusion of blood or blood products between January 1978 and July 1985 in the United States of America; or
- i. the individual had a transfusion of blood or blood products in any other country at a time when the blood supply of that country was not screened for HIV infection.

3. Risk factors related to children and adolescents and associated with the child's behavior or with direct transmission from another person after the child's birth:

- a. the child has symptoms consistent with HIV infection;
- b. the child has been sexually abused;
- c. the child has engaged in sexual activity;
- d. the child has a history of sexually transmitted diseases, such as syphilis, gonorrhea, hepatitis B, or genital herpes;
- e. the child is known or reported to have had multiple sex partners or engaged in the exchange of sex for money, drugs, food, housing, or other things of value;
- f. the child has a history of tuberculosis
- g. the child is known or reported to inject illegal drugs or share needles, syringes or other equipment involved in drug use or body piercing;
- h. the child is known or reported to use non-injection illegal drugs, such as crack cocaine;
- i. the child had a transfusion of blood or blood products between January 1978 and July 1985 in the United States of America; or
- j. the child had a transfusion of blood or blood products in any other country at a time when the blood supply was not screened for HIV infection.

E. OBTAINING LEGAL CONSENT FOR HIV TESTING WHEN RISK IS IDENTIFIED

If the required HIV risk assessment for a child in foster care identifies one or more risk factors for the child, the authorized agency must obtain legal consent from an appropriate individual before the child's HIV test can take place.

1. When a child lacks capacity to consent and is placed in foster care under Article 10 of the Family Court Act as an abused or neglected child, or has been taken into or kept in protective custody or removed from the place where the child was residing pursuant to section 417 of the SSL or section 1022, 1024, or 1027 of the FCA, and HIV risk is identified, designated staff must:

- a. make a reasonable effort to inform the parent or guardian of the child of a positive HIV risk assessment and recommendation for testing;

b. request that the parent or guardian provide written permission within 10 business days for the testing of the child (see Appendix D for model form);

c. if permission signed and dated by the parent is received within the required timeframe, make an effort to discuss with the parent the parent's ability and willingness to accompany the child to the test site;

OR

explain to the parent that the agency will take responsibility for making arrangements for the testing, accompanying the child to the testing site, and providing the official consent signed by the commissioner or designated representative, keeping the parent informed of the procedures and results;

d. if there will be parental participation in the testing process, assist by arranging an appointment, providing transportation as needed, and informing the parent that staff at the testing site will provide pre- and post-test counseling and require the parent's signature on the official Department of Health informed consent form;

e. if the child's parent does not respond within the required timeframe, refuses to consent to the testing, or is unwilling or unable to participate in the testing procedures for the child, make arrangements for the HIV testing of the child and obtain the required written informed consent form (see Appendix C for the official form) signed by the commissioner or designated representative who must provide legal consent in such circumstances for the child's HIV test;

f. retain in the medical record section of the uniform case record a copy of the official Department of Health written consent form signed by the commissioner or designated representative and provided to the testing site.

2. When a child lacks capacity to consent, is placed in foster care as a result of parental surrender or termination of parental rights by the court, and HIV risk is identified, designated staff must:

a. make arrangements for the child to be tested;

b. obtain legal consent from the commissioner or designated representative who must provide the necessary signed official written informed consent on the Department of Health form (Appendix C);

c. retain a copy of the signed consent form provided to the testing site in the medical record section of the uniform case record.

3. When a child lacks capacity to consent, is placed in foster care voluntarily by his or her parents or by the court as a Person in Need of Supervision (PINS) or a Juvenile Delinquent (JD), and HIV risk is identified, designated staff must:

a. immediately inform the parent or guardian of the results of the assessment, and recommend testing;

b. explain testing procedures to the parent or guardian;

c. request written permission from the parent or guardian within 10 business days to make arrangements for HIV testing of the child (see model form in Appendix D);

d. if written permission is received, make arrangements for the test and for the parent or guardian to accompany the child to sign the official Department of Health written informed consent form at the test site;

e. if permission is denied by the parent or guardian, offer the parent/guardian the opportunity to meet with agency staff to discuss the assessment of risk factors and the importance of testing in order to provide medical care and services for any child who is HIV-infected;

f. if the parent/guardian continues to refuse permission, document that fact in the case record. Without parental consent, HIV testing of the child in this category cannot take place unless the agency secures a court order based on urgent medical necessity (as defined on pages 16-17 of this directive).

g. if the parent/guardian cannot be located, is incapacitated or deceased, seek a court order to allow for HIV testing.

4. When a foster child has been determined by the authorized agency to have the capacity to consent, and HIV risk has been identified, the child or youth has the right to make all decisions regarding an HIV test, the type of test, and a limited right to make certain decisions regarding disclosure of information related to an HIV test. Designated staff must respect these rights and must never use threats or coercion in an effort to persuade the child or youth to consent to testing.

In following required procedures to obtain consent from the child, the designated staff must:

a. inform the child of the results of the assessment of risk factors for HIV infection, including the specific risk factor(s) identified as the basis for the recommendation for HIV testing, and counsel the child regarding the benefits of being tested for HIV infection in order to receive medical care and services if an HIV infection is present;

b. inform the child that arrangements may be made for agency-supervised confidential HIV-related testing and that anonymous testing is available as an alternative;

c. provide information to the child of the requirements regarding the confidentiality of HIV-related information and the disclosures of confidential HIV-related information to certain persons and entities, as described in Section 441.22(b) (8) of Department regulations;

d. after providing the initial counseling and information to the child, ask the child whether he or she will agree to be referred for agency-supervised confidential HIV-related testing or anonymous testing;

e. if the child indicates that he or she will agree to be referred for agency-supervised confidential HIV-related testing, request that the child provide the authorized agency with written permission for such a referral and, within 30 business days of receiving such written permission, arrange for the HIV-related testing of the child including obtaining the necessary pre-test counseling for the child, written informed consent of the child and post-test counseling for the child in accordance with Article 27-F of the Public Health Law; OR

if the child indicates that he or she will agree to be referred for anonymous testing, offer to assist the child in obtaining access to an anonymous testing site; OR

if the child indicates that he or she will not agree to be referred for either form of testing, continue as part of the ongoing casework contacts with the child to discuss the importance of HIV related testing.

f. Regardless of whether a child who has the capacity to consent agrees to be referred for HIV-related testing, designated agency staff must continue to provide on-going counseling to the child regarding the importance of preventing and reducing behaviors that create a risk of HIV infection.

g. The child's decision pertaining to consenting or not consenting to HIV-related testing must be documented in the child's case record, and a copy of any signed written

agreement to be tested (see model form in Appendix E) also must be retained in the case record

h. Ensure that the child understands that, at any future time, the issues of HIV risk and testing may be reopened and discussed either at the request of the child or by agency staff.

+++++

Authorized agencies must inform certified foster parents, approved relative foster parents, and prospective adoptive parents that they do not ever have legal authority to provide written consent at a testing site for HIV testing of children placed in their care.

+++++

F. HIV TESTING OF CHILDREN IN FOSTER CARE

1. If a child in foster care is determined to have one or more of the risk factors listed in section IV. D of this directive, authorized agency staff must make arrangements for HIV testing to take place provided the required legal consent has been obtained:

a. within 30 business days of the child's entry into foster care if the initial assessment of the child indicated no possibility of capacity to consent (Please note that this timeframe is intended to correspond to the requirement for the child's initial comprehensive physical examination within 30 days of entry into care in accordance with section 421.22 of Department regulations and 90 ADM-21.);

b. within 60 business days of the child's entry into foster care if the initial assessment of the child indicated that there was a possibility that the child may have a capacity to consent, and the follow-up assessment completed within 30 days of entry resulted in a decision that the child did not have capacity to consent;

c. within 60 business days of the child's entry into foster care if the child was determined to have the capacity to consent and agreed to provide written consent to testing.

2. When a medical provider for the child in foster care recommends the HIV testing of the child based on medical/social history or symptoms, the authorized agency must begin immediately to initiate the procedures necessary to obtain legal consent before such testing can take place, unless the physician determines there is a medical emergency, in which case the physician may require the test be performed without consent. The child with capacity to consent retains the right in such situations to make his or her own decision regarding testing.

3. The HIV testing of a child or youth in foster care must be conducted:

a. under the direction of licensed medical personnel, who may be medical staff employed by the authorized agency or in designated testing centers or clinics;

b. at a designated testing center, medical facility or office.

4. Each service plan review and each periodic medical examination of a child that occurs after the initial assessment of the child pursuant to Section 441.22(b)(2) of Department regulations must include an assessment by designated agency staff of whether HIV-related testing is recommended based on the child's medical history and any information regarding the child obtained since the initial assessment of the child, the prior service plan review of the child or the prior periodic medical examination of the child, as applicable. If it is determined that HIV testing is recommended, the authorized agency must initiate the process to obtain legal consent. If the written informed consent for the HIV-related testing of the child is obtained, the agency must arrange for testing within 30 business days of the recommendation.

G. SERVICES REQUIRED FOLLOWING HIV TESTING OF A CHILD IN FOSTER CARE

If a child in foster care tests positive for HIV infection, the authorized agency must:

1. provide or arrange for counseling of the child as needed and age appropriate in addition to any post-test counseling at the test site (see pages 17-20 for a discussion of practice issues involved in providing or arranging counseling for the child, for foster parents, prospective adoptive parents, or the parent/guardian of the child);

2. arrange for all follow-up medical services needed by the child as a result of the HIV test, including any additional tests recommended by the child's medical provider;

3. provide support services and counseling as needed to the child's parents and foster parents caring for a child who tests positive for HIV infection.

H. DOCUMENTATION RELATED TO THE ASSESSMENTS AND HIV TESTING OF A CHILD IN FOSTER CARE

Authorized agencies must document specific information related to the assessments and HIV testing of a foster child in the uniform case record. The authorized agency must document the following information in the medical record section of the uniform case record:

1. decision on the assessment of the child's capacity to consent, reason for the decision, and the date of the decision;

2. confirmation that the assessment of HIV risk factors was conducted within required timeframes;

3. identification of any risk factors listed on pages 23 and 24 of this directive;
4. information on any follow-up assessments;
5. a copy of the written consent for HIV testing provided by the parent or guardian of the child, the child with capacity to consent, or the commissioner or designated representative, as applicable;
6. documentation of the parent's or child's refusal to provide consent, as applicable;
7. date and location of any HIV testing of the child;
8. type of HIV test:
 - a. confidential or anonymous (anonymous is a choice available in foster care only to the child/youth with capacity to consent);
 - b. antibody (elisa, western blot) or viral (polymerase chain reaction (PCR));
9. results of the HIV test and any recommendations by the medical provider for follow-up tests or medical treatment for the child;
10. information and counseling sessions provided to an HIV-infected child;
11. information and counseling sessions provided to the parent of an HIV-infected child without capacity to consent who has a permanency planning goal of return home;
12. information and counseling sessions provided to the parent of an HIV-infected child with capacity to consent only if the child/youth has provided written consent to provide such HIV-related information concerning himself or herself to the parent;
13. information and counseling sessions provided to the foster parents or prospective adoptive parents caring for an HIV-infected child;
14. specific plans for training and support services for foster parents or prospective adoptive parents caring for an HIV-infected child.

I. CONFIDENTIALITY AND DISCLOSURE OF HIV-RELATED INFORMATION CONCERNING THE FOSTER CHILD

All person-specific HIV-related information must be maintained in a confidential manner, as required by Section 431.7 of Department regulations. In all cases when HIV-related information is made available as described in this section, a warning statement against further disclosure or redisclosure must be provided to those

receiving such information except those persons listed in paragraph 4 of this section. (For a copy of the warning statement, see Appendix A.)

1. Authorized agencies must insure that direct access to HIV-related information concerning a foster child is limited to:
 - a. an authorized agency responsible for the foster care or adoption of such child;
 - b. staff within that authorized agency who need to know such information in order to supervise, administer, monitor, or provide services for the specific HIV-infected child or child's family;
 - c. the child's medical care provider or medical facility;
 - d. the child with capacity to consent;
 - e. a person authorized by law to consent to health care for a foster child who lacks capacity to consent.

2. Authorized agencies must disclose HIV-related information concerning a specific foster child, whether or not the child has capacity to consent, to the following:
 - a. certified foster parents and approved relative foster parents caring for the HIV-infected child;
 - b. prospective adoptive parents and adoptive parents of the child freed for adoption;
 - c. another authorized agency when the child is transferred to that agency or agency facility for placement or treatment;
 - d. the law guardian of the child;
 - e. a foster child discharged to his or her own care; and
 - f. an adopted former foster child upon request.

3. Authorized agencies must disclose HIV-related information concerning a specific foster child to the following only under certain conditions:
 - a. the parent or guardian of the foster child if the foster child lacks capacity to consent;
 - b. the parent or guardian of the foster child with capacity to consent only if the child provides written consent to disclosure of the information to the parent or guardian;
 - c. in a court hearing related to the foster child only when directly ordered by a judge after a hearing on the issue of

disclosure (such information must not be provided in response to a subpoena, in accordance with Public Health Law, Article 27-F);

d. external services providers only when necessary to obtain essential health or social services for the foster child and only when the commissioner or designee has signed specific authorization for the release of such information, including the reason for the release, the warning statement against any redisclosure, the signature and date of signature from the person receiving such information. Examples: psychologist, home aide, day care or school staff (day care or school staff only when medication or other medical necessity directly related to HIV infection or AIDS is involved). (See model form in Appendix B.)

4. The right of a person in #2 or #3 to redisclose confidential HIV-related information concerning a foster child is limited to the following persons:

a. a prospective adoptive parent of a foster child freed for adoption, or an adoptive parent, without condition;

b. a certified foster parent or approved relative foster parent caring for the child, only when necessary for the care, treatment or supervision of the child;

c. the law guardian of the child when necessary to represent the child without capacity to consent in court proceedings;

d. the law guardian of the child when necessary to represent the child with capacity to consent in court proceedings only if the child with capacity to consent has provided written consent for such disclosure.

J. RECRUITMENT OF FAMILIES TO CARE FOR HIV-INFECTED CHILDREN IN FOSTER CARE

Authorized agencies operating foster boarding home and/or adoption home programs must include in their community relations efforts information regarding the need for foster and prospective adoptive families who may be able and willing to provide care for HIV-infected children identified by these HIV assessment and testing requirements.

V. REPORTING AND SYSTEMS IMPLICATIONS

Each authorized agency is required to document the HIV risk assessment and testing, as appropriate, for each child in foster care in accordance with Department regulations and this directive.

VI. ADDITIONAL INFORMATION

Additional information is provided through Appendices attached to this directive.

Date July 24, 1997

Trans. No. 97 ADM-15

Page No. 33

VII. EFFECTIVE DATE

The effective date of this Administrative Directive is August 15, 1997, retroactive to August 23, 1995 which was the effective date of Department regulations requiring authorized agencies to implement the HIV assessment and testing program for New York State children in foster care.

Rose M. Pandozy
Deputy Commissioner
Division of Services and
Community Development

APPENDIX A

WARNING NOTICE

AGAINST REDISCLOSURE

OF CONFIDENTIAL HIV-RELATED

INFORMATION

This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

(See other side for Spanish translation.)

NOTIFICACION DE ADVERTENCIA
CONTRA LA REVELACION DE INFORMACION CONFIDENCIAL
RELACIONADA AL HIV

La información que se le ha revelado proviene de récords confidenciales que están protegidos por la ley del Estado. La ley del Estado le prohíbe a usted proveer más revelaciones con respecto a esta información sin la aprobación específica de la persona a quien se refiere o sin el permiso de la ley. Cualquier revelación adicional que no esté autorizada constituye una violación de la ley del Estado y puede que resulte en una multa o una sentencia de cárcel o ambas. Una autorización general para proveer información médica u otro tipo de datos no constituye una autorización suficiente para hacer más revelaciones.

APPENDIX B

Authorization for Redisclosure of Confidential HIV-Related Information
[Please Note: This completed form must be returned to the agency responsible for the care of the child.]

I hereby authorize redisclosure of confidential HIV-related information
by (name of agency)
concerning (child's name)
to (person or agency)
for the following time period (check one):
specific dates:
while child remains in care of above-named person(s)
until services are completed

The purpose for authorizing redisclosure as permitted by Article 27-F of the Public Health Law and Department regulations:

I am legally permitted to authorize redisclosure because I am:
the child named above
the birth parent or legal guardian of the child (where the child lacks capacity to consent)
the social services commissioner
the designated representative of the commissioner (indicate title with signature)

Signature
Title (if appropriate)

Warning Statement on Redisclosure Except to Authorized Persons
This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

Receipt of Confidential HIV-related Information
I have received confidential HIV-related information and have read the warning statement required by law. I understand the penalties for further redisclosure without written permission.

Signature Date
(person receiving confidential information in order to provide services)

APPENDIX C
REQUEST FOR PARENTAL PERMISSION TO TEST CHILD FOR HIV INFECTION
(For a child without capacity to consent)

I have been informed that my child, _____, has been found by the agency where he/she has been placed in foster care, to be at risk for HIV infection. The agency recommends testing to determine whether the child is infected so that care and treatment can be given as necessary.

I understand that the agency is requesting my permission for the child to be tested, and that this form must be returned to the agency within 10 business days.

I understand that if I give my permission for my child to be tested, the agency will make arrangements for the test.

If the agency asks me to go to the HIV test site with my child and I agree to go, I understand that I would be asked to sign the Department of Health consent form and receive pre-test counseling at the test site.

I would need transportation to the testing site in order to take my child.

Yes___ No___

If my child was placed in foster care by the court for abuse or neglect, I understand that the agency may give consent and arrange for my child to be tested for HIV even if I do not sign and return this permission slip or if I refuse to give my permission for the test.

If my child was placed in foster care for reasons other than protective removal or placement (abuse or neglect), I understand that the agency may not give consent and arrange for my child to be tested for HIV. My child will not be tested unless I give permission or a court order is obtained. If I give permission, I understand that I must go with my child to the testing site.

I give my permission for my child placed in foster care to be tested for HIV infection.

Yes___ No___

I understand that the agency will inform me regarding the results of the HIV test.

Signed by _____ (parent)

Date _____

Received by agency staff _____ (signature)

Date _____

APPENDIX D

DECISION REGARDING TEST FOR HIV INFECTION BY CHILD WITH CAPACITY TO CONSENT

I have been informed by agency staff that they believe I am at risk for HIV infection. Agency staff have explained the reason(s) why they believe I am at risk for HIV infection. I understand the importance of being tested in order to receive any necessary treatment and services.

I understand that if I agree to be tested, I will receive pre-test counseling at the testing site and will be asked to sign the official Department of Health written informed consent form.

I understand that if I agree to be tested, I may choose between confidential (agency-supervised) testing or anonymous testing (where I would be identified only by number).

I understand that I will be given the results of the test, whether confidential or anonymous. If I choose anonymous testing, no other person or agency will be given the results of the test. If I choose confidential testing, the agency will also receive the results of the confidential test, as will other persons required by law to be given the results. In either case, my parents could not be given the results without my written permission.

I understand that the agency will make arrangements for the test and for any necessary transportation to the test site.

I agree to be tested for HIV infection.

Yes _____ No _____

If I have checked "Yes," I choose:

Confidential testing _____
Anonymous testing _____

Signed _____

Date _____

Agency staff _____

Date _____

APPENDIX H

NEW YORK STATE INDEPENDENT LIVING TRAINING NETWORK
WITH INFORMATION AND RESOURCES AVAILABLE ON ADOLESCENT ISSUES

Region 1:

Buffalo State College
Center for Development of
Human Services
Campus West
1300 Elmwood
Buffalo, NY 14222

(716) 882-1117

Region 2:

Buffalo State College
Center for Development of
Human Services
1210 Jefferson Road
Rochester, NY 14623

(716) 292-5010

Regions 3 and 4:

State University of New York
at Albany
Professional Development Program
135 Western Avenue
Albany, NY 12222

(518) 442-5700

Region 5:

State University of New York
at Stony Brook
School of Social Welfare
Stony Brook, NY 11794-8231

(516) 444-7565

Region 6:

South Bronx Human Development
Center
One Fordham Plaza, Suite 900
Bronx, NY 10458

(718) 295-5501

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 91 ADM-36

TO: Commissioners of
 Social Services
 Directors of Voluntary Child
 Caring Agencies

DIVISION: Family &
 Children
 Services

DATE: September 16, 1991

SUBJECT: Foster Care and Adoption: HIV-Related Issues and
 Responsibilities

 SUGGESTED

DISTRIBUTION: | Directors of Services
 | Services Staff
 | Staff Development Coordinators
 | Legal Staff

CONTACT

PERSON: | Your Regional Office Director

| Albany: John O'Connor, (518) 432-2751
 | Buffalo: Linda Brown, (716) 847-3145
 | Metropolitan: Fred Cantlo, (212) 804-1202
 | Rochester: Linda Kurtz, (716) 238-8200
 | Syracuse: Jack Klump, (315) 428-3235

ATTACHMENTS:

| Appendix A: References to Title 18 Regulations
 | Affected by HIV Confidentiality (available on-line)
 | Appendix B: Authorization for Rediscovery
 | (Model Form) (available on-line)
 | Appendix C: Warning Statement in English and
 | Spanish (available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serve Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
85 INF-14 90 ADM-21	85 INF 14	(See list in Appendix A)	SSL 372 373-a 383-b PHL Article 27-F		

DSS-296EL (REV. 9/89)

Table of Contents

	<u>Page</u>
I. <u>Purpose</u>	6
II. <u>Background</u>	
- Chapter 584 of Laws of 1988	6
- Definition of "Confidential HIV-related information"	6
- Chapter 592 of Laws of 1990	7
III. <u>Program Implications</u>	7
A. <u>Access to Confidential HIV-related Information</u>	7
1. Mandatory access	8
- definition of "prospective adoptive parent"	8
- pre-placement willingness and capacity to care for HIV-infected child	8
2. Access permitted on basis of "need to know"	9
- definition of "authorized employee or agent"	9
B. <u>Safeguards to Access</u>	10
1. Written management plan	10
2. Staff information and training	10
- warning statement to be given to all persons with current or past access	11
- penalties for unauthorized disclosure	11
C. <u>Redisclosure of Confidential HIV-Related Information</u>	11
1. Persons permitted to redisclose without written authorization	11
2. Guidelines for foster parent redisclosure	12

	<u>Page</u>
3. Required written authorization for redisclosure	13
- definition of "capacity to consent"	13
- persons who may consent to release	13
4. Responsibility for providing warning statement and authorization form	14
D. <u>Medical Records</u>	15
1. Safeguarding confidentiality	15
2. Items to be included in comprehensive health history of child	15
3. Providing child's health history to certain persons as mandated by law	15
E. <u>Training of Staff</u>	16
F. <u>HIV Testing of Foster Children</u>	16
1. Criteria for testing a foster child for HIV infection	16
2. Consent for HIV testing	17
3. Requirements for pre-test information	17
4. Requirements for post-test counseling	18
5. Counseling with foster parents	18
6. Results of HIV test included in uniform case record	18
IV. <u>Required Action</u>	19
A. <u>Eligibility for Services</u>	19
B. <u>Safeguarding Confidentiality of Records</u>	19
1. Security of confidential HIV-related information from unauthorized access	19
2. Access restricted to employees and agents who "need to know"	20

	<u>Page</u>
3. Written management plan required	20
4. Warning statement to employees with access	20
C. <u>Mandated Disclosure of Medical History</u>	21
1. Persons to whom medical history must be provided	21
-Right of child with capacity to consent	21
2. Information to be included in medical history	22
3. Provision of medical history at time of placement	22
D. <u>Procedures for Redisdisclosure</u>	22
1. Requirement for written authorization for redisdisclosure	22
2. Required signature for authorization	23
3. Required information for authorization	23
4. Oral consent procedures	24
E. <u>Training of Staff</u>	24
1. Required annual training for all staff with access to confidential HIV-related information	24
2. Topics which must be included in staff information and training	24
F. <u>Reporting Requirement</u>	25
G. <u>Purchase of Services</u>	25
1. Requirements of POS contract with agencies caring for HIV-infected children	25
2. Out-of-state POS contract requirements	26
V. <u>Systems Implications</u> (none)	26
VI. <u>Additional Information</u>	
<u>Definitions</u>	26

	<u>Page</u>
VII. <u>Effective Date</u>	27
Appendix A - References to Department (Title 18) Regulations Affected by HIV Confidentiality	
Appendix B - Authorization for Redisclosure (Model Form)	
Appendix C - Warning Statement in English and Spanish	

I. PURPOSE

The purpose of this directive is to inform you of the requirements of Chapter 584 of the Laws of 1988 and Chapter 592 of the Laws of 1990 concerning confidentiality of AIDS and HIV-related information affecting foster and adoptive children and families. This directive also discusses implementation of Department regulations mandated by Chapter 584.

The directive requires non-discrimination in eligibility determination and provision of services for children and families affected by AIDS or HIV infection; adoption of local procedures to safeguard confidential information related to HIV infection (including AIDS or HIV-related illnesses); and procedures for access to and redisclosure of confidential HIV-related information when authorized by Chapter 584 and by Chapter 592.

II. BACKGROUND

In response to issues resulting from the human immunodeficiency virus (HIV) epidemic, the New York State Legislature enacted Chapter 584, including a new Article 27-F of Public Health Law (PHL), which addressed the issues of disclosure of confidential HIV-related information and administration of HIV-related tests. Chapter 584 also amended Section 373-a of Social Services Law (SSL) to authorize disclosure of confidential HIV-related information to foster parents, prospective adoptive parents and adoptive parents. Chapter 584 became effective on February 1, 1989.

The legislative intent was to assure that confidential HIV-related information is not improperly disclosed and that clear standards exist for disclosing such information. State agencies which receive confidential HIV-related information were required to promulgate regulations to implement the new law. While Chapter 584 applies to HIV-tested and HIV-infected persons of all ages and circumstances, State Department of Social Services regulations were amended to include those individuals and families in need of expanded human services because of HIV infection. These regulations became effective on September 12, 1989.

PLEASE NOTE: According to law, "Confidential HIV-related information means any information in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV-related information concerning whether an individual has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more of such conditions..."

By assuring protection of the confidentiality of HIV-related information, the Legislature hoped to encourage voluntary testing for the virus by persons at risk "so that individuals may come forward, learn their health status, make decisions regarding the appropriate treatment," and change at-risk behavior. There was also intent to limit the risk of discrimination which might be caused by unauthorized disclosure of confidential HIV-related information.

Following implementation of Chapter 584 through regulatory amendments, social services agencies and foster parents raised numerous questions regarding the difficult relationship between the law's confidentiality requirements and the foster family's ability to care for and access services for HIV-infected foster children. As a result, the Legislature enacted Chapter 592 of the Laws of 1990, exempting foster parents from the confidentiality provisions of Article 27-F of Public Health Law when disclosure of confidential HIV-related information is necessary "for the purpose of providing care, treatment or supervision" of the foster child. Chapter 592 also exempts from such confidentiality restrictions prospective adoptive parents with whom a child has been placed for adoption. The same law adds the law guardian to the list of those who are authorized to have access to confidential HIV-related information concerning a foster child under specific circumstances.

The number of HIV-infected children in New York State has continued to rise. While the highest percentage of cases is concentrated in New York City, all regions of the State are currently affected. All agencies need to be prepared through staff training and planning to meet the needs of families and children affected by HIV infection and to meet the requirements of the law and regulations. This directive addresses the particular confidentiality issues affecting foster and adoptive children with HIV infection.

III. PROGRAM IMPLICATIONS

A. Access to Confidential HIV-Related Information

Authorized agencies should be aware that access to confidential HIV-related information in the case files of foster or adoptive children must be given to specific persons or agencies. Access is also authorized to governmental agencies, and health or social services providers when it is reasonably necessary for the supervision, monitoring, administration, or provision of services to the child or child's family. The development and oversight of safeguards to the access of confidential HIV-related information in case files are responsibilities of the local district social services commissioner and directors of voluntary agencies.

1. Social Services Law 373-a and Section 357.3(b) of Department regulations require that a child's comprehensive medical history, including HIV-related information, must be provided to the following:
 - a. another authorized agency to whom the care of a foster child is transferred;
 - b. certified foster parents or approved relative foster parents;
 - c. prospective adoptive parents* and adoptive parents;
 - d. the child's parents or guardian when the child is released to their care;
 - e. the child discharged to his or her own care;
 - f. any adopted former foster child, upon request, as required by Chapter 165 of the Laws of 1990.

Prior to placing an HIV-infected child with either foster or prospective adoptive parents, the caseworker should determine whether the parent is willing to care for an HIV-infected child, since children infected with this disease may require substantially more support and care than other children. If the response is positive, then the caseworker will need to make a further assessment of the emotional stability, attitudes and physical ability of the parents to provide the exceptional level of care such children may need. Preliminary discussions concerning placement of an HIV-infected child should be general and should not provide confidential HIV-related information about a child until a specific placement plan is being considered.

EXCEPTION: In the case of placement in an approved relative foster home, which often occurs as an emergency situation, obviously a specific child or children will be involved. In such cases it is essential to inform the relative of the child's condition, if known, and assess prior to placement the relative's willingness and capacity to care for or adopt the HIV-infected child.

*"Prospective adoptive parents" are persons who have met criteria and standards for adoption through screening and home study as specified in Section 421.16 of Department regulations, who have indicated an interest in adopting a particular child, and for whom the authorized agency has begun the placement agreement process described in Section 421.18 of Department regulations.

Certified foster families who are willing to accept responsibility for the care of such children should be informed before the actual time of placement if a child to be placed in their care is known to be an HIV-infected child. Except in extreme emergency situations, persons accepting such children should be offered advance preparation and counseling prior to placement. In any case, Department regulations require that such information must be given to the foster parent at the time of the child's placement.

Again, confidential information on the HIV status of a particular child may not be given to applicants for adoption until the authorized agency has begun the specific placement agreement process described in Section 421.18 of Department regulations. However, caseworkers should determine whether the applicants are willing to accept an HIV-infected child. The general questions of willingness and capacity to care for such a child should always be resolved prior to actual placement. Child-specific HIV-related and other health information may appropriately be given, for example, when visitation prior to placement is being arranged between the prospective adoptive parents and the adoptable HIV-infected child. At that time agency staff should discuss with the prospective adoptive parents the HIV status of the child.

2. The law and Department regulations clearly permit access to confidential HIV-related information in case records when there is a "need to know" in the ordinary course of business and provision of services. Specifically, an authorized employee or agent* of an authorized agency may have access to such information when it is reasonably necessary for the supervision, monitoring, administration, or provision of services to the child or child's family. The same standard is applicable to facilities operated by authorized agencies, including agency boarding homes, group homes, group residences and institutions. The medical history, including any confidential HIV-related information, of each child placed in foster care in such facilities, should be accessible to the caseworker, supervisor, health personnel, treatment team or other persons needing such information in order to supervise, monitor, administer or provide services to the child.

*The law defines "authorized employee or agent" as "any employee or agent who would, in the ordinary course of business of the provider or government agency, have access to records relating to the care of, treatment of, or provision of a health or social service to the protected individual."

Local agency officials will determine which staff persons "need" to have access to this information. Practical, common sense judgment will dictate these decisions. For example, the caseworker assigned to a specific case, as well as the caseworker's supervisor, will need access to the case file which includes records of all medical tests and diagnoses. A support staff person assigned to enter case information into computerized records has a "need to know." The third party reviewer of a case record involving confidential HIV-related information has a "need to know."

In all circumstances when access to confidential HIV-related information is necessary, the authorized agency's administration is responsible for providing to those persons receiving the information the written statement (Appendix C) warning of penalties for unauthorized redisclosure.

The law guardian of the child, appointed to represent the child in legal proceedings, has a "need to know" confidential HIV-related information as authorized by Chapter 592 of the Laws of 1990. However, the law guardian's authority to redisclose such information is limited (see C.1.b. on p. 12).

B. Safeguards to Access

1. In order to ensure that confidential HIV-related information is accessible only to authorized employees and that policies are in place to safeguard access, each authorized agency is responsible for developing a written management plan which will be available for review upon the request of the Department. (See Section 431.7(a)(1) of Department regulations.) Since all child welfare case files are confidential, it is assumed that basic procedures for protection of information are already in place. Such procedures should be reviewed to ensure that access to files is limited to authorized persons and that files are secured. Confidential HIV-related information which is stored electronically must also be protected from access except by authorized individuals.
2. It is essential that authorized agencies provide information and training for all staff in the requirement for confidentiality of HIV-related information and in the legal penalties for unauthorized access and redisclosure. The law requires that the following written warning statement must be provided to all persons with current or past access to such information:

This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

(See Appendix C for warning statement in English and Spanish for reproduction and distribution.)

Unauthorized disclosure of confidential HIV-related information, whether through deliberate action or negligence, will result in the person disclosing such information to be subject to civil penalties not to exceed \$5,000 for each occurrence. A person willfully disclosing such information without authorization may also be found guilty of a misdemeanor, according to Article 27-F of the Public Health Law.

C. Redisclosure of Confidential HIV-related Information

Redisclosure of confidential HIV-related information concerning a foster or adoptive child by persons or entities with authorized access to such information is permitted under certain circumstances and when required procedures are followed.

1. Persons who may redisclose without prior written authorization or consent:

a. the local social services commissioner and his/her designated representative when the child lacks capacity to consent and:

- (1) the social services district has taken protective custody of the child; or
- (2) the child has been adjudicated as an abused or neglected child and custody has been transferred to the social services district; or
- (3) the guardianship of the child has been transferred to the social services district after parental surrender or termination of parental rights.

- b. the law guardian of the child "for the sole purpose of representing the minor" child if that child lacks capacity to consent. (See III.C.3 on p. 13 for definition and discussion of capacity to consent.) If a determination has been made that the child has capacity to consent, the law guardian may not redisclose confidential HIV-related information without the child's written consent.
- c. the prospective adoptive parent with whom an HIV-infected child has been placed for adoption.
- d. the foster parent caring for an HIV-infected child when redisclosure is necessary for the purpose of providing care, treatment, or supervision of the foster child.

Persons to whom foster parents redisclose confidential HIV-related information should be provided the warning statement (Appendix C) against further redisclosure.

- 2. The following guidelines indicate acceptable reasons for foster parents to redisclose to otherwise unauthorized persons confidential HIV-related information concerning the foster child in their care:
 - a. to persons living in the household with the child and providing care and/or emotional support for the child;
 - b. to relatives, neighbors or others directly and substantially involved in the care or supervision of the child;
 - c. to other members of a support group for foster parents caring for HIV-infected children. The formation of such support groups of foster parents with a common experience in caring for HIV-infected children is highly desirable and is to be encouraged. Such groups can be essential in sharing information related to the disease and to the care of such children and in providing strong emotional support which will assist in the care, treatment and supervision of the child.
 - d. to in-home services providers when necessary for the medical care of the child or to obtain specialized services. These may include home health aides, homemakers, respite care providers, in-home day care providers, or in-home educational personnel.
 - e. to day care providers and schools only when medical necessity, such as giving a medication prescribed by a physician, requires redisclosure.

PLEASE NOTE: Out-of-home day care providers and schools are not permitted to require confidential HIV-related information as a condition for admission.

Caseworkers are advised to counsel with foster parents of older pre-adolescent or adolescent foster children regarding their planned redisclosure of confidential HIV-related information concerning such children. Foster parents, while given the right to redisclose for the purposes specified above, should be sensitive to children's feelings about redisclosure and should consider how the children and the informed persons are likely to respond. Caseworkers and/or foster parents may find a discussion of this issue with older children appropriate and beneficial.

PLEASE NOTE: A child with capacity to consent* (for example, an adolescent) cannot prohibit access or redisclosure to persons or entities expressly authorized by law to receive confidential HIV-related information (for example, foster parents and authorized agencies).

3. Except as discussed above in Section C.1 and 2, redisclosure of confidential HIV-related information to previously unauthorized persons is not legally permitted without specific written authorization by the person or entity legally authorized to consent to medical care for the child or by the child with capacity to consent.

Persons who may provide written authorization/consent for redisclosure:

- a. The foster/adoptive child himself or herself with "capacity to consent."

* According to law, "capacity to consent" means an individual's ability, determined without regard to the individual's age, to understand and appreciate the nature and consequences of a proposed health care service, treatment or procedure, or of a proposed disclosure of confidential HIV-related information, as the case may be, and to make an informed decision concerning the service, treatment, procedure or disclosure.

The question of capacity to consent to redisclosure requires a determination by the local social services commissioner or designated representative in consultation with other professional staff who may include a physician, psychologist, or caseworker, as well as the foster or adoptive parents. A decision should take into consideration the maturity of the child and the child's ability to fully comprehend and appreciate the consequences and implications of the redisclosure of such information. Even for older children who may be deemed fully able to understand, counseling and interpretation are essential prior to the child's signing an authorization for redisclosure.

b. The birth parent of a child placed voluntarily into foster care.

A signed authorization for redisclosure of confidential HIV-related information concerning the child may be requested from the parent at the time a child is voluntarily placed in care. In the absence of written parental consent where applicable, and when a child lacks capacity to consent, court authorization or conversion of the case to protective custody under Article 10 may be necessary to allow redisclosure to persons or entities not expressly granted access.

c. The social services commissioner or designated representative.

When a local social services commissioner has taken a child into protective custody or has been awarded custody or guardianship of the child by the court, the local commissioner or designated representative may authorize redisclosure to specific, named persons, stating the reason for such redisclosure. Again, this written authorization to redisclose is not required for adoptive parents, for law guardians representing minors, or for foster parents when redisclosure is necessary for the care, treatment and supervision of foster children.

4. When written authorization to redisclose confidential HIV-related information to a specific person is necessary, the local social services commissioner or designated representative is also responsible for providing to the person to whom the information is given the warning statement required by law. A model form for this purpose, "Authorization for Redisclosure of Confidential HIV-related Information," is attached in Appendix B. Please note that this form includes both the authorization and the warning statement and is to be signed by both the person authorizing redisclosure and the person receiving the confidential information.

D. Medical Records

1. In safeguarding medical records within the uniform case record, the authorized agency is obligated to review its continuing practices of maintaining confidentiality of all records. In addition to physical security and protection of files, the agency is responsible for ensuring that only authorized employees (see IV.B. for definition and standard) have access to such records. It is not recommended that the uniform case records of HIV-infected children be set apart in any way from those of other children. Generally, to flag or separate such cases would be to call attention to them and therefore may actually reduce the security of information.
2. Information appropriate for inclusion in the comprehensive health history of the HIV-infected child within the uniform case record includes, but is not limited to, names and addresses of medical providers; actual medical records of treatment and tests provided by physicians, dentists, pharmacists, laboratories, hospitals, or clinics; summaries of medical treatment, psychological testing or counseling, and caseworker observations provided by appropriate professionals; information on health issues provided by parents, relatives, foster parents, school personnel, other persons known to the child; and the progress notes documenting activities such as dates of appointments, dates of consultation with medical providers, dates of transportation provided or arranged for in connection with medical care.
3. Sharing the information in the comprehensive health history of the child with certain persons is mandated by law and regulation (see III.A.1. or IV.C.1.). There is no mandate, however, to turn over copies of the actual medical records of the child.

Authorized agencies may use limited discretion as to whether it is administratively feasible to copy the entire file to present to those persons entitled to the child's medical history. An acceptable alternative may be an informational conference with foster or prospective adoptive parents in which all information is discussed and presented. However, if foster or adoptive parents request copies of documents in the child's health record, copies of those documents should be provided. In such cases, the requirement to safeguard all confidential HIV-related information should be emphasized.

In emergency situations, the caseworker should offer orally to foster parents or residential directors as much information as is available and then follow up with a conference or copied file within the next 72 hours. It is not recommended that agency caseworkers attempt to write summaries of the medical records.

E. Training of Staff

It is essential that each social services district and all other authorized agencies provide information and training for their staff on the law and regulations related to provision of services and confidentiality issues affecting HIV-infected children and families. All those who are involved in the administration, support services, supervision, and casework in the areas of foster care and adoption will need information on policies and procedures required in the care and protection of confidentiality for HIV-infected foster and adoptive children.

Such information and training may be provided through any combination of formal training, informal discussion, and informative materials, so long as all topics required by Section 431.7(c) of Department regulations are covered. (See IV.E. of this directive.)

Some of the required topics are included in an ongoing AIDS training curriculum provided by agencies contracting with the Department or with the New York State Department of Health. Instruction based on local administrative decisions, such as the agency's management plan for safeguarding confidential HIV-related information, will need to be developed locally by staff development personnel. In reviewing the law and regulations governing confidentiality issues, this directive should be utilized so that all staff are aware of the guidelines under which they must perform their tasks. Clearly, it is not necessary for an agency to develop a totally new and comprehensive training curriculum so long as the required topics are covered through one or more training sessions. New staff must be provided with appropriate informational materials and some form of training (formal or informal) on required confidentiality issues within 45 days of employment.

F. HIV Testing of Foster Children

Among issues affected by confidentiality and consent requirements in law and regulation is the question of testing foster children for HIV infection. In view of other policies which may have been established prior to this directive, authorized agencies should review their current practices and policies on HIV testing for compliance with the following Department policy:

1. Testing a child for HIV infection after a child has been placed in foster care is permitted only when, in the judgment of a physician, there is a need for such diagnostic testing on the basis of the child's age, medical history, environmental background, and current physical/developmental condition;

and

when the necessary written, informed consent has been provided.

PLEASE NOTE: Agencies should be aware that commonly available HIV tests for infants are not considered definitive for HIV infection, and that seroconversion from positive to negative often occurs in the first two years of life.

2. Consent for HIV testing of a foster child may be provided by the following persons:

a. the child with capacity to consent (see pages 13 and 14 for definition and discussion);

or

b. the child's parent or legal guardian in cases of voluntary placement or in cases of placement under Articles 3 and 7 (JD and PINS) of the Family Court Act if the child lacks capacity to consent;

or

c. the local social services or health commissioner, if the child lacks capacity to consent, when the child has been taken into protective custody or has been placed in the care and custody of the local social services commissioner as an abused or neglected child under Article 10 of the Family Court Act (FCA).

EXCEPTION: If a physician determines there is immediate and urgent medical necessity for HIV testing of a child in foster care, and if the child lacks capacity to consent, and if the child's birth parents with legal right to consent cannot be located after reasonable effort, the physician may order such testing.

3. The foster child with capacity to consent to HIV testing or the person with legal authority to give consent (e.g., the parent, guardian, commissioner or designated representative), is to receive pre-test information, according to law (PHL Section 2781). The physician who orders the test must certify that written informed consent has been given following provision of information concerning

the test. Such information must include, at a minimum, an explanation of:

- a. the test itself;
- b. the procedures which will be followed;
- c. the confidentiality protections against disclosure except to persons authorized to receive the information;
- d. the nature of AIDS and HIV-related illness;
- e. the possible problems of discrimination if test results are disclosed to unauthorized persons, and the legal protections against such discrimination;
- f. information about behavior which could lead to HIV-infection.

Especially in the case of adolescents in foster care who have been determined to have capacity to consent, the authorized agency should ensure that the child's caseworker or other staff with required training (see III.E.), as well as the child's physician, have made diligent effort to discuss these issues with the adolescent who is to be tested.

Caseworkers should ensure that counseling the adolescent with capacity to consent includes discussion of the requirement for testing information to be recorded in the child's health history which must be given to foster parents. If an adolescent for whom testing is medically indicated refuses to give consent for testing because of this required redisclosure, the worker should refer the adolescent to an anonymous, confidential testing site where counseling and follow-up services are available. The adolescent should be encouraged to reconsider sharing the information in order to receive services and support as needed.

4. Following HIV testing of the foster child, and at the time of giving the test result to the child with capacity to consent, or to the birth parent or guardian, or other person who gave consent for the test, the medical provider who ordered the test and the child's caseworker are responsible for counseling or referring for post-test counseling as appropriate. Such counseling is to include:

- a. coping with emotional consequences of a positive test result;
- b. possible discrimination problems that disclosure of test results may cause;
- c. behavior to prevent transmission or contraction of HIV infection;

- d. available medical treatment;
 - e. in the case of adolescents, the need to notify any sexual contacts;
 - f. an explanation to the tested person of those to whom the test results must be disclosed by law (see IV.C.) and those who are authorized to have access to the foster child's medical record with HIV tests results included.
5. If a physician determines that testing a foster child for HIV infection is necessary, and required consent has been given, the authorized agency placing the child should ensure that the foster parent is given pre-test information and post-test counseling regarding the test implications and results. Such counseling may be given by trained agency staff in consultation with health care providers or may be provided through referrals to other professional counselors. The topics listed in paragraphs 3 and 4 of this section may be used as guidelines.
 6. Results of HIV testing must be included in the child's comprehensive health history in the uniform case record, with access to that information restricted to those who are authorized by law and regulation to have access.

IV. REQUIRED ACTION

In order to comply with Chapter 584 of the Laws of 1988 and Chapter 592 of the Laws of 1990 and related Department regulations, the following actions are required:

A. Eligibility for Services

Authorized agencies must ensure that safeguards are in place to prevent discrimination against HIV-infected children or families in determining eligibility for services. Further, the social services district is responsible for ensuring that no adverse action occurs against any foster or adoptive child because of a test for or a diagnosis of HIV infection, AIDS, or an HIV-related illness. This will require periodic reviews of procedures, training of staff, and adequate supervision.

B. Safeguarding Confidentiality of Records

1. While the confidentiality of all uniform case records must be safeguarded, the authorized agency must take particular care to ensure that the records containing the comprehensive health history of HIV-infected foster and adoptive children are secured from access by unauthorized persons.

2. Each authorized agency must determine which employees will be specifically authorized to have access to confidential HIV-related information on children and families. According to law and Department regulations, only those employees or agents of the authorized agency who have a "need to know" for administration, supervision, monitoring, or provision of services to HIV-infected children and their families may have access to confidential HIV-related information. The local social services commissioner is ultimately responsible for ensuring that procedures are in place to restrict access, both in the local district offices and within any contractor child caring or services agencies.
3. In order to assure such security of access, each authorized agency must develop a written management plan describing procedures for safeguarding records containing the health histories of HIV-infected children. The plan must be available for review by the Department and must include:
 - a. a list by title and/or function of employees authorized to have access to such records because they "need to know" for supervision, monitoring, administration or provision of services;

PLEASE NOTE: In addition to caseworkers, supervisors and administrators who have a "need to know" confidential HIV-related information, support staff involved in record keeping, data entry or accounting are examples of those who may be included in the list of employees authorized to have access and who must be provided with the warning statement (Appendix C) against further redisclosure. Third party reviewers also have a "need to know."
 - b. measures which are in place to ensure the protection of electronically-stored confidential HIV-related information from access by persons not authorized under paragraph a. above;
 - c. assurance that the agency is providing information and training on required topics (see IV.E.) for all appropriate staff annually and for new staff within 45 days of employment.
4. All employees with past or current access to confidential HIV-related information must be given the written statement warning against further disclosure of the information without specific authorization.

(See Appendix C for warning statement in English and Spanish for reproduction and distribution.)

C. Mandated Disclosure of Medical History

1. The comprehensive health history of a child, including any confidential HIV-related information, must be given to designated persons according to Section 373-a of Social Services Law and Section 357.3(b) of Department regulations.

Those persons to whom all available health and medical information must be given include the following:

- a. an authorized agency to which a foster child is transferred from another authorized agency;
- b. certified foster parents or approved relative foster parents;
- c. prospective adoptive and adoptive parents (see definition of prospective adoptive parents on p. 8 of this directive);
- d. birth parents or guardian when the foster child is released to their care;
- e. a foster child discharged to his or her own care;
- f. any adopted former foster child, upon request, as required by Chapter 165 of the Laws of 1990.

PLEASE NOTE: When the birth parents of the child placed in foster care retain guardianship of the child, they should be notified of any HIV-related or any other medical information concerning the child, even if those parents have signed over release/consent for health care to the commissioner.

EXCEPTION: The right of the child who has capacity to consent and who objects to confidential HIV-related information being given to the birth parents overrides the right of parents to receive such information. (Public Health Law Article 27-F)

However, the child with capacity to consent may not prohibit confidential HIV-related information from being given to foster and prospective adoptive and adoptive parents as provided by Section 373-a of Social Services Law.

2. Information which must be included in the comprehensive health history is listed in Section 357.3(b)(6) of Department regulations and in 90 ADM-21, "Medical Services for Children in Foster Care." Among the items to be included in the health history, to the extent available, are results of diagnostic tests, including HIV-related tests, medical treatment and medications prescribed for HIV-infected children.
3. The comprehensive health history of the child must be provided to foster parents at the time of placement, to the extent available. In emergency/crisis situations when placement must be made prior to access to the complete records, the comprehensive health history of the child, to the extent known, must be provided to the foster parents within 72 hours. Moreover, in all cases, a known HIV-infected child should be placed only with foster parents who have previously indicated a willingness to care for such a child.

D. Procedures for Redisdisclosure With Authorization

1. A written and signed authorization for release of confidential HIV-related information concerning a foster child must be provided before redisdisclosure by those persons who have such information except in the following cases:
 - a. A written authorization is not necessary if the person or entity receiving the information is also authorized to have access or is mandated by law to be given such information concerning the specific child.
 - b. In addition, the following persons do not need a written authorization to redisdisclose confidential HIV-related information under certain circumstances:
 - (1) A physician may redisdisclose to the person legally authorized to consent to health care for the foster child when medically necessary to provide timely care and treatment for the child.
 - (2) Foster parents may redisdisclose when redisdisclosure is for the purpose of providing care, treatment or supervision of the foster child placed in their care. (See discussion and guidelines on pp. 11-13.)
 - (3) Prospective adoptive parents with whom the HIV-infected child has been placed for adoption may redisdisclose.

(4) A law guardian may redisclose only when such redisclosure is for the purpose of representing a minor child without capacity to consent or when the child with capacity to consent has given written consent for redisclosure.

2. When an authorization for redisclosure (see Appendix B for model form) of confidential HIV-related information is necessary, it must be written, designated for a specific person or persons and signed by one of the following:

a. the child, if he or she has the capacity to consent and fully understands the implications of such an authorization (see definition of "capacity to consent" on p. 13 of this directive);

or

b. the birth parent or legal guardian of the child if the parent or guardian retains parental rights and can be located;

or

c. the local social services commissioner, or designated representative, when the commissioner is responsible for the health care of the child under conditions specified in Section 383-b of Social Services Law; or has been awarded custody and guardianship of the child by the court, or has assumed guardianship of the child through a voluntary surrender.

A designated representative may be a staff person within the social services district or a voluntary agency, but must function at an administrative level.

3. The written authorization for redisclosure must:

a. be dated;

b. specify the time period during which the release is effective;

c. specify the reason for authorizing redisclosure;

d. include the warning statement (Appendix C) against further redisclosure without written authorization.

A model form incorporating these requirements is attached to this directive as Appendix B. Both the person consenting to release of the confidential HIV-related information and the person receiving the information are required to sign the form which must be retained in the uniform case record.

Example: A commissioner or designated administrative representative signs the authorization form to permit release of confidential HIV-related information concerning a foster child by a caseworker to a counselor working with a special needs child. The staff person must then obtain the counselor's signature indicating receipt of the information and awareness of the warning statement. The signed document is placed in the uniform case record.

4. If, because of some urgent and unforeseen situation, redisclosure becomes immediately necessary for the welfare of the child, the local social services commissioner or a designated representative with authority to redisclose may give oral consent, but must follow up with a written and signed authorization as soon as possible, and in no case later than 10 calendar days from the date of the oral authorization.

E. Training of Staff

1. Each local department of social services and other authorized agencies involved in the care of HIV-infected foster and adoptive children must provide information and training to all staff persons having access to any files or records containing confidential HIV-related information.
 - a. Initial information and training (formal or informal) must be provided within 45 days of employment for all new staff given access to confidential HIV-related information.
 - b. Annually, updated information and refresher training on HIV-related issues must be provided for all staff with access to confidential HIV-related information through any combination of formal training, informal discussion and informative materials, so long as all required topics are covered.
2. Staff information and training must include the following:
 - a. a review of State laws and Department regulations on confidentiality of HIV-related information, including the necessity for written authorization for redisclosure to otherwise unauthorized persons and the warning statement on penalties for unauthorized redisclosure;

- b. a review of the list of persons who have authorized access and those to whom the child's health history, including confidential HIV-related information, must be given by law and regulation (see Section 357.3 of Department regulations and IV.C.1. of this directive);
- c. a review of the agency's written management plan for maintaining security of records;
- d. information on factors (principally blood and semen) and the circumstances which may constitute significant risk of contracting or transmitting HIV infection;
- e. current information which concludes that HIV disease is not transmitted by casual contact or in ordinary home and family care of children;
- f. hygienic measures (universal precautions) recommended to protect persons caring for an HIV-infected child and to protect the HIV-infected child from exposure to other infections. These hygienic measures include:
 - (1) standard practices for thorough cleanliness and infection control; and
 - (2) the use of preventive barriers, such as protective gloves, if the caretaker's skin has open wounds or abrasions, or if there may be presence of blood.

F. Reporting Requirement

All social services districts are required to maintain a tracking file of known HIV-infected children in foster care and to report such children to the Department. Because of the complex issues involved in addressing service needs for these children, discrete tracking information is essential in order to develop resources and to ensure effective program planning for their care. In New York City the tracking file is computerized. All other social services districts must report on DSS Form 3851 (Revised) as soon as information is available concerning HIV infection in a particular child. Information is to be reported by CIN number, not by name, and all information is governed by confidentiality requirements already in place.

G. Purchase of Services

- 1. Social services districts purchasing services and/or foster care maintenance from local public or private non-profit or private proprietary agencies for HIV-infected children must ensure that the written contract includes the following, as well as other requirements of Section 405.3 of Department regulations:

- a. specific procedures to safeguard the child's medical history from unauthorized access or disclosure;
 - b. statements assuring that required information and training will be given annually and to newly employed staff within 45 days of employment;
 - c. statements ensuring that staff who "need to know" confidential HIV-related information for the administration, supervision, monitoring, or provision of services will be fully informed of the penalties for unauthorized redisclosure;
 - d. assurance that any disclosure of confidential HIV-related information will be accompanied by the required warning statement (Appendix C).
2. Foster care maintenance purchased from out-of-state agencies for HIV-infected children must comply with the Interstate Compact On the Placement of Children (see Section 374-a of Social Services Law), and social services districts must ensure that written contracts incorporate the requirements in G.l.a. through d. above.

V. SYSTEMS IMPLICATIONS

None.

VI. ADDITIONAL INFORMATION

Definitions:

- A. The term "handicap" includes being diagnosed as having AIDS, testing positive for HIV infection, or being perceived as susceptible to AIDS or HIV infection. Such persons must be protected from discrimination in accordance with all applicable provisions of Department regulations. (18 NYCRR 303.7)
- B. "AIDS" means acquired immune deficiency syndrome, as may be defined from time to time by the Centers for Disease Control of the United States Public Health Services. (Section 2780(1) of PHL and 18 NYCRR 360-8.1)
- C. "HIV infection" means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS. (Section 2780(2) of PHL and 18 NYCRR 360-8.1(a)(2))
- D. "HIV-related illness" means any illness that may result from, or may be associated with, HIV infection. (Section 2780(3) of PHL and 18 NYCRR 360-8.1(a)(3))

- E. "HIV-related test" means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause, or to indicate the presence of AIDS. (Section 2780(4) of PHL and 18 NYCRR 360-8.1(a)(4))
- F. According to law, "capacity to consent" means an individual's ability, determined without regard to the individual's age, to understand and appreciate the nature and consequences of a proposed health care service, treatment or procedure, or of a proposed disclosure of confidential HIV-related information, as the case may be, and to make an informed decision concerning the service, treatment, procedure or disclosure. (Section 2780 (5) of PHL and 18NYCRR 360-8.1 (a)(8))
- G. "Authorized employee or agent" means any employee or agent who, in the ordinary course of business of the provider or government agency, has access to records relating to the care of, treatment of, or provision of a health or social service to the protected individual. (Section 2782(6)(b) of PHL)

VII. EFFECTIVE DATE

The requirements of this release are effective on October 1, 1991, retroactive to February 1, 1989, the effective date of Chapter 584 of the Laws of 1988. This release also incorporates the requirements of Chapter 592 of the Laws of 1990, effective July 18, 1990.

Joseph Semidei
Deputy Commissioner
Division of Family
and Children Services

APPENDIX A

References to
Title 18 Regulations Affected by HIV Confidentiality

<u>AMENDED</u>	<u>ADDED</u>
357.1	303.7
357.3(b)(2), (3)	357.2(b)
357.3(b)(6)	357.3(h)
404.1(a)	360-8.1
405.1(a)	403.9
405.3(g)(12) and (13)	404.1(c)(5) & (6)
432.2(e)(3)(xxix) & (xxx)	405.3(g)(14)(15) & (16)
441.22(b)(2)(viii)	421.1(k)
441.22(c)	421.2(d)
441.22(i)(1)(ii) & (iii)	431.7
441.22(n)(1)	432.2(e)(3)(xxxi)
444.5(c)(13) & (14)	441.22(i)(1)(iv)
444.8(c)(13) & (14)	444.5(c)(15)
487.10(d)(3)	444.8(c)(15)
488.10(c)(2)	485.11(g)
489.14(a)(13)	487.10(d)(4)
491.14(f)(2)	488.10(d)(4)
507.2(a)(2)(viii)	489.14(a)(4)
	490.4 and 491.14(f)(3)
	900.3(b)(1)(xxv)
	900.19

Authorization for Redisclosure of Confidential HIV-Related Information

[Please Note: This completed form must be returned to the agency responsible for the care of the child.]

Date _____

I. I hereby authorize redisclosure of confidential HIV-related information

by _____

(name of agency)

concerning _____

(child's name)

to _____

(person or agency)

for the following time period (check one):

- a. ___ specific dates: _____
- b. ___ while child remains in care of above-named person(s)
- c. ___ until services are completed

II. The purpose for authorizing redisclosure as permitted by Article 27 F of the Public Health Law and Department regulations:

III. I am legally permitted to authorize redisclosure because I am:

- a. ___ the child named above
- b. ___ the birth parent or legal guardian of the child (where the child lacks capacity to consent)
- c. ___ the social services commissioner
- d. ___ the designated representative of the commissioner (indicate title with signature)

Signature _____

Title (if appropriate) _____

Warning Statement on Redisclosure Except to Authorized Persons

This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

Receipt of Confidential HIV-related Information

I have received confidential HIV-related information and have read the warning statement required by law. I understand the penalties for further redisclosure without written permission.

Signature _____ Date _____

(person receiving confidential information in order to provide services)

APPENDIX C

WARNING NOTICE

AGAINST REDISCLOSURE

OF CONFIDENTIAL HIV-RELATED

INFORMATION

This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure.

(See other side for Spanish translation.)

NOTIFICACION DE ADVERTENCIA
CONTRA LA REVELACION DE INFORMACION CONFIDENCIAL
RELACIONADA AL HIV

La información que se le ha revelado proviene de récords confidenciales que están protegidos por la ley del Estado. La ley del Estado le prohíbe a usted proveer más revelaciones con respecto a esta información sin la aprobación específica de la persona a quien se refiere o sin el permiso de la ley. Cualquier revelación adicional que no esté autorizada constituye una violación de la ley del Estado y puede que resulte en una multa o una sentencia de cárcel o ambas. Una autorización general para proveer información médica u otro tipo de datos no constituye una autorización suficiente para hacer más revelaciones.

 | ADMINISTRATIVE DIRECTIVE | TRANSMITTAL: 90 ADM-21

 TO: Commissioners of Social Services
 Directors of Voluntary Child Caring Agencies
 DIVISION: Family and Children Services
 DATE: July 6, 1990
 SUBJECT: Foster Care: Medical Services for Children in Foster Care

 SUGGESTED DISTRIBUTION: Directors of Services
 Children's Services Staff
 Medical Assistance Staff
 Staff Development Coordinators
 CONTACT PERSON: Program questions - your Regional Office Director:
 Albany - John O'Connor, (518) 432-2751; Buffalo - Linda Brown, (716) 847-3145; Metropolitan - Fred Cantlo, (212) 804-1202; Rochester - Linda Kurtz, (716) 238-8200; Syracuse - Jack Klump, (315) 428-3235.
 Systems-related questions - Gerald Seeley, Bureau of Services Information Systems, 1-800-342-3727, ext. 2-2937. Medical Assistance/C/THP questions - Barbara Meg Frankel, 1-800-342-3715, ext. 3-4054.
 ATTACHMENTS: There are no attachments to this release.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other	Manual Ref.	Misc. Ref.
		18 NYCRR	Legal Ref.	C/THP	
		Parts 357		Program	
75 ADM-73	76 ADM-5	428	SSL 365-a	Manual	
81 ADM-10	84 ADM-40	441	SSL 366		
84 ADM-4		442	SSL 373-a	1988	
87 ADM-22		447	SSL 398	Model	
88 ADM-40		448		Foster	
		463	Public	Parents	
		507	Health Law	Manual	
		508	Article 27		
				Standards	
			PL 101-239	of Payment	
				Program	
				Manual	

DSS-296EL (REV. 9/89)

I. PURPOSE

The purpose of this directive is to inform you of the provisions of Department regulations which establish comprehensive standards for medical services for children placed in foster care. The regulations establish uniform requirements, consistent with current recommended medical practice, for the content and frequency of medical examinations. They also require documentation and monitoring of medical services through recording of medical service activities in the progress notes of the uniform case record and the entry of medical examination dates into the Child Care Review Service (CCRS).

II. BACKGROUND

New provisions in law, concern for the health status of all foster children, and a rising number of infants coming into foster care with serious health problems have contributed to the realization that the State Department of Social Services must address significant health services issues for children in foster care through new and amended regulations. As a result, standards for medical services for children were revised and promulgated in regulations which became effective on January 13, 1989.

Authority and mandate for such services is clear in the law. Section 366 of the Social Services Law requires that Medical Assistance be provided to an otherwise eligible child under the age of 21 years receiving care away from his or her own home. Medical Assistance is defined by Section 365-a of the Social Services Law to mean, in part, "payment of part or all of the cost of care, services and supplies which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, or result in illness or infirmity...."

Such care includes early and periodic screening and diagnosis of eligible persons under 21 years of age to determine any physical and mental disabilities and to treat such disabilities and conditions. The Child/Teen Health Plan (C/THP) in New York State meets the federal mandate for an Early Periodic, Screening, Diagnosis and Treatment Program (EPSDT).

Further, Section 398 of the Social Services Law, which pertains in part to children in foster care, requires the commissioner of a local district to "provide for expert mental and physical examinations of any such child whom he has reason to suspect of mental or physical disability or disease and pay for such examination from public funds, if necessary" and to "provide necessary medical or surgical care in a suitable hospital...."

Another aspect of medical services, access to the child's medical history, is addressed in Section 373-a of the Social Services Law. Previously this law required the medical history of the child, to the extent available, to be provided to an adoptive or prospective adoptive parent and to the child discharged to his or her own care. Chapter 584 of the Laws of 1988 amended this law to extend provision of such information to foster parents. This change was effective Feb. 1, 1989.

III. PROGRAM IMPLICATIONS

A. Uniform Standards for Medical Services

Authorized agencies are responsible for providing comprehensive medical services for all foster children, for documenting such services, and for maintaining current records. The amended Department regulations now set standards based on currently recommended medical practice, sound casework practice, and required health services supervision.

Uniform standards for content and frequency of medical examinations follow the recommendations of the American Academy of Pediatrics of the American Medical Association. To assist authorized agencies in implementing the new medical services standards, the regulations:

1. consolidate regulatory references on medical services for foster children in Section 441.22 of Department regulations;
2. clarify and define the roles and responsibilities of local districts, voluntary agencies, foster parents, and medical providers, all of whom are involved in providing medical services for children in foster care;
3. specify responsibility for reporting and monitoring of medical services by authorized agencies;
4. clarify the requirement that Medicaid-eligible foster children be offered C/THP services;
5. provide for follow-up services after discharge from care;
6. list the individuals who must be provided the comprehensive medical history of the child, to the extent it is available.

B. Medical Examinations

Standards ensure that all foster children receive the full range of preventive and primary health care services, including diagnosis and treatment of neglected, chronic or acute medical conditions. The agency responsible for the child's care is also responsible for ensuring that the initial and periodic examination schedule is

followed. Emphasis is on the detection and treatment of any physical or emotional difficulties a child has while in foster care.

C. Informing Foster Parents

Effective casework practice has always included informing foster parents about local agency policies and procedures to be followed in providing medical services for children in their care. Now the law and regulations require that foster parents are provided with the comprehensive health history, to the extent known, of the child placed in their care. Sharing such information is not only required by law, but also enables foster parents to better anticipate the needs of the child in their care and encourages greater involvement in the child's health supervision and treatment plan.

Local agencies are encouraged to review their foster parent manual to be certain it provides foster parents with emergency contacts and procedures in accordance with Section 443.3(p) of Department regulations. (See 88-ADM-40, The 1988 Model Foster Parent Manual.)

In addition, foster care staff, working in cooperation with Medical Assistance staff, need to be well-informed about the range of medical services available in their communities, including psychological services, in order to assist foster parents in formulating a health care plan for the child and to provide appropriate referrals. The local social services district, under Medical Assistance regulations, must keep a list of Medicaid-approved medical providers.

D. Monitoring and Maintaining the Foster Child's Health History File

Documenting the medical services provided and maintaining a health history file for each child in foster care are essential tasks to ensure the child's health needs are met. In addition, oversight and monitoring of the child's medical record by caseworkers, Medical Assistance staff, and supervisors will require ensuring that all items listed for a complete examination have been performed, and that recommendations and referrals for follow-up treatment have been carried out.

E. Medical Services at the Time of Discharge and After Discharge

Since foster children may have less access to medical care after discharge to return home or to independent living, provision is made in the regulations for agencies to assist in the continuation of some medical services for the child. These include discussing with the child's parent or guardian, or with the child discharged to independent living, the importance of continuing medical care. Assistance may also be needed by the family or child in understanding the child's comprehensive health history; the Medical Assistance staff and services caseworker should be knowledgeable and available to provide interpretation and explain recommendations for follow-up

care. Helping the child's family or the child discharged to his or her own care to locate a physician or medical clinic from the district's list of Medicaid providers is the responsibility of the authorized agency at the time of the child's discharge from foster care.

Scheduling comprehensive medical examinations for children prior to discharge to independent living is another agency task in providing medical services. A child returning to care after 90 days have passed is to be considered for health and medical purposes in the same category as a new case and is to receive a comprehensive initial medical examination. While not required, serious consideration should be given to scheduling such examinations when children return to care within 90 days after discharge or after absence without consent, depending on the child's previous history and current condition.

If a child with a goal of independent living is absent without consent, and the case is subsequently closed by the social services district, the agency is not responsible for a final medical examination. Documentation of this situation in the child's health history file is important for possible future case reviews and in the event of the child's return to foster care.

IV. REQUIRED ACTION

A. Disclosure of Health History

According to Social Services Law and Department regulations, the comprehensive health history of a child in foster care must be provided, to the extent known and available, to the following persons:

1. to the receiving agency when the care of the child is transferred from one authorized agency to another for placement;
2. to foster parents at the time the child is placed. If a child is placed on an emergency basis, the health history and medical condition must be immediately provided, to the extent known, and more complete information must be provided as soon as possible, but in all cases within 72 hours.
3. to adoptive parents and prospective adoptive parents*;

* "Prospective adoptive parents" are persons who have met criteria and standards for adoption through screening and home study as specified in Section 421.16 of Department Regulations, who have indicated an interest in adopting a particular child, and for whom the authorized agency has begun the placement agreement process described in Section 421.18 of Department regulations.

4. to parents or guardians at the time of discharge of the child from foster care, including all medical treatment during the time in foster care;
5. to the child himself or herself at the time of discharge to independent living;
6. to the child's physician or medical provider in order to facilitate care and treatment for the child.

PLEASE NOTE: Results of HIV testing and presence of HIV-related illness must be included in medical records of children in foster care, and such information must be given to all the above persons. However, redisclosure of this information by those persons to other persons is forbidden by law without signed informed consent or official written authorization. The following warning statement must be given to all persons to whom the confidential HIV information is disclosed:

"This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure."

In order to facilitate foster care and adoptive placements while ensuring compliance with the law and regulations governing confidentiality of information related to HIV infection and AIDS, persons applying to become foster or adoptive parents should be asked by the agency at the time of application if they wish to consider fostering or adopting a child with HIV disease. If the response is negative, then no child known to be HIV-infected should be considered for placement in those homes. If the response is positive, then the agency may suggest a child with HIV disease to prospective adoptive parents and may place HIV-infected children in such foster homes. It is essential that the caseworker make a diligent effort to ascertain from the foster or prospective adoptive parents their attitude toward and capacity for caring for an HIV-infected child prior to placement; in no case should a foster parent or prospective adoptive parent be surprised with such information following a placement if that information is known at the time of placement. Nor should persons with a casual and general interest in adoption or foster care be provided with HIV-related information about a particular child.

However, when the agency is certain that the foster parents and prospective adoptive parents are willing to accept such children, the complete medical history, including HIV-related information, must be provided to them.

B. Medical History Documentation and Record Keeping

For each child in foster care the authorized agency caring for the child must maintain a continuing individual medical history in the uniform case record. If the child-caring agency is a voluntary agency, copies of additions to the medical history file must be forwarded to the social services district which has ultimate responsibility for the child's welfare whenever a significant change occurs in a child's health status or treatment, but in no case later than the next six month case review and reassessment.

Such changes might include hospitalization, emergency treatment, diagnostic testing, or necessity for extended follow-up care.

Locally established written procedures must ensure that social services district foster care staff provide any medical or health-related information in the uniform case record as requested by the Medical Assistance and C/THP Units of the agency. Such cooperative communication procedures are necessary to assure that all medical service requirements for the child are met.

The comprehensive health history of each child must include, but is not limited to, the following, where known:

1. hereditary conditions or diseases;
2. drugs or medications taken by the child's mother during pregnancy;
3. immunizations received by the child (type and dates);
4. medications dispensed to the child;
5. allergies exhibited by the child;
6. results of diagnostic tests and evaluations, including developmental and psychological tests, given to the child;
7. results of laboratory tests, including tests for HIV;
8. names and addresses of the child's health/medical provider(s);
9. follow-up or continuing treatment provided to, or still needed by, the child;

10. medical equipment/adaptive devices currently used or required by the child (e.g., wheelchair, feeding pump, mechanical breathing supports, eyeglasses, hearing aids).

In addition, the following forms and notices must be included in the health history section of the uniform case record:

1. Past medical records of the child. Diligent effort must be made to obtain records of any previous medical, psychological, or dental treatment of the child placed in foster care. Prior to accepting a child into care, or within 10 days after admission, a request must be made to the child's parent or guardian for written authorization for release of the child's past medical records. In the absence of parental consent, the local social services commissioner is authorized to sign the request for release of such records. Written requests with attached release authorization for the child's treatment history and records must be sent to known medical providers who have treated the child.
2. Form DSS 711, Child's Medical Record, or copies of a comparable medical record form. Some agencies prefer to provide an alternative form, and many physicians have designed forms for their own use. Any such forms are acceptable as long as they record the results of the initial and periodic medical examinations given the child. Form DSS 711 is available from NYSDSS Forms and Publications or through your local social services district office.
3. Form DSS 704, Medical Report on Mother and Infant. This form must be submitted to the appropriate hospital or physician with a request for all pre-natal and birth information available for each pre-school child placed in foster care. A consent release (see B.1.) must be attached. Diligent effort must be made to obtain such information, and all such information received, in whatever form, should be attached to Form 704 and retained in the case file.
4. Progress Notes. Form DSS-3306 is the official cover sheet for progress notes in the uniform case record. Any comparable form may be used to record information summarizing medical/health history-related activities. Activities which must be noted include the dates of medical and dental appointments, examinations and services, a record of referrals, follow-up activities, and transportation provided by the authorized agency. It is not necessary to summarize the child's medical record or results of examinations since the examination record forms must be retained in the same file.
5. Consent forms. At the time a child is placed in foster care voluntarily, the agency must request during the admission process, or within 10 calendar days after admission, an

authorization in writing from the child's parent or guardian for medical or psychological assessment, examination, and treatment, and for emergency medical or surgical care in case the parent or guardian cannot be located at the time the care is necessary.

At the same time, request must be made to the parent(s) for authorization for release of medical records from providers who have previously treated the child.

In cases of involuntary placement involving an abused, abandoned, or neglected child, if parental consent is not available, the local social services commissioner may provide both written authorizations for treatment and for release of medical records. According to Section 383-b of Social Services Law, "the local commissioner of social services or the local commissioner of health may give effective consent for medical, dental, health and hospital services for any child who has been found by the family court to be an abused child or a neglected child, or who has been taken into or kept in protective custody or removed from the place where he is residing, or who has been placed in the custody of such commissioner."

In all cases the signed consent forms must be retained in the uniform case record with other items on the child's health history.

6. Family planning notices to foster parents. A copy must be kept in the child's health history file to indicate that the required notice of family planning services has been sent within 30 days of placement to all foster parents caring for children 12 years of age or older. This notice, which must also be sent annually to such foster parents, informs them of the availability of social, educational, and medical family planning services for the adolescent as is required by section 463.2 of Department regulations.

7. Notice of family planning services directly to adolescents (optional). If the local social services commissioner has approved a district-wide plan to make an offer directly to all foster care adolescents within his or her jurisdiction of family planning services, then a copy of the information provided to the child must be retained in the health history file. The availability of such services may be discussed orally with the young person, but must also be offered in writing. A policy to make such direct offers of services is a local option, but the established policy must have district-wide implementation.

8. Notice of C/THP services. Within 60 days of entry into foster care of a Medicaid-eligible child, the local department of social services must notify in writing the foster parents, or the institution, group residence, group home, or agency boarding

home of the availability of Child/Teen Health Plan (C/THP) services. A copy of the notice must be kept in the child's health history file. This written notice must also be provided to the caretakers of the child at least annually as required by Section 508.4(a) of Department regulations.

9. Child Care Review Service (CCRS). Data related to the foster child's appointments for medical, psychological, and/or dental examinations and treatment must be entered into the Child Care Review Service (CCRS) system in a timely manner. The dates and types of exams must be entered in order to track required timeframes for both the initial and periodic examinations. This computerized record will serve as an administrative tool to cue workers for scheduling purposes. It is not intended as a sanctionable requirement, but may be used for future reviews and reports.

C. The Initial Medical Examination

1. Each child entering foster care must be given an initial comprehensive medical examination no later than 30 days after admission. This requirement also applies to children returning to foster care after a period of 90 days following discharge, trial discharge, or absence without consent.

EXCEPTION: The initial comprehensive medical examination may be waived if the child has been given such an examination within 90 days prior to admission into foster care, records are obtained to document the examination, and the child's health status does not warrant a second comprehensive examination.

2. The initial comprehensive medical examination is optional when a child returns to care within 90 days after discharge, trial discharge, or absence without consent. However, in making such a decision, a careful assessment should be made of the child's previous history and current condition. Such an examination is also optional when a child is transferred from one agency to the care of another agency.

3. For each foster child's initial medical examination, the local social services district or voluntary agency is responsible for:

- a. scheduling the examination for the child or assisting the foster parent to schedule within the required timeframe;
- b. offering to provide or arrange for transportation as needed;

- c. providing the physician with the child's available medical history at the time of the exam or as soon thereafter as possible;
- d. ensuring that the physician is familiar with the requirements for a comprehensive examination (see IV.E.);
- e. ensuring that the examination is completed in those situations when the foster parent assumes responsibility for scheduling and taking the child to the examination without the caseworker;
- f. ensuring that the results of the initial examination and any referrals for follow-up care are retained in the child's health history file in the uniform case record. The date of the initial examination must be entered into the Child Care Review Services (see V.A.).

D. Periodic Medical Examinations

1. Every child in foster care must receive complete periodic individualized medical examinations on a continuing schedule. The required foster care periodic schedule is the same as that required by the Child/Teen Health Plan (C/THP) and follows the recommendation of the American Academy of Pediatrics of the American Medical Association. It is a standard for basic health care for all children, but each child's health care needs beyond this basic care must be met on a case-by-case assessment.

Examinations must follow current recommended medical practice and cover the requirements listed in IV. E. below. Agencies must ensure that children are examined according to the following schedule:

Age 0-1 year: 2-4 weeks / 2-3 months / 4-5 months / 6-7 months / 9-10 months

Age 1-6 years: 12-13 months / 14-15 months / 16-19 months / 23-25 months / 3 years / 4 years / 5 years

Age 6-21 years: 6-7 years / 8-9 years / 10-11 years / 12-13 years / 14-15 years / 16-17 years / 18-19 years / 20 years

2. Every foster child 3 years of age or older must have an annual dental examination by a dentist and must be provided with any other dental care as needed.

3. Authorized agencies must inform foster parents that assistance is available in scheduling appointments and providing or arranging for transportation to medical providers.

4. Records on the results of such examination, referrals for follow-up care, and casework activities related to scheduling these examinations must all be kept in the uniform case record as items in the child's health history file. Dates of such examinations must be entered into the Child Care Review Service system in a timely manner to maintain current information.

E. Contents of Comprehensive Medical Examinations

Medical examinations must take into account the age, environmental background and development of the child and must include the following:

1. a comprehensive health and developmental history;
2. a comprehensive unclothed physical examination;
3. an assessment of the child's immunization status and the provision of immunizations as necessary;
4. an appropriate vision assessment;
5. an appropriate hearing assessment;
6. laboratory tests as appropriate for specific age groups or because the child presents a history or symptoms indicating such tests are necessary;
7. dental screening and/or referral. All children up to age three should have their mouths examined at each medical examination and, where appropriate, should be referred for dental care. All children three years of age or over must have a dental examination by a dentist annually and must be provided with any dental care as needed; and
8. observation for child abuse and maltreatment which, if suspected, must be reported to the State Central Register of Child Abuse and Maltreatment.

These requirements follow current medical guidelines developed by the American Academy of Pediatrics.

F. Follow-Up Services

Agencies must ensure that follow-up health care is provided or arranged for each foster child as needed or recommended by the child's physician. Staff must consult with medical and other appropriate professionals and the child's foster parents regarding health services necessary to meet the child's needs. Written procedures must be developed locally to ensure that foster care services and Medical

Assistance staff, including Child/Teen Health Plan staff, cooperate and communicate in regard to their shared responsibility for follow-up services.

Following each comprehensive medical examination, agency staff must:

1. review the child's medical examination record form to determine whether the physician recommended further treatment, referrals, medications, or other follow-up care;
2. contact the medical provider as appropriate to obtain necessary information on follow-up care and treatment;
3. offer assistance to the foster parent(s) in arranging for follow-up care and transportation as necessary;
4. in cases requiring ongoing medical care, encourage the medical provider to contact the agency caring for the child concerning follow-up, referrals, missed appointments, or other important information.

G. Discharge from Foster Care

1. When a child is discharged from foster care, the comprehensive health history of the child must be provided:
 - a. to the child's parents or guardian if the child is released to their care; or
 - b. to the child himself or herself if the child is discharged to independent living.
2. Prior to final discharge agency staff must:
 - a. assist the parent(s) and/or child with interpretation of the health history;
 - b. discuss with the child's parents or the child to be discharged to his or her own care the importance of periodic medical assessments, follow-up treatments, and any medications prescribed by the physician;
 - c. discuss with the child's parents or the child to be discharged to his or her own care the availability of Child/Teen Health Plan (C/THP) services and eligibility for Medicaid;
 - d. assist the child's parents or the child to find a physician or medical provider organization in an appropriate

location through referrals and/or medical provider lists which must be maintained by social services Medical Assistance units;

e. make diligent effort to obtain the name and address of the child's post-discharge medical provider in order to provide the child's comprehensive health history to that provider.

3. Prior to discharge to independent living, a child must be given a comprehensive medical examination unless such an examination has been provided within one year of the date of discharge.

4. When a child is freed for adoption and is to be discharged from foster care to adoptive placement, a comprehensive medical examination must be provided unless such an examination has been given within 6 months prior to the adoptive placement.

V. SYSTEMS IMPLICATIONS

A. CCRS Reporting

1. To provide administrative assistance in the monitoring of required periodic medical examinations, local agencies must report to CCRS that the required medical examinations have been performed.

When the medical exam has been completed, the following CCRS activity code must be entered for each child in the prescribed manner:

H100 - MEDICAL EXAM PERFORMED. The activity date is the date the medical exam was done. There are no modifiers required. The entry of the H100 activity will release/suppress all prior cues for examinations that may not have been performed.

2. Within one year prior to the anticipated date of discharge for a child with a permanency planning goal of 03 - Discharge to Independent Living or 10 - Independent Living - Unaccompanied Refugee Only, a medical examination is necessary. When the PPG of 03 or 10 is entered on the assessment service plan, districts should also enter the anticipated completion date for the permanency planning goal of 03 - Discharge to Independent Living or 10 - Independent Living - Unaccompanied Refugee Only. In the future, a cue/notice will be generated six months prior to the anticipated completion date for any child with a PPG of 03 or 10 to assist districts in monitoring this requirement.

B. CCRS Caseload Report

To assist agencies in the management of medical exams for children in foster care, two additional cues/notices will appear on the CCRS Caseload Report. The cues are A660 - Medical Exam Due and C660 - Medical Exam Overdue. These cues will be generated for the following situations:

1. When the child is placed in foster care, the initial medical examination cue will be generated from the movement activity (M910), placement in care, reported to CCRS.
2. When the child has been absent from foster care for 91 days or more, the initial medical exam cue will be generated when the movement activity, "return to care," is reported to CCRS.

PLEASE NOTE: The movement activities must be reported to CCRS in the month in which they occur in order for the cues to be displayed on the appropriate month's report.

3. Periodic cues based on the date of birth of the foster child will be generated based on the schedule detailed in section IV. D, Periodic Medical Examinations, in this Directive.

C. Conversion

Six months from the effective date of this Directive, districts must have completed the following actions:

1. Entry of all appropriate H100 - Medical Exam Performed codes into CCRS activities. Only the most recent exam should be reported.
2. For each child with a PPG of 03 or 10, enter the anticipated completion date for the PPG.

VI. ADDITIONAL INFORMATION

A. Medical Assistance Eligibility

Local social services departments must determine Medical Assistance eligibility when a child is placed in foster care. Medical Assistance eligibility for children placed in foster care who are not eligible for and in receipt of Title IV-E foster care maintenance payments must be determined as described in 75 ADM-85 and 81 ADM-10. In accordance with 81 ADM-10, a child's Medical Assistance eligibility must be determined as a separate household of one, and must be based solely on the child's own income and resources and on the amount of support the parents contribute. The child's Medical Assistance eligibility level equals the foster care rate or the Medicaid level for a household of

one, whichever is higher. Children who are eligible for and in receipt of Title IV-E foster care maintenance payments are automatically eligible for Medical Assistance. (See 84 ADM-4.) Furthermore, all children who are eligible for Medical Assistance are entitled to receive Child/Teen Health Plan (C/THP) services.

B. Costs of Medical Examinations

Costs of medical examinations for all those children who are eligible for Medical Assistance, if not included in a voluntary agency's per diem child caring rates, will be paid through MMIS. Costs of examinations for children who are not eligible for Medical Assistance should be paid by the local district and claimed on Schedule K as federally non-participating (FNP) on line 4a or 4b, whichever is applicable.

C. Allocation of Program Costs

Appropriate reporting and allocation of program costs should follow directions specified in the Standards of Payment for Foster Care of Children Program Manual.

D. Annual Establishment of Medicaid Rates for Child Care Agencies

The Department will, on an annual basis, review agency reports of costs incurred in the delivery of medical services to children in care in order to determine the per diem rates for the subsequent year. Rates will be based on reasonable costs incurred in comparison to programs of similar type and geographic location, trended forward to reflect changes in prices for similar medical services.

VII. EFFECTIVE DATE

The effective date of the actions required by this Directive is August 1, 1990, retroactive to January 13, 1989, the date the regulations concerning medical services to children in foster care became effective.

Joseph Semidei
Deputy Commissioner
Division of Family and
Children Services



David A. Paterson
Governor

NEW YORK STATE
OFFICE OF CHILDREN & FAMILY SERVICES
52 WASHINGTON STREET
RENSSELAER, NY 12144

Gladys Carrión, Esq.
Commissioner

Informational Letter

Transmittal:	09-OCFS-INF-01
To:	Commissioners of Social Services Executive Directors of Voluntary Authorized Agencies
Issuing Division/Office:	Strategic Planning and Policy Development
Date:	January 16, 2009
Subject:	Health Care Coordination for Children in Foster Care: Approaches and Benefits
Suggested Distribution:	Directors of Social Services Foster Care Supervisors Medical Directors Health Services Staff
Contact Person(s):	Any questions concerning this release should be directed to the appropriate Regional Office: Buffalo Regional Office – Mary Miller (716) 847-3145 Mary.Miller@ocfs.state.ny.us Rochester Regional Office – Linda Kurtz (585) 238-8201 Linda.Kurtz@ocfs.state.ny.us Syracuse Regional Office – Jack Klump (315) 423-1200 Jack.Klump@ocfs.state.ny.us Albany Regional Office – Kerri Barber (518) 486-7078 Kerri.Barber@ocfs.state.ny.us Spring Valley Regional Office – Pat Sheehy (845) 708-2498 Patricia.Sheehy@ocfs.state.ny.us NYC Regional Office – Patricia Beresford (212) 383-1788 Patricia.Beresford@ocfs.state.ny.us Native American Services – Kim Thomas (716) 847- 3123 Kim.Thomas@ocfs.state.ny.us
Attachments:	Yes
Attachment Available Online:	Yes

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
				Working Together: Health Services for Children in Foster Care	The New York State Care Coordination Pilot Project: Process & Impact Evaluation Study

I. Purpose

The purpose of this Informational Letter is to transmit to social services districts and voluntary authorized agencies a practice guidance paper, “Health Care Coordination for Children in Foster Care: Approaches and Benefits.” This paper, developed by the Office of Children & Family Services (OCFS) in conjunction with Welfare Research Incorporated (WRI), describes the lessons learned during a four-year pilot project and provides social services districts and voluntary authorized agencies with useful information regarding health care coordination for children in foster care. The pilot and its evaluation were supported with Child Welfare Quality Enhancement Funds.

II. Background

Children who enter foster care are more likely than other children to have a wide array of health care needs and issues. With changes in placement, the use of numerous medical providers and emergency rooms, occasionally incomplete information on health care prior to placement, and multiple demands on foster care caseworkers, meeting the health care needs of these children can become a serious challenge. To address these issues, the American Academy of Pediatrics and The Child Welfare League of America recommend that child welfare agencies adopt a care coordination approach to the health assessment, treatment, and follow-up of children residing in foster care.

In an effort to enhance the child welfare system’s capacity to identify and address the health-related needs of children in foster care, OCFS developed a pilot project to support the creation of health care coordination programs in eight service providers around the state. Funded sites were selected to reflect the various geographical areas, levels of care, health service delivery models, and authorized agencies that make up the foster care system in New York. The participating agencies determined how to implement care coordination within their existing structures. The attached paper describes their experiences, the benefits and challenges they addressed, and includes recommendations for putting care coordination into practice.

The New York State Care Coordination Pilot Project – Process & Impact Evaluation Study Findings is available at: <http://www.ocfs.state.ny.us/main/reports/>

III. Program Implications

The attached guidance document discusses staffing and service delivery considerations, and key elements to a successful care coordination program. It also provides suggestions for initiating implementation of care coordination on a limited scale.

OCFS is sharing this for local districts' and authorized agencies' information and use as you review current processes for coordination and oversight of health services for children in foster care.

/s/ Nancy W. Martinez

Issued By:

Name: Nancy W. Martinez

Title: Director

Division/Office: Strategic Planning and Policy Development

Health Care
Coordination for
Children in Foster
Care: Approaches
and Benefits

A White Paper

New York State Office
of Children and Family Services

January 2009

Health Care Coordination for Children in Foster Care

Acknowledgments

The New York State Office of Children and Family Services (OCFS) would like to thank the following agencies for their contribution to this project:

Abbott House

Catholic Guardian Society and Home Bureau

Child and Adolescent Treatment Services, Inc.

Episcopal Social Services

Erie County Department of Social Services

Green Chimneys Children's Services

The House of the Good Shepherd

Kinship Family and Children's Services

St. Vincent's Services, Inc.

Mary Skidmore, Bureau of Planning and Intervention Design, Strategic Planning and Policy Development, OCFS, coordinated the development of this White Paper.

Welfare Research, Inc. (WRI) provided writing and design assistance.

Health Care Coordination for Children in Foster Care

In this White Paper, the Office of Children and Family Services (OCFS) provides guidance to agencies in the creation and implementation of a health care coordination approach for children in foster care. Health includes all aspects of the child’s well-being—physical, dental, developmental, and mental health. The paper defines health care coordination and briefly describes models used in other states and in specific agency programs in New York State. In accordance with standards adopted by New York State and widely accepted in the child welfare field, OCFS recommends that all agencies incorporate a health care coordination approach in their provision of health services to children in foster care.

“Since implementing our enhanced health care coordination project, we have experienced a marked improvement in communication with mental health, developmental, and educational services, and better responsiveness of these service providers to the needs of the children. The health care coordinators are very knowledgeable about these systems, and how to access services that optimally match the particular needs of each child.”

Abbott House

1. Introduction

Overview

Coordination of health care is a valuable service for everyone. Given the segmented system of care currently prevalent in the United States, coordinating the services provided by more than one doctor or other health care professional can present a significant challenge. In the child welfare system, however, health care coordination is not only critical but also attainable. Built into the system of agency and court oversight are opportunities for care coordination not available in the general population. Along with case management, service planning, and permanency planning, health care coordination can and should be provided.

In child welfare, the overall purpose of health care coordination is to coordinate children’s health care needs and services within the context of foster care placement and agency efforts to enhance the safety and well-being of children and plan for their permanency. As such, health care coordination plays a supportive role in service planning and permanency planning for children—a role that is increasingly valued as children come into placement with multiple physical, emotional, and developmental needs. This role is emphasized by the American Academy of Pediatrics (AAP) in *Fostering Health: Health Care for Children and Adolescents in Foster Care* (2005).

Children who are removed from their homes often enter the foster care system with multiple and sometimes complex health-related needs. Because of their experiences, they may have serious emotional, mental health, and behavioral problems. They generally have higher rates of developmental delays and physical disabilities than children not placed outside their homes.

Given the diversity and range of their medical needs, children in foster care may receive assessment and treatment from a number of health care providers, or their needs may be overlooked, and they may not receive necessary services. The function of health care coordination is to manage all of the child’s

Health Care Coordination for Children in Foster Care

health-related needs and issues including mental health, developmental, and substance abuse issues. This paper provides suggestions on how agencies may wish to integrate this function into their program.

What is health care coordination?

To promote optimal health of children in foster care, health care professionals, casework staff, agency staff, caregivers, birth parents, and service providers should work collaboratively toward implementing an integrated plan of care. To make this happen effectively, the function of health care coordination is crucial. Health care coordination is a series of activities that support oversight and responsibility for all aspects of health services for children in foster care.

The role of health care coordination is important so that: each child receives all necessary medical, developmental, mental health, dental, and substance abuse assessments in the specified time frames while in foster care; the foster family / caregiver supports the medical plan for the child; and information is shared appropriately among professionals involved in the child's care. Key health care coordinator activities include: collecting and updating health information, accessing and coordinating health services, health education, discharge planning, and facilitating communication between families and health care professionals.

Specific activities of health care coordinators may include the following:

- Collect information on a child/family's health history.
- Establish and maintain a comprehensive and up-to-date medical file.
- Obtain medical consent(s) as needed.
- Establish a medical home for the child (i.e., an established, ongoing relationship with a primary health care provider).
- Schedule and oversee the completion of medical, dental, developmental, mental health, and substance abuse assessments at foster care intake.
- Obtain any necessary and appropriate follow-up evaluations and services.
- Obtain documentation from health service providers for the child's medical file.
- Record current and ongoing health status and activities.
- Establish service relationships with health care providers.
- Coordinate and monitor ongoing health-related services.
- Communicate the results of initial assessments and ongoing health care treatment with the child's primary care provider, case manager, and other relevant service professionals, as authorized.
- Educate the child, birth parent / guardian, and foster family / caregiver about a child's health needs and issues, as authorized.

Health Care Coordination for Children in Foster Care

- Coordinate treatment team meetings with caseworker, supervisors, agency health staff, childcare staff, and caregivers as appropriate.
- Facilitate the development and incorporation of health-related goals in the child's Family Assessment and Service Plan (FASP).
- Compile health, mental health, developmental, and substance abuse information for the court.
- Communicate with schools regarding the health and developmental needs of the child, as authorized.
- Develop a discharge plan and establish a medical home (*see above*) for children preparing to exit foster care.

Care coordinators accomplish many of these functions by working closely with child welfare staff, specifically case managers (caseworkers) and the child's medical home and other providers. Communication with case managers is integral to providing information and guidance on health-related matters to reach the goals of safety, well-being, and permanency for children in foster care. Although health care coordination may be conducted by a variety of individuals, it is recommended that a lead person with a health background be identified to provide or assist with health care coordination (*see section 4, Guidance for Agencies Implementing Health Care Coordination*).

What Does Health Care Coordination Look Like?

What health care coordination looks like depends on the agency and its characteristics: its mission, purpose, structure, resources, and community. Although health care coordination encompasses certain common activities, the way it is implemented can vary tremendously. The "what" is generally the same; the "how" differs depending on particular circumstances. This is good news in terms of implementing health care coordination statewide: agencies have the flexibility of designing a model that meets their needs.

Section 2 of this paper briefly describes models of health care coordination that have been used in other states.

Section 3 addresses the implementation of a four-year health care coordination pilot in eight sites supported by OCFS from 2003 to 2007. As will be apparent, each agency funded by the project designed a different model depending on the agency's foster care programs, staffing, and ages and characteristics of children in care.

Section 4 provides guidance to agencies in implementing health care coordination.

2. Health Care Coordination Models in Other States

Health care coordination has also been implemented in other states, including California, Colorado, Connecticut, Massachusetts, Michigan, New Hampshire, New Jersey, and Wyoming. This section summarizes the efforts in four of these states.

In California, a public health nurse provides care coordination, within county child welfare service agencies and probation departments, under the supervision of a public health nurse manager. The local Child Health and Disability Prevention (CHDP) program is responsible for the administration of the Health Care Program for Children in Foster Care. The public health nurse works to ensure that the medical, mental health, dental, and developmental needs of those in foster care are being met. In addition, the public health nurse also collaborates and consults with the foster care team, including social workers and probation officers, in order to provide specialty services as well as comprehensive care.

Through Colorado's Department of Public Health and Environment's Health Care Program for Children with Special Needs, health care coordination has been implemented in 41 local and 14 regional public health agencies. A multidisciplinary team of health care coordinators includes community health nurses, social workers, family advocates, speech pathologists, registered dietitians, and a variety of other specialties. The health care coordination team assesses the child's medical and educational needs and then works with the family to produce a plan for care coordination. As the plan is implemented, the team monitors and evaluates the effectiveness of the plan to determine if desired outcomes have been reached.

In New Hampshire, the Department of Health and Human Services district offices have nurse coordinators on staff to ensure that children in foster care and relative home placement are receiving appropriate medical, dental, and mental health care. The nurse coordinator acts as a liaison between those who are involved with the health care needs of the child. This includes all those who are concerned with the safety of the child, including the child's birth and foster family, the child protection service worker, the juvenile probation and parole officer, and the medical community. The nurse coordinator assesses the child's past and current health status in a health care planning meeting and determines the best way to implement the ongoing health care of the child by coordinating both immediate and long-term care.

New Jersey began implementation of mini-health units in each of the local Division of Youth and Family Services offices in 2007 for children in out-of-home placement. Run by nurses, these mini-health units are charged with coordinating medical scheduling, participating in visits and meetings with families and their children, and collecting health records. The health units schedule appointments for initial medical exams, coordinate medical and mental health assessments, and monitor follow-up appointments. Further, they work to ensure continuity of care, which includes continuing care with the child's provider prior to placement, if possible; maintaining a single medical home for the child throughout placement; and ensuring a smooth transition after permanency has been achieved.

Health Care Coordination for Children in Foster Care

3. Health Care Coordination Approaches in New York State

New York State Care Coordination Pilot Project

In an effort to enhance the child welfare system's capacity to identify and address the health-related needs of children in foster care, OCFS developed a pilot project to support the creation of health care coordination programs in eight service providers around the state. Initiated in 2003, these programs sought to improve the health, well-being, and permanency of children living in foster care by designating a particular individual (i.e., a care coordinator) or set of individuals to monitor, coordinate, and facilitate all aspects of a child's health care while in foster care.

Sites were selected to reflect the various geographic areas, levels of care, health service delivery models, and authorized agencies that make up the foster care system in New York State. OCFS provided a conceptual framework and mandatory outcomes for the project, but agencies were expected to work out the details of operationalizing health care coordination within their existing structures. In this way, pilot agencies have paved the road for the implementation of care coordination in other agencies.

Although specific models and operating procedures varied across the selected sites, each of the sponsored programs was designed to enhance the comprehensive identification of children's health problems, timely access to necessary programs and services, health education for staff and families, and communication among health professionals, service providers, and families. Long-term goals included reducing time to permanency and pregnancy prevention.

Participating agencies were: Abbott House, Catholic Guardian Society and Home Bureau, Child and Adolescent Treatment Services, Episcopal Social Services, Green Chimneys Children's Services, The House of the Good Shepherd, St. Vincent's Services, and Kinship Family and Youth Services. The Jewish Board of Family and Children's Services participated for one year.

Funds for the NYS Care Coordination Pilot Project were drawn from the OCFS-administered Quality Enhancement Fund (QEF), which uses Temporary Assistance for Needy Families (TANF) dollars to support the development and evaluation of innovative child welfare services aimed at promoting a family's ability to safely care for children in their own homes and preventing teen pregnancy. Pilot agencies were required to track activities in a database for evaluation purposes.

Anticipated Benefits of Health Care Coordination

The thinking behind the pilot project was that the anticipated benefits from providing health care coordination would be both short-term and long-term. When care coordinators have the management of children's health-related needs and issues as their primary responsibility, they can devote the time needed to arrange and monitor health and health education services, with the goal of identifying and appropriately treating children's health-related issues. Regular, repeated contact with treatment providers may also facilitate the establishment of strong working relationships between a care coordinator and local health care professionals, potentially facilitating timely access to services. Thus, anticipated short-term benefits included:

- an increased likelihood that a child will receive a full array of comprehensive health-related assessments at foster care intake;
- better identification and documentation of health care needs;

Health Care Coordination for Children in Foster Care

- more timely access to health care and service providers; and
- increased education of and communication among birth parents, caregivers, and service providers regarding a child's health needs and services.

It was felt that improvement of the overall health and well-being of children resulting from the short-term benefits may in the long run promote permanency. Potential long-term benefits included:

- decrease in changes in foster care placement due to fewer demands placed on caregivers;
- reduction in time in placement due to education of birth parents/caregivers about a child's health needs and involvement of family members in the child's health care, addressing a possible barrier to reunification; and
- reduction of risky behavior and teenage pregnancy due to increased access to health education, reproductive services (family planning, gynecological care, etc.), and mental health and/or substance abuse services.

Program Settings, Staffing, and Models

While each participating program served children placed into foster care as a result of child abuse and neglect, the level of foster care in the eight participating sites ranged from regular foster boarding homes to institutional settings. Other differences included: environment (rural, urban), location (upstate or NYC), size and staffing, facility resources, and health services delivery systems. The main characteristics of each program are displayed in the chart on the next page.

The qualifications of care coordinators also differed across sites. Requirements set by the individual agencies for their care coordination staff included: Registered Nurse (RN), Licensed Practical Nurse (LPN), Bachelor of Arts (BA), Master of Arts (MA), Master of Science in Education (MSED), Master of Social Work (MSW), and Master of Public Health (MPH). One agency used foreign-licensed physicians in the process of obtaining licensure in the United States.

To help promote the development of programs that were responsive to local needs and issues, OCFS encouraged the agencies to develop the service delivery model best suited to their target population, staffing resources, and existing operational structure. As a result, each of the eight models in the pilot project is unique. Each reflects the agency's characteristics as well as the creativity and energy of the agency's staff.

“The Care Coordinator has allowed for an additional layer of oversight, and central point of Health information. This has improved communication among the Treatment Team.... As the Care Coordinator has shared her experience with the Social Services department and other clinical and campus staff, there is an increased awareness among staff about medical issues present in our client population.”

Green Chimneys Children's Services

Health Care Coordination for Children in Foster Care

Agency Settings & Staffing			
Agency	Setting	Health Services Delivery	Care Coordinator Qualifications & Caseloads
Abbott House	Bronx Regular agency-certified and kinship foster boarding homes Short-term diagnostic group homes	Neighborhood-based clinics and hospitals Halfway through project, agency opened an on-site clinic for primary care	Experienced caseworkers with bachelor's degrees Foster homes–1 FTE care coordinator for 35 children Group homes–1 FTE care coordinator for 15 children
Catholic Guardian Society and Home Bureau	Manhattan, Bronx, Staten Island Regular foster boarding homes–most children qualified for special or exceptional board rates Mother/baby group homes	Community health providers	Medical social workers for foster care Registered nurses for mother/baby homes Foster homes–1 FTE care coordinator for 40 children Mother/baby group homes–0.5 FTE care coordinator for 12 mothers and their babies
Child and Adolescent Treatment Services	Erie County–urban and suburban Regular foster boarding homes	Medicaid managed care. All foster children go to one medical home for primary care	Bachelor's or master's degree in social work or related field 1 FTE care coordinator for 30 to 45 children
Episcopal Social Services	Manhattan, Bronx Special needs (medically fragile) foster boarding homes	On-site medical clinic for primary care, dental, mental health	Physicians trained outside of U.S. 0.5 FTE care coordinator for 13 children
Green Chimneys Children's Services	Putnam County–rural, close to New York City Residential Treatment Center for young children	On-site medical clinic for primary care, developmental, dental, mental health	Master of Social Work 1 FTE care coordinator for 15–25 children
The House of the Good Shepherd	Oneida County–small city and rural Therapeutic foster boarding homes Residential Treatment Center	Foster boarding homes used community health providers Residential Treatment Center used on-site clinic for primary care	Master of Social Work Foster homes–1 FTE care coordinator for 30 children Residential Treatment Center–1 FTE care coordinator for 30 children
Kinship Family and Children's Services	Steuben County–rural with children from many counties Therapeutic foster boarding homes	Community health providers Contract psychologist conducts all mental health assessments	Registered nurse Master of Science in Education 2 FTE care coordinators for 30–40 children
St. Vincent's Services	Brooklyn Regular foster boarding homes	On-site medical clinic for primary care, agency mental health and chemical dependency clinics	Medical social worker, registered nurse 2 FTE care coordinators for 60 children

Health Care Coordination for Children in Foster Care

Despite these differences in program setting and structure, which were evident in the applications for funding, the day-to-day functions of the care coordinator were expected to be similar across pilot sites. In all of the programs, care coordination staff were expected to work with the caseworker assigned to the child's family by the local social service agency, and to assume primary responsibility for managing all aspects of the child's health care.

Managing all aspects of the child's health care includes working with the child's primary care provider and any other health-related providers (mental health, developmental) as well as agency staff dealing with medical issues. Care coordinators were also expected to work closely with other providers such as the Early Intervention (EI) Services Coordinator for children up to three years old receiving EI services and the School Supportive Health Services Program for children with handicapping conditions receiving Committee on Special Education (CSE) services. As educational services and assessments are integral to other health issues, particularly for children with special needs, care coordinators became key liaisons between the agency and the child's school.

Challenges

As with any new approach involving staffing and organizational considerations, challenges will occur in getting the program off the ground and keeping it going smoothly. The agencies participating in the pilot faced several challenges, some of which they shared but dealt with differently. Their challenges are much the same as those that might be experienced by any agency seeking to implement health care coordination effectively. Learning how agencies dealt with these challenges may be helpful to agencies implementing health care coordination.

This section briefly describes each agency in the pilot, the challenges faced by the agency or program, and the solutions used to deal with the challenges.

Primary challenges included:

- Clarifying the roles of the care coordinator
- Handling staff turnover and retention
- Establishing relationships with casework and supervisory staff
- Meeting the needs of children
- Gaining trust and involvement of birth parents
- Obtaining health records from providers
- Accomplishing data collection and input for the pilot

Health Care Coordination for Children in Foster Care

Agencies and Their Solutions

Abbott House

Abbott House provides several levels of foster care: foster boarding homes (FBH), including kinship and emergency; therapeutic foster boarding homes (TFBH), group homes, and a residential treatment center (RTC), as well as diagnostic reception centers. Abbott House serves metropolitan New York City and the surrounding counties. The main agency offices, located in Westchester County, have a medical department and dentist. However, it is not practical for foster parents in the Bronx to bring children there for care, so community health care services were used at the inception of the project.

Care coordinators were employed for the Bronx foster boarding home program initially, and later for the short-term, diagnostic group home program as well. Experienced, motivated foster care caseworkers were selected from existing staff for these positions. A nurse devoted part of her time to providing technical assistance to the care coordinators.

Even before participating in the pilot project, Abbott House had been providing health care coordination for children in its foster boarding homes, but there were challenges in fulfilling this function for children receiving health care services in the community. It was difficult for foster parents to access health care (e.g., for initial assessments) on a timely basis and there were problems from both sides (foster parents and providers) in obtaining medical documentation of appointments. Halfway through the project, it became apparent to the agency that there was a need for on-site services, and they opened a medical clinic in the Bronx office and contracted with a mobile dental van.

Some adjustments in staffing were made to fully integrate the health care coordination function into the programs at Abbott House. The care coordinators now took on the responsibilities for all medical, mental health, developmental, educational, and dental assessments and treatment. Since foster care caseworkers were previously responsible for these functions, they—along with foster parents and birth parents—were confused about the role of the care coordinator. “This adjustment within the organizational structure had an enormous impact on Abbott House and the children served within this project,” reported the medical director.

Solutions: The medical clinic and dental van provided the opportunity for a full health care coordination function to operate successfully and as a team (medical director, nurses, and health care coordinators). Establishing an on-site clinic addressed the two issues of access and documentation: the agency was now able to provide timely initial assessments and to schedule child/parent medical visits. Routine visitations between birth parents and their children were scheduled at the Bronx office for clinic days. This way, parents were able to attend the clinic appointments and learn about their child’s health needs without making an extra trip.

To clarify their roles, the care coordinators and caseworkers held weekly team meetings to update one another on their areas of responsibilities. Each child’s status was reviewed once a month. These team meetings became one of the most critical elements in the success of care coordination at Abbott House. To reduce any confusion among foster parents and birth parents, the care coordinators attended the 72-hour conference to introduce themselves and explain their role in the case. The care coordinator accompanied the caseworker on home visits to the foster parents and birth parents to speak about the health and educational needs of the children and support communication among the parents.

Health Care Coordination for Children in Foster Care

As an agency that contracts with the New York City Administration for Children's Services (ACS), Abbott House must comply with ACS requirements. The health care coordinators identified and used community providers that were willing to follow the rules and regulations set forth by ACS and provide the agency with necessary documentation. Mandated contacts with foster and birth parents were increased as a result of the care coordinators' involvement.

Abbott House will continue to use the health care coordination, incorporating the position into ACS' new Improved Outcomes for Children (IOC) model.

Catholic Guardian Society and Home Bureau

In 2006, during the period of the pilot project, the former Catholic Guardian Society merged with Catholic Home Bureau, forming a large foster care agency offering foster family care and group homes along with supportive services primarily serving Manhattan and the Bronx through five community-based centers. The congregate care program serves youth in four boroughs.

Catholic Guardian's care coordination services were integrated into the agency's existing range of services, using such approaches as early engagement and intervention along with family involvement in services and planning. Most of the many tasks of care coordination were completed during interactions with birth parents, children, foster parents, child care staff, caseworkers/supervisors, and medical, mental health, and educational providers.

The care coordinators assigned to the mother-child group homes were experienced registered nurses who enjoyed the challenge of working with youth in foster care. The nurses conducted all initial assessments except mental health, which were completed by a psychologist.

The care coordinators assigned to the foster boarding home (FBH) program were medical social workers who worked closely with the nurse assigned to the cases on their caseload. This allowed for adequate monitoring and consultation on health and mental health issues with health care providers. Children selected for participation in the project were already in foster care, rather than new admissions. The care coordinators focused on working with the birth parents to increase their involvement with the children and capacity to bring them home.

Solutions: The establishment of a designated care coordinator supervisor at the Washington Heights site was instrumental in providing ongoing supervision of the care coordinators; monitoring so that all assessments were completed within the required time frame; and calling team meetings to discuss issues around case planning, problem-solving, and rectifying organizational problems such as staff shortages and turnover.

It took some time for staff and families in the Washington Heights site to understand the role of the care coordinator. Over time, the care coordinators were able to establish non-threatening relationships with birth parents: they advocated for birth parents, included them in decision-making, educated them on the health needs of their children, and helped them obtain medical and mental health services. The care coordinators complemented the caseworkers so that together they were effective in working with the children, foster parents, and birth parents. Foster parents were educated on the health needs of the children in their care, asked to attend all medical appointments, and encouraged to partner with the birth parents around medical care.

Health Care Coordination for Children in Foster Care

The most important challenge for the care coordinator for the mother/child group homes was to establish a relationship with the teen mothers. The coordinators used a variety of ways to build this relationship, including group meetings focused on activities with infants, nutrition, and safety in the home. The care coordinator encouraged expression of feelings and provided emotional support while teaching healthy behaviors in a nonjudgmental fashion. Fathers were encouraged to be involved. During the project, sexual acting out and subsequent pregnancies were significantly reduced.

Catholic Guardian Society and Home Bureau will continue to use the health care coordination model by incorporating the costs into their Medicaid per diem.

Child and Adolescent Treatment Services

Unlike the other health care coordination contractors, Child and Adolescent Treatment Services (CATS) is not an authorized foster care agency. CATS is a community organization that provides counseling and treatment services in accessible, child-friendly offices throughout Erie County, as well as in schools and other community-based settings. The staff of multidisciplinary mental health professionals provides specialized programs for children with emotional disorders, victims of physical and sexual abuse, suicide prevention, and violence prevention, as well as guidance for parents. This care coordination model comprised an agreement between a Medicaid Managed Care Plan and a large urban county social services agency.

The care coordination program, known as Care4Kids, is a Medicaid Managed Care Plan under the auspices of CATS. Prior to this project, the Child Advocacy Center (CAC), also a part of CATS, conducted sexual abuse exams for chronically abused children, as well as pre-placement foster care physicals. Through Care4Kids, the CAC was established as the medical home for children in direct care with the Erie County Department of Social Services (DSS). Virtually all children entering foster care in Erie County receive comprehensive medical, dental, and behavioral health assessments through the CAC. With access to the agency's on-site medical and mental health professionals, the Care4Kids program could provide children in the pilot quality comprehensive medical care through 30-day follow-up examinations, improved recordkeeping, and a focus on the need for early mental health assessments.

Solutions: The most difficult challenge was clarifying the role between CATS and Erie County DSS. As an outside organization, CATS was providing services to children not directly in its care. At times, children were moved without notification to the care coordinator, contact information on birth parents was not available, and caseworkers did not understand the care coordinator's role in the service plan review. For this model of care coordination to succeed, a liaison is critical: Erie County DSS provided a liaison who helped implement the program and explained it to caseworkers and other DSS staff.

One staffing challenge involving delays in hiring a health care coordination supervisor was solved by reconfiguring the position from a nurse to a master's level human services candidate. Staff included two social workers (one a medical social worker), nurse manager, and a secretary.

Over time, as the care coordinators made connections with health care providers in the community, the children were more likely to be seen more quickly; as a result, foster parents overcame initial resistance to the "extra work" coming from the care coordinators and began to understand their role and see them as being supportive to them as well as to the children. Erie County caseworkers also began to be aware of and appreciate the work being done on behalf of the children in their caseload by care coordinators.

Health Care Coordination for Children in Foster Care

Another challenge was the delay in Medicaid coverage for some of the foster children in the pilot. The delay caused problems in accessing necessary referrals for mental health counseling and other specialty care services such as vision and eye glasses. This was addressed by notifying Erie County DSS caseworkers of the delay.

Upon completion of the pilot project, the medical component of Care4Kids will continue in that all children entering foster care will receive a pre-placement physical and 30-day recheck at the Child Advocacy Center. If possible, Erie County DSS will pick up the care coordination component.

Episcopal Social Services

Located in Manhattan and the Bronx, Episcopal Social Services offers foster care, adoption, and preventive services, group homes, Early Intervention services, and Early Head Start, among other programs. Two on-site medical clinics provide a comprehensive range of health services: pediatric medicine, child psychiatry, child psychology, dental services, and services for vision, hearing, sex education, and immunizations.

Because Episcopal Social Services made education of the caregivers and birth parents the overarching goal of their project, health care coordinators were called health educators. The children receiving care coordination services were medically fragile; some of the presenting problems included HIV infection, shaken baby syndrome, seizure disorder, diabetes, sickle-cell disease, autism, and cerebral palsy. Though primary pediatric care, including dental and mental health, was provided by agency clinics, these children needed care from medical specialists in the community. The health care coordinators served as liaisons between hospital staff and parents (birth and foster).

Solutions: To help prevent multiple transfers from one foster home to another, the families received close supervision and support. Birth parents and foster parents were given a thorough explanation of the children's conditions and provided the opportunity to ask questions and get answers. To increase health knowledge and engagement with the child, the health care coordinator insisted that foster parents go to all specialty appointments. The care coordinators worked closely with the social work staff, conducted monthly home visits, addressed language barriers, advocated for the children, and facilitated compliance with treatment recommendations.

The agency medical director, who is board certified in pediatrics and child psychiatry, occasionally called specialty physicians directly to break through bureaucratic barriers in obtaining necessary services for these children.

The most important challenge was to verify that each child was safe in an environment that allowed for personal growth and a healthy lifestyle. This challenge was addressed by providing education for caregivers and birth parents on the type of care needed for medically fragile children. When given a comprehensive understanding of the child's needs and the necessary skills to address those needs, foster parents have the confidence and support to maintain the placement, and birth parents can work toward the child's return home.

The care coordination model continued at the agency upon the pilot's end.

Health Care Coordination for Children in Foster Care

Green Chimneys Children’s Services, Inc.

Green Chimneys operates residential treatment for children and a special education school on a 200-acre farm in Brewster, NY. The agency offers specialized treatment and educational and recreational services to children in New York City, upstate New York, and western Connecticut. Using animal-assisted therapy, the Farm & Wildlife Rehabilitation Center is an important component of the treatment program. Green Chimneys provides extensive structure and support to children aged 5-13 (upon admission) with diagnoses such as Attention Deficit Hyperactivity Disorder (ADHD), Asperger’s Syndrome, Pervasive Developmental Disorder, Anxiety and Social Phobia, Post Traumatic Stress Disorder, Reactive Attachment Disorder, and Oppositional Defiant Disorder.

Through the project, an MSW became the health care coordinator for a group of 25 children with a high level of medical, mental health, and developmental needs. A population of mostly girls (aged 5 to 14) was identified for care coordination. Health care needs of the children are addressed on campus. The Health Center provides medical, dental, developmental, and mental health services for residents, and children attend an on-campus school. The care coordinator focused on communication issues. She provided a central point of health information, increased communication among the treatment team members, increased awareness among casework staff about medical issues, helped train clinical staff to work more effectively with families, and bridged the gap between school staff and cottage staff.

Solutions: Prior to implementation of care coordination, a social work model of care was in place. Each child was assigned a social worker who provided therapy, worked with the family, and completed caseworker duties. The care coordinator took over some of the duties that would typically be done by a caseworker, such as oversight of all medical and health services, liaison with ACS/DSS case planners, and discharge planning. The result was a dual track approach that clarified and defined roles. Social workers now provide family and group therapy, and caseworkers attend case conferences and provide other common casework functions.

To address the fact that because the agency had a higher population of boys than girls its services were geared more toward the needs of boys, the project brought a focus on activities that would encourage girls’ self-esteem. While living at home, many of these girls were exposed to domestic violence, witnessed sexual activity, and/or were victims of sexual abuse. Targeted activities provided them with appropriate role models, information on healthy development, and self-esteem.

Having a health care coordinator has also allowed for a clear role—a person that others can go to regarding coordination and communication between clinical/health staff, education staff, and caseworkers, as well as parents. The health care coordinator successfully opened lines of communication between the agency and their outside contractor for substance and “children of abusers” services. She provided feedback to the agency from the birth parents around issues of health care management. She also assisted in identifying the need for a different level of care when appropriate, and developed discharge plans.

The health care coordination model has continued at Green Chimneys.

The House of the Good Shepherd

Located in Utica, The House of the Good Shepherd (HGS) provides residential care including a residential treatment center and group homes, as well as foster boarding homes and preventive services in the surrounding counties. The agency’s Health Department provides pediatric health services for children

Health Care Coordination for Children in Foster Care

living on campus; a nurse coordinates health care with primary care providers in the community for children in foster boarding homes.

The care coordination project focused on the children who would be most likely to benefit from aggressive coordination of services. Children selected displayed evidence of serious mental health disorders or severe dysfunction. Two master's level social workers served as care coordinators—one for the therapeutic foster boarding home program and one for the Residential Treatment Center (RTC). These coordinators were responsible for a plan of care that ensured that services provided by a multi-disciplinary team of social work, educational, medical and residential staff or foster parents were delivered and communicated in a timely, organized, and coordinated fashion. Even though the youth in the RTC received health services on campus and the children in therapeutic foster care received care in the community, the care coordination functions were similar.

Like Green Chimneys, the House of the Good Shepherd used a “primary therapist” model, wherein one individual was responsible for all aspects of the child’s treatment. Handing health concerns over to the new care coordinators was a significant change, but benefits to the therapist became quickly apparent.

Solutions: Although nursing and therapist staff had undertaken many of the care coordination tasks before the project began, the formalization of the care coordination roles resulted in a stronger program in delivering educational services such as pregnancy prevention (through a contract with Planned Parenthood) and substance abuse education. Weekly communication with service providers, attendance at treatment planning meetings, and supervision with staff were required so that service needs were met.

The RTC care coordinator initiated regular team meetings among the clinicians and residential supervisors that helped to address treatment challenges, increase communication and coordination, and provide greater opportunity for successfully maintaining stability in placement. As a result of the pilot project, treatment team supervisors now oversee the work of the therapists in the RTC.

While care coordination as described above did not continue after the pilot, it set the stage for more collaboration between clinical and social work aspects of treatment. The nurse practitioner now participates in treatment planning and is involved in many of the activities that had been completed by the care coordinator.

Kinship Family and Children’s Services

Kinship Family and Children’s Services offers residential care, preventive services, therapeutic foster care, child health care, and parenting skills education throughout the rural Finger Lakes and Western Regions of New York State. The agency is a division of Catholic Charities of Rochester, Inc. Except for mental health services, which are available through contract, health services are provided in the community.

This is a small agency and children come from several surrounding counties. All children placed in the therapeutic foster boarding home program received care coordination services. Due to the geography in this area of the state, transportation to medical appointments was a challenge.

With the goal of providing services to children with severe mental health and behavioral needs living in therapeutic foster care, the RN care coordinator shared responsibility with an education specialist with a master of science in education (MSED) degree. Responsibilities were differentiated: the RN became responsible for coordination of services, documentation, tracking, and oversight of health services, while

Health Care Coordination for Children in Foster Care

the education specialist focused on areas of special need such as special education and birth parent involvement.

Solutions: After some organizational adjustments, it became apparent that it would be more effective to divide the responsibilities between the RN and MSED staff. Rather than maintaining their own caseload, the two care coordinators worked collaboratively with all children in the program. This division of roles worked well to facilitate continuity of health care and sharing of accurate information with all involved in the children's care.

The challenge of documenting and tracking health services by agency staff, foster parents, and birth parents was addressed by frequent phone calls and reminder letters. Kinship developed a brief form that foster parents bring to medical appointments. The health provider fills it out and it becomes a record of the appointment. Samples of these forms can be found in the manual *Working Together: Health Services for Children in Foster Care* at http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp

Care coordinators were invited to attend weekly team meetings that reviewed placement referrals, new admissions, discharges, moves, and health-related issues. The care coordinators assisted in identifying appropriate placements for children coming into the agency. In one case, contact by the care coordinators resulted in a birth mother providing transportation to her daughter for health appointments while the child was in care. As a result, the mother was effectively engaged in family counseling and the child was discharged earlier. The project as a whole resulted in significant reductions in movement while in care and quicker discharges.

The care coordination team continued to serve the children at Kinship for another year after the pilot ended.

St. Vincent's Services

St. Vincent's Services offers a broad array of services including foster care, group homes, a program for children with AIDS and other medically fragile conditions, a licensed mental health and chemical dependency clinic, and services for the developmentally disabled. The agency is located in Brooklyn and serves all of New York City.

The medical caseworker (social worker) and RN worked as a care coordination team to serve large sibling groups, teen mothers with their children, and adolescents. As the program progressed, children with more intense medical needs were added to the group served. They described their service population as those "children who are falling through the cracks." The associate director of the Medical Department directly coordinated the project and held weekly team meetings, which included data entry staff, who were integral to the project. Identified needs were to involve more birth parents in their children's health care, increase discharge planning services, better engage the teen population to prepare them to address their own health needs, and educate birth parents and foster parents on health care issues.

Solutions: Initially uncertain of the project's impact, eventually casework staff welcomed the interventions of the medical caseworker in several areas: decreasing the caseloads of existing staff, providing comprehensive case management to families and better quality of service including specialty care, and meeting mandated requirements.

Data entry staff handled documentation requirements and also helped the care coordination team to assess the service provided and identify needs.

Health Care Coordination for Children in Foster Care

To enhance training of youth and parents, the project obtained a portable DVD to facilitate educational activities. A system was put in place for rescheduling missed appointments and providing follow-up, including a reward system. To encourage going to the dentist, the care coordinators initiated “dental dates” in which children were rewarded by going out to lunch or receiving special attention from staff in conjunction with their dental appointment.

The more intense case management provided resulted in many children feeling comfortable enough to reveal past sexual abuse, which could then be addressed. As with many agencies, St. Vincent’s found that heightened awareness and communication resulted in more identification and quicker intervention for health issues. Some children were transferred to the specialized medical program to provide a higher level of service.

St. Vincent’s is unable to maintain the intensity of case management in the pilot project. However, second year MSW students will become a part of the medical department.

Benefits of Health Care Coordination in Pilot Programs

According to one pilot agency, “Overall, the significant benefit of enhanced health care coordination is a magnified focus on the health care issues of children in care, which has resulted in rapid identification of health needs and establishment of health services, improved communication among various entities (health and mental health providers, developmental and special education services, pediatric subspecialists), improved compliance of foster parents, and involvement of birth parents.”

The program evaluation of the pilot project documented the following program benefits:¹

- Higher rates of initial assessment completion and timeliness. Following establishment of their care coordination programs, sponsored agencies significantly increased the number of children under their care who received initial physical, dental, mental health, developmental, and substance abuse assessments within state recommended time frames.
- Better identification of health care needs. Children were more likely to have documentation of physical, mental health, developmental and educational problems diagnosed and/or identified by a health care professional.
- Improved documentation of access to health care professionals. Documentation of well child care, preventive dental exams, mental health therapy, Individual Education Plans, and Early Intervention service receipt was significantly higher for children in care coordination.
- Increased communication with service providers and caregivers. Care coordination staff had more contact with birth parents, foster parents, and service providers about a child’s health-related needs than foster care staff working without health care coordination.

In addition to the evaluation findings, the pilot sites reported that enhanced attention to health services resulted in benefits at the institutional level. Participants were motivated to shift their broader agency culture to a more integrated, health-oriented model of service delivery. As a result, some agencies designed new mechanisms for gathering and tracking health care information; developed assessment

1 NYS Office of Children & Family Services. *The New York State Care Coordination Pilot Project: Process & Impact Evaluation Study Findings* (March 2007). Available at <http://www.ocfs.state.ny.us/main/reports/>

Health Care Coordination for Children in Foster Care

protocols for new admissions; enhanced parent education services; established agency-community provider partnerships; and established or improved on-site health facilities. Many agencies noted that the project was instrumental in identifying service gaps, preventing issues from falling through the cracks, and reducing duplication of effort. Care coordination staff also acted as a model for other agency staff, piloting and sharing new ways for addressing health issues.

Agencies found that health care coordinators served as an additional support to caseworkers and birth parents alike. Caseworkers became comfortable with care coordinators addressing all aspects of health care. Birth parents perceived the care coordinators as a nonthreatening resource within the agency. Trust was built between birth parents and care coordinators as both focused on the child's well-being and worked together to understand and support the child.

“Having a dedicated person (Care Coordinator) who can ‘shepherd’ and monitor the completion of evaluations and subsequent follow-ups has been particularly valuable in the physical health area. Our experience is that we have more timely completions of evaluations and a much tighter process of ensuring that follow-up treatments are provided. As an indirect result, we have also revised our physical health assessment form to be much more comprehensive and in line with the Working Together manual.”

The House of the Good Shepherd

4. Guidance for Agencies Implementing Health Care Coordination

Health care coordination will look different across New York State because of the variety of health service delivery models in our agencies and local departments of social services. In planning implementation, agencies should consider a variety of factors, including available resources. Two important factors to consider are how health services are delivered to children in foster care, and how the agency currently monitors or oversees the services.

Health Services Delivery

Children in foster care receive medical care in a variety of ways. Methods of communication and collaboration between the provider and care coordinator will differ across these models. Some typical health delivery models include:

- **Community providers.** Children in foster homes receive their care from providers within the community. These may include doctors and clinics that the foster parents or agency know to be reliable and familiar with the needs of children in foster care. Typically, the foster parent accompanies the child to the appointment, keeps track of appointments, and informs the caseworker about the outcome of the appointment.
- **Agreements with providers.** The LDSS or voluntary agency may have agreements or contracts with community or hospital-based providers to serve children in foster care. For example, a specific psychologist may contract with the agency to conduct all initial mental health assessments, or a mobile dental van may be engaged on a regular basis.

Health Care Coordination for Children in Foster Care

- **Agency clinic.** The LDSS or agency may operate its own medical clinic for children in care. Children may still use community or hospital providers for specialty care.

Oversight

The coordination, monitoring, and oversight of health services are dependent on the staffing model at the agency or LDSS with whom the child is placed, as well as the level of care. Identifying individuals who are currently carrying out the care coordination activities is an important step in determining what changes, if any, will take place. Typical oversight models:

- Foster parents may play a major role by scheduling appointments, accompanying the child to appointments, and advocating for specialty services. The foster parents keep the agency informed of health-related activities.
- The case manager or caseworker may be responsible for arranging and reminding caregivers of appointments, assisting with transportation, and obtaining copies of records.
- The agency may employ health care coordinators and/or nursing staff that track attendance at appointments and review records to determine what additional services are needed. This model is often employed in congregate care settings.

Critical Elements

Although the models created varied, the pilot agencies agreed that certain activities were critical to the success of their health care coordination projects.

- **Designation of care coordinator.** The single most important factor in the success of health care coordination is the designation of an individual whose sole responsibility is care coordination. That person is freed from the many tasks, concerns, and responsibilities that foster care staff must address. The care coordinator can simply concentrate on the child's health and well-being.
- **Organizational support.** The decision to incorporate health care coordination for children in foster care must be supported by administrators and managers throughout the organization.
- **Clarification of roles.** Staff must understand which activities will now be performed by the care coordinator. Among other things, the care coordinator's role in service plan development and review, and working with foster and birth parents should be clearly defined.
- **Team meetings.** Pilot agencies found that regular team meetings with health care coordinators, caseworkers, supervisors, and in-house medical staff were instrumental in sharing information and fully integrating health issues into the child's service and permanency plans.

Health Care Coordination for Children in Foster Care

Activities That Benefit the Agency

Depending on the size, capacity, and experience of the staff responsible for health care coordination, additional support may be provided to the agency in a variety of ways. These include:

- Coordination of training efforts around health topics. Both caseworkers and caregivers need information about the unique health care needs of children in foster care. Community health providers may also appreciate information on child welfare issues to help them understand the children they are serving. Health care coordination serves a central role in identifying, arranging, and tracking the provision of health training and education.
- Consultation and advocacy on special medical issues.
- Assistance and support for the caseworker around special services such as Early Intervention (EI), Bridges to Health (B2H), or the Committee on Special Education (CSE). More information on these services can be found in the manual *Working Together: Health Services for Children in Foster Care*. http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp
- Documentation and update of agency protocols and procedures. These may address topics such as confidentiality, maintenance of the child's medical record, billing procedures for providers and emergency rooms, protocols around the use of psychiatric medications, or the development of specialized forms or systems for tracking health activities.
- Monitoring and evaluation of the overall quality of health services provided to children in foster care. This information can prove valuable in overcoming barriers to optimal health services. It can also inform management and local government on the strengths and areas for improvement in the local health care delivery system. State, county, and voluntary agencies should cooperate in the development and implementation of Quality Improvement Programs for health services for children in foster care.

Getting Started

After consideration of the health services delivery model, current practice, and resources, your agency may choose to delegate some health care coordination activities to designated staff. It is recommended that a lead person with a health background be identified to provide or assist with health care coordination. This individual may be an RN, LPN, psychologist, LCSW, LMSW, or social worker with experience in addressing the physical and mental health needs of children in foster care. If the individual does not have training or experience in a health field, health practitioners should be identified to provide technical assistance.

A starting point allows for agencies to learn how this function would work in their environment and with their own model of health care delivery. Here are some suggestions for implementing care coordination on a limited scale:

- Start small. Have one care coordinator work with a couple of caseworkers in one unit with a supervisor that supports the concept.

Health Care Coordination for Children in Foster Care

- Pilot agencies identified the population most likely to benefit from care coordination to be children in foster homes receiving health services in the community. Start with this group.
- Target only the neediest children. Identify children with the most complex health needs or those in a special program within your agency for care coordination.
- Target service gaps. If a specific issue has been identified, such as birth parents not understanding their children's health needs, focus care coordination on that issue.
- Limit the length of time that care coordination services are provided. Have the care coordinator be responsible for newly admitted children receiving timely assessments, identifying specialty providers, and verifying that a service plan is in place, then give oversight responsibility back to the caseworker.

Asked about the impacts of the health care coordination pilot, one agency noted, "This program has helped us ensure that families have access to the services needed as quickly as possible without unnecessary barriers or duplication." Such an outcome is desirable in all areas of our work to benefit the health, safety, and well-being of children in foster care. If care coordination can have this impact in the area of health, it is well worth the effort and time to set up and incorporate within our agencies.

"Oversight and implementation of care coordination provided higher standards and accountability for those involved in the health care needs of children in our program. Duplication of services decreased, accurate healthy history and information was obtained and shared with all persons involved in the care of the child. Positive relationships were established and maintained with service providers, which improved communication and quality of services which resulted in improvement of services our children received."

Kinship Family and Children's Services



Eliot Spitzer
Governor

NEW YORK STATE
OFFICE OF CHILDREN & FAMILY SERVICES
52 WASHINGTON STREET
RENSSELAER, NY 12144

Gladys Carrión, Esq.
Commissioner

Informational Letter

Transmittal:	08-OCFS-INF-02
To:	Commissioners of Social Services Executive Directors of Voluntary Authorized Agencies OCFS Facility Directors
Issuing Division/Office:	Strategic Planning and Policy Development
Date:	February 13, 2008
Subject:	The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care
Suggested Distribution:	Directors of Social Services Planning Coordinators Health Care Coordinators Medical Directors of Voluntary Authorized Agencies Program Directors of Voluntary Authorized Agencies DJJOY Facility Health Staff
Contact Person(s):	See page 10
Attachments:	Yes
Attachment Available Online:	http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp

Filing References, if applicable

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		18 NYCRR 441.15 18 NYCRR 441.17(g) 18 NYCRR 441.22	SSL 383-b FCA 355.4 NY Penal Law 70.20(4)(b)&(c) MHL 81 MHL 33.21(e) PHL 2504.1	Working Together: Health Services for Children in Foster Care	See References list

I. Purpose

The purpose of this Informational Letter is to provide guidance on the safe and appropriate use of psychiatric medications for children and youth in the custody of OCFS, local social services district commissioners or voluntary agencies who have been placed in an out-of-home setting. The guidance presented is consistent with current research and professional publications that address psychiatric medication and children. For further information, a list of references is included in this document.

This Informational Letter also provides information on the authority to provide routine and informed consent for medical care of children in placement.

II. Background

Children in care often have biological, psychological, and social risk factors that predispose them to emotional and behavioral disturbances. These may include a family history of mental illness, in utero exposure to alcohol or drugs, medical illnesses, a history of abuse and neglect, disrupted attachments, and exposure to violence in the home or community. Additionally, the stress experienced by families as they address the child's mental illness may be a contributing factor to the child's placement in care. For many of these children, medication has been identified as an integral component of a comprehensive mental health treatment plan.

Psychiatric Medications, also called psychotropic, psychoactive or behavioral medications, are chemical substances that act primarily upon the central nervous system where they alter brain function, resulting in temporary changes in perception, mood, consciousness and/or behavior. They are used to treat the symptoms associated with mental health disorders such as attention deficit-hyperactivity disorder (ADHD), psychosis, depression, and anxiety.

The advent of symptom-targeted medications for mental illness has had a significant impact on patients, physicians, medical practice and society. Physicians have tools for treatment that are effective, enabling some individuals with debilitating symptoms to function in the community. Additionally, the stigma of mental illness has decreased. Since the introduction of lithium in the 1940's, the pharmaceutical industry has produced an array of psychiatric medications. The availability of multiple medications that address specific symptoms allows prescribers considerable latitude in choosing a medication or combination of medications to produce the desired outcome while minimizing undesirable effects. But these practices also raise concerns about the impact of psychiatric medications on children's developing brains and bodies.

Scientifically controlled double-blind studies, the “gold standard” for research, have shown that psychiatric medications are generally safe and effective for adults. However, many psychiatric medications have not undergone clinical trials with children to prove their efficacy, safety, and long-term impact. The Food and Drug Administration (FDA) determines whether a medication is safe and effective prior to approving it for marketing. Though pharmaceutical companies cannot market medications for a use not indicated by the FDA, physicians may prescribe the medication for “off-label” use. “Off-label” refers to the use of drugs for patient populations or conditions other than those for which the FDA has “approved” them as “safe and effective.” This does not necessarily mean that these medications are not safe and effective for this population (Malkin, 2005). For these reasons, care must be taken in prescribing and administering psychiatric medications for children and youth, particularly in regard to “off-label” use of such medications.

III. Program Implications

As part of their responsibility for the safety, permanency and well-being of children and youth placed in their care, OCFS facilities, local social services districts and authorized foster care agencies are advised to provide diligent and thoughtful oversight of medical care provided, particularly in regard to the use of psychiatric medications. A suggested framework for this oversight is provided below.

Assessment

Any child being considered for psychiatric medication must have thorough medical and mental health assessments. These are completed upon the child’s entry into care and at periodic intervals thereafter as set forth in 18 NYCRR 441.22.

The medical assessment is critical in that the symptoms attributed to mental illness may have a variety of causes. Conditions such as Fetal Alcohol Spectrum Disorder (FASD), lead poisoning, significant head trauma, premature birth, and substance abuse by the child may result in problems with executive functioning, cognition or emotional regulation. All medical conditions should be identified so that suitable interventions will be chosen by the medical practitioner and treatment team.

The central component of a mental health assessment is a clinical appointment with a qualified mental health practitioner. Refer to Chapter 1 of “Working Together: Health Services for Children in Foster Care” for a listing of the elements of the mental health assessment and those who would be considered qualified mental health professionals. This section is also attached herein and the entire manual is on the OCFS website.

(http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp)

The qualified mental health practitioner should be provided with the results of the medical assessment and a complete history of the child's functional status and behavior in various settings, such as the foster home or facility, school, day care center, and playground. If the child was taking psychiatric medication when he or she entered care, that prescription should be verified with the prescriber. Psychiatric medication should only be discontinued under the supervision of a medical practitioner, as side effects can result from the sudden cessation of some medications.

To accurately determine the impact of new medications, baseline functioning is best assessed by the administration of a pre- and post-symptom scale (e.g., Connors' Rating Scales for attention deficit hyperactivity disorder, Overt Aggression Scale for aggression, Children's Depression Inventory for depression). If this is not practical, it is recommended that the frequency and severity of target symptoms be quantified before and after the medication has been added. In addition to measurements of mental health symptoms, baseline information is also needed on the child's physical health status (e.g., weight, blood pressure, blood tests) to determine the impact of the medication.

Diagnosis

The mental health assessment may result in a diagnosis with corresponding numerical codes from the multi-axial system outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This system organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of the disorder or disability:

Axis I – clinical disorders, including major mental disorders, as well as developmental and learning disorders

Axis II – underlying pervasive or personality conditions, as well as mental retardation

Axis III – medical conditions which may be relevant to the understanding and treatment of the mental disorder

Axis IV – psychosocial and environmental factors contributing to the disorder

Axis V – Global Assessment of Functioning (GAF) on a scale of 100 to 0

A DSM diagnosis is a helpful starting point in understanding the child's behavior, mood, cognition, and adjustment. However, it may be difficult to formulate an accurate diagnosis of mental illness in children based on the DSM. Children may not fit the symptom criteria established for adults for certain disorders, such as bipolar. The developmental changes experienced by children as well as their malleability can make a stable diagnostic label hard to come by. Additionally, the trauma experienced by many children prior to placement as well as issues such as disrupted attachments, school problems, and substance abuse may result in a presentation which points erroneously toward mental illness.

For these reasons, treatment of children with psychiatric medication should focus on the relief of undesirable symptoms (Malkin, 2005). Accurate diagnosis can be a guide to treatment, but the effectiveness of the medication regimen is best determined by the alleviation of targeted symptoms with minimal undesirable side effects.

Behavioral Planning

Many children and youth in out-of-home placements present behavioral challenges for their caregivers at some point. Assisting the child in adjusting to placement and managing emotions and behavior is integral to well-being. The mental health assessment is an important tool in identifying the child's strengths and past traumas, and a thorough assessment should include treatment recommendations that can be incorporated into a behavioral plan. This plan could include strategies such as a tiered reward system, play therapy, trauma work, sensory integration exercises, or recreational activities. The behavioral plan should be incorporated into the Family Assessment and Service Plan (FASP).

Psychiatric medication may be part of the plan. These medications may assist the child in managing strong emotions, such as rage, so that he or she is better able to benefit from a treatment like cognitive behavioral therapy. They may also help the child to concentrate in school, improve peer relationships, sleep better, and enjoy life. However, because the effects of psychiatric medications on any individual cannot be guaranteed, it is important to try a variety of alternative interventions before prescribing medication. Medication should not be the sole component in the behavioral plan.

After the child's behavior and mood become stable, it is recommended that the prescriber adjust the medication dosage to the minimum dose at which the medication remains effective and side effects are minimized. Attempts may also be made to discontinue the medication (Bellonci, 2006; Irwin, 2002), as the child may have benefited sufficiently from alternative interventions to function well without medication. This practice reinforces the development of coping, anger management and problem-solving skills, and builds the child's sense of control and self-reliance. It also assists in determining the soundness of initial diagnostic impressions. As diagnoses can have lasting consequences, it is important to determine if the child is accurately diagnosed with a mental illness that is alleviated with medication, or if the presenting problems can be explained and addressed in other ways.

Communication Protocols

Clear communication protocols are important when a child is taking psychiatric medications. The decision to treat a child with psychiatric medications should be made in consultation with the parent or guardian and a team that should include the caseworker, caregivers, health care coordinator, agency staff with oversight responsibilities, pediatrician, and psychiatrist. The

team must carefully balance the risks of medication with the anticipated benefits.

Drug information sheets should be provided to caregivers and the parent or guardian as soon as reasonably possible. Caregivers will need detailed instructions on administering the medication. They also need to know what to expect from the medication and be alert for effects, both desirable and undesirable. Understanding the role that the medication plays in the overall treatment plan helps caregivers to comply with the regimen and monitoring requirements.

Agency policies should establish clear protocols for information sharing that include the following:

- The use of a Medication Administration Record (MAR);
- Dissemination of information to caregivers, team members and parent or guardian;
- Proactive policy for seeking and collecting information on the child's status from caregivers, school personnel, community programs, parent or guardian, and other parties that observe the child in various settings;
- Providing current information to persons administering medication outside the foster care setting (e.g., during home visits); and
- Discussion of medication during routine caseworker visits to foster homes.

General Authority to Consent to Medical Care

In accordance with New York State laws and regulations, any medical care for a child in placement must be provided pursuant to an authorized consent. Who may consent to medical care for a child in placement depends on how the child came into placement.

Article 3 (Juvenile Delinquent) Placements

Children may be placed under Article 3 of the Family Court Act (FCA) with a local social services district or with OCFS. Where a child is placed with a local social services commissioner, the regulations at 18 NYCRR 441.22(d) require the district to request authorization in writing from the child's parent or guardian for routine medical and psychological assessments, immunizations, medical treatment, and emergency medical or surgical care if the parent or guardian is unavailable when such care becomes necessary. This request must be made within 10 days after the child is taken into care. Absent consent, the local commissioner or authorized agency has no inherent authority to provide medical care. Accordingly, for those juvenile delinquents placed with a local commissioner where the parents or guardians do not consent to routine care, a court order providing appropriate authority should be sought.

Where children are placed under Article 3 of the FCA with OCFS, Section 355.4 of the FCA provides that OCFS has the authority to consent to routine medical, dental and mental health services and treatment. Thus, if a child is

adjudicated as a juvenile delinquent and placed with OCFS and OCFS then places the child with a voluntary authorized agency, OCFS would have the authority to consent to routine medical, dental and mental health services and treatment in the absence of the parent or guardian. The placement order permits administration of psychiatric medications only if such medication is part of an ongoing mental health plan that existed prior to placement with OCFS, unless the court order specifically provides otherwise.

Article 7 (Person in Need of Supervision) Placements

For children placed with a local social services commissioner under Article 7 of the FCA, the regulations at 18 NYCRR 441.22(d) require the district to request authorization in writing from the child's parent or guardian for routine medical and psychological assessments, immunizations, medical treatment, and emergency medical or surgical care if the parent or guardian is unavailable when such care becomes necessary. This request must be made within 10 days after the child is taken into care. Absent receipt of such consent, the local commissioner has no inherent authority to provide medical care, so a court order providing appropriate authority should be sought.

Article 10 (Child Protective) Placements

Where children are removed and/or placed with a local social services commissioner or voluntary authorized agency under Article 10 of the FCA, the regulations at 18 NYCRR 441.22(d) require the local commissioner or authorized agency to request authorization in writing from the child's parent or guardian for routine medical and psychological assessments, immunizations, medical treatment, and emergency medical or surgical care if the parent or guardian is unavailable when such care becomes necessary. Again, this request must be made within 10 days after the child is taken into care. If consent is not given, or pending receipt of such consent, where the child has been removed under Article 10 or placed by a court into the custody of the local commissioner of social services under Article 10, the local commissioner has the authority under Section 383-b of the Social Services Law (SSL) to give consent for medical, dental, health and hospital services for the child. Section 383-b clearly covers routine care and we understand it to also cover emergency care and non-routine care. However, it is still best to get parental consent if possible.

Juvenile Offender Placements

Where juvenile offenders are placed with OCFS under Section 70.20 of the Penal Law, the court is required to ask parents or guardians to consent to routine medical, dental and mental health services and treatment. If the parents or guardians do not consent, the commitment order is deemed to give OCFS consent for routine medical, dental and mental health services and treatment. The placement order permits administration of psychiatric medications only if such medication is part of an ongoing mental health plan that existed prior to placement with OCFS, unless the court order specifically provides otherwise.

Voluntary Placements

Where a child is placed through a voluntary placement under Section 384-a of the SSL, the placement is under such terms as are agreed to by the parties. If the placement agreement specifies terms on consent to medical care, those terms will govern. If the issue is not addressed in the agreement, the local social services district or voluntary authorized agency has no authority to consent to any sort of medical care. The best practice in voluntary placements is to be certain the issue of consents for medical care is addressed in the placement agreement.

Surrender of Parental Rights

Where there has been a surrender of parental rights under Section 383-c or 384 of the SSL, the surrender ends the parental rights of the biological parent and the biological parent has no authority to consent to any form of medical care for the child, including the administration of psychiatric medications. If both parents have surrendered their parental rights, then the local commissioner or authorized agency having guardianship of the child has full authority to consent to any medical care or procedure.

Termination of Parental Rights

Similarly, where that has been a termination of parental rights under Section 384-b of the SSL, the termination ends the parental rights of the biological parent and the biological parent has no authority to consent to any form of medical care for the child, including the administration of psychiatric medications. If the rights of both parents have been terminated, then the local commissioner or authorized agency having guardianship of the child has full authority to consent to any medical care or procedure.

Informed Consent and Capacity to Consent to the Administration of Psychiatric Medications

The authority to consent to medical care described above generally applies to routine medical care. However, for certain types of medical care or treatments, including the administration of psychiatric medications, medical practitioners will usually require informed consent. Having the authority to consent to routine medical care will not necessarily authorize OCFS, the local commissioner or the authorized agency having custody of a child to also give informed consent, as informed consent will generally be sought by medical practitioners only for non-routine care or treatments.

Informed consent requires that the person giving consent:

- (1) be told details of the proposed care or treatment, such as the duration and the procedures to be followed;
- (2) have the opportunity to ask questions about the proposed care or treatment; and
- (3) have the risks, benefits and alternatives to the proposed care or treatment clearly explained to them.

Informed consent means that the person giving consent has been provided comprehensive information on the medication and understands the risks, benefits, and alternatives of treatment. Information should be offered in a language and terminology understood by the consentor. The person being asked to provide informed consent should be provided with written information as well as an opportunity to ask questions. Refer to Chapter 6 of “Working Together” for additional considerations. This section is also attached herein.

This leads to the question of who may issue informed consent and under what circumstances. As a general rule, prior to the administration of psychiatric medication to children in placement, informed consent must be requested from the parent or guardian. However, there are two exceptions to this general rule.

1. Pursuant to Section 2504 of the Public Health Law, a person who is 18 years of age or older, is married or is the parent of a child may give consent, including informed consent, to any medical care and treatment, including the administration of psychiatric medications. No one else is authorized to consent for care in this case unless the court has determined that the individual is incapacitated and appointed a guardian or has otherwise intervened to authorize this type of medical care.

2. If the parental rights of both parents have been surrendered or terminated, only the commissioner or authorized agency with guardianship, or the court, can give informed consent to this type of medical care. (Please note that references hereafter to obtaining the consent of the parent or guardian are inapplicable to situations where the parental rights of both parents or a guardian other than the commissioner or an authorized agency have been surrendered or terminated.)

Outside of those two situations, OCFS recommends that informed consent be first sought from the parent or guardian.

If the parent or guardian objects to the medication, OCFS, the social services district or authorized agency should:

- work with them to understand the basis of the objection,
- pursue any reasonable treatment options that the parent or guardian suggests,
- provide the parent or guardian an opportunity to meet with the prescriber and treatment team, and
- assist the parent or guardian in obtaining a second opinion, if requested.

If the parent or guardian and the treatment team cannot agree on the use of psychiatric medication, the OCFS facility, local district or authorized agency should seek legal counsel to determine if court intervention is advisable.

If the parent or guardian is unavailable or the parent or guardian does not respond to repeated requests to provide informed consent, consent may be provided in accordance with the legal placement authority.

- If the child is placed pursuant to an order or adjudication under Article 10 (child protective) of the FCA, the social services commissioner or his or her designee can provide consent.
- If the child is placed voluntarily or pursuant to FCA Article 7 (PINS), a court order must be sought to authorize the medication.
- If a youth is placed pursuant to FCA Article 3 (juvenile delinquent) in the custody of a local social services district, a court order must be sought to authorize the medication.
- If the youth is placed pursuant to FCA Article 3 in the custody of OCFS and psychiatric medications were part of an existing health care plan at the time the youth was admitted to OCFS custody, the placement order authorizes OCFS to continue the existing course of treatment without additional consent. The introduction of new psychiatric medications would require a court order.
- If a youth is placed pursuant to Penal Law 70.20 (youthful offender), a court order must be sought to authorize the medication.
- If a child is placed pursuant to a surrender or termination of parental rights, the social services commissioner or authorized agency with guardianship of the child provides consent. Parental consent is not sought.

The commissioner or designee and the court if applicable must also receive information on the medication in order to provide an informed consent.

Additionally, there are provisions in Section 33.21(e)(2) of the Mental Hygiene Law that empower a minor 16 years of age or older residing in a psychiatric hospital to consent to the administration of psychiatric medication if:

- The minor has the capacity to consent, and
- A physician determines that the medication is in the minor's best interest, and
- The parent or guardian is not available or refuses to give consent, and a psychiatrist agrees with the first physician that the child has capacity to consent and that the medication is in the minor's best interest; or requiring the consent of the parent or guardian would have a detrimental effect on the minor, and a psychiatrist agrees with the first physician that the child has capacity to consent, that the medication is in the minor's best interest, and that requiring consent of the parent or guardian would have a detrimental effect.

In cases where the parent or guardian is refusing to consent to the administration of psychiatric medication or has not made him or herself available for purposes of providing consent, the medical professional should evaluate whether the refusal or failure to be available creates reasonable cause to suspect child maltreatment for failing to provide adequate medical care and

should make a report to the Statewide Central Register of Child Abuse and Maltreatment, if appropriate.

Assent

In addition to informed consent from the parent or guardian, the assent of the child should be sought for psychiatric medications. The child needs to understand, in accordance with his or her developmental status, how the medication may impact the way he or she feels, acts, and thinks, and the benefits and risks. Older youth may be concerned about side effects such as weight gain, or being labeled with a diagnosis of mental illness. If the treatment team, caregivers, and parent or guardian have communicated well and agreed on the course of treatment, the child will receive consistent support in complying with the plan.

Where a child has the authority to give informed consent but the child does not wish to take the medication, we recommend spending some time talking with the child to understand and address his or her concerns. It may be helpful for a foster parent, caseworker, or facility staff to accompany the child to an appointment with the prescriber to help the child better understand the recommendation for medication and the risks to the child if the child does not take the medication.

When the child's condition or actions present a serious and immediate threat to personal safety, it may be necessary to administer a psychiatric medication over the child's objection on the advice of medical professionals. These circumstances should be addressed in agency policies and procedures.

Prescribing Psychiatric Medications

Ideally, psychiatric medications are prescribed by a psychiatrist (preferably specializing in child and adolescent psychiatry), psychiatric nurse practitioner, or developmental pediatrician. Given the shortage of these practitioners, medication may be prescribed by the medical home (primary care) physician if recommended as a result of the mental health assessment. The use of a psychiatrist consultant can enhance the medical home physician's ability to manage psychiatric medication regimens.

In identifying clinicians in the community to treat children in placement, we recommend seeking out those who follow the recommended prescribing principles below. If the prescriber diverges from these practices, discuss the rationale for the medication therapy with the prescriber, and request that this rationale be documented. The following list of recommended prescribing principles has been developed to assist social services districts, authorized agencies and OCFS facilities in their oversight and monitoring of psychiatric medications prescribed for children in care. ***It is not intended to dictate treatment decisions by clinicians.***

Recommended principles for prescribing psychiatric medications for children are as follows:

- Individualize medication decisions for each child.
- Identify the symptoms targeted by the medication.
- Consider the balance between benefits and risks.
- Choose medications in this order of preference, as appropriate:
 - 1) FDA approved for psychiatric use in children;
 - 2) Approved for the presenting symptoms or diagnosis in adults with evidence of effectiveness and safety in children;
 - 3) Approved in children for a different usage but with evidence of effectiveness and safety in children.
- Medications with more data regarding safety and efficacy are preferred over those new to the market.
- “Start low and go slow”; i.e., begin with low dosages and increase slowly.
- Allow sufficient time for the effects to be seen before increasing the dosage or determining that the medication is ineffective.
- Make only one change at a time; e.g., change a dosage or add a different medication.
- If a medication does not result in the desired effect, adjust the dosage or discontinue the medication (this must be done gradually for some medications).
- If side effects of the medication are not tolerable, try a different medication rather than adding a medication to counter the side effects.
- After the child has been stable for a period of time, medication dosages should be adjusted by the prescriber to the minimum dose at which a medication remains effective and side effects are minimized. Attempts may be made at the prescriber’s discretion to discontinue the medication to determine if it is still needed.
- Explain to the child, in a developmentally appropriate manner, what to expect from the medication.

References for above list: (Bellonci, 2006; Arizona, 2006; Irwin, 2002; NYS OMH, 2004)

Monitoring

Periodic monitoring by the prescriber is necessary for all children taking psychiatric medications. Recommended monitoring includes the following:

- Clinical assessment for treatment effect;
- Clinical assessment for side effects (may include height, weight, blood pressure, involuntary movements, electrocardiogram);
- Laboratory tests as indicated for specific medication;
- Review of observations from the child, caregivers and treatment team on the effects of the medication;
- Objective evaluation of targeted symptoms, such as repeating symptom inventories or scales that were performed prior to initiation of medication; and

- Immediate communication with the child, caregivers and treatment team on recommended changes in the current medication regimen.

The frequency of medication monitoring appointments will vary depending on the medications involved and the child's condition. For example, monitoring may be needed as often as weekly if the child is unstable or many medications are involved. The medication manufacturer may recommend a monitoring schedule. If the agency has specific requirements for the frequency of psychiatric medication monitoring, these must be communicated to the prescriber, the caregivers, the treatment team and the child to support compliance.

Indicators for Independent Review

It is beneficial for districts and agencies to develop the capacity for a high-level review or second opinion by a medical expert of the medication regimen for children in placement. Circumstances that may warrant an independent review include but are not limited to the following:

- Child prescribed more than three psychiatric medications (Bellonci, 2006);
- Child prescribed more than one psychiatric medication from the same class of medications (e.g., two anti-psychotics) (Bellonci, 2006);
- Psychiatric medication prescribed for a child younger than 5 years of age (Coyle, 2000; Rey, 2000);
- Medications needed to manage target symptoms are causing significant side effects (e.g., dramatic weight gain, sleep disturbance) (Irwin, 2002; Irwin, 2004); and
- Prescribing practices vary significantly from those recommended above.

In these cases, it is recommended that the prescriber document an explanation for the recommended course of treatment and that an independent reviewer examine the mental health assessment, the presenting symptoms and behaviors, the rationale for the medications prescribed, the status of non-medication interventions, and previous medication trials. The risks of the medication regimen must be balanced against the benefits to the child in his or her unique circumstances. Long-term effects should be considered as well as immediate concerns.

Quality Assurance

A quality assurance plan is recommended to monitor the use of psychiatric medications in the out-of-home population. Agencies and districts are encouraged to develop a plan to obtain aggregate data on the use of psychiatric medications for children in their care; identify and use mental health professionals that implement the practices recommended above; and routinely review samplings of individual records. Any concerns should be addressed through a process of continuous quality improvement.

Individual record reviews should address the following questions:

- Did the child receive a comprehensive medical and mental health assessment prior to the initiation of medication?
- Have appropriate consents been obtained?
- Is there adequate communication about medication among all parties, including the child and parent or guardian?
- Has a multi-faceted behavioral plan been developed, documented and implemented?
- Are recommended prescribing and monitoring practices followed?
- Have independent reviews been conducted when indicated?
- Does documentation include the rationale for the medication regimen?
- Are clinical and laboratory monitoring reports documented, and resulting concerns addressed?

IV. Contact Persons

Questions concerning this Informational Letter may be directed to:

Buffalo Regional Office – Mary Miller	(716) 847-3145
User ID: Mary.Miller@ocfs.state.ny.us	
Rochester Regional Office – Linda Kurtz	(585) 238-8200
User ID: Linda.Kurtz@ocfs.state.ny.us	
Syracuse Regional Office – Jack Klump	(315) 423-1200
User ID: Jack.Klump@ocfs.state.ny.us	
Albany Regional Office – Glenn Humphreys	(518) 486-7078
User ID: Glenn.Humphreys@ocfs.state.ny.us	
Yonkers Regional Office – Pat Sheehy	(914) 377-2080
User ID: Patricia.Sheehy@ocfs.state.ny.us	
New York City Regional Office – Patricia Beresford	(212) 383-1788
User ID: Patricia.Beresford@ocfs.state.ny.us	
Native American Services – Kim Thomas	(716) 847- 3123
User ID: Kim.Thomas@ocfs.state.ny.us	

/s/ Nancy W. Martinez

Issued By:

Name: Nancy W. Martinez

Title: Director

Division/Office: Strategic planning and Policy Development

References

American Academy of Child and Adolescent Psychiatry. (2007) *Practice Parameter for the Assessment and Treatment of Children and Adolescents With Bipolar Disorder* Available at

http://www.aacap.org/galleries/PracticeParameters/JAACAP_Bipolar_2007.pdf

American Academy of Child and Adolescent Psychiatry. (2003) *AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline* Available at

http://www.aacap.org/galleries/PracticeInformation/FosterCare_BestPrinciples_FINAL.pdf

American Psychiatric Association. *DSM-V Prelude Project*. Available at

<http://dsm5.org/index.cfm>

Arizona Department of Health Services, Division of Behavioral Health Services. (2006). *Practice Protocol: Psychotropic Medication Use in Children, Adolescents and Young Adults*. Available at

<http://www.azdhs.gov/bhs/guidance/psychotropic.pdf>

Arroyo, W. (2001). Chapter 2: Children, Adolescents and Families. *Ethics Primer of the American Psychiatric Association*. Available at

http://www.psych.org/edu/res_fellows/ep/DL02.pdf

Bellonci, C. (2006). *Medication Monitoring Guidelines*. Tennessee: Brian A. Protection From Harm Settlement, Psychotropic Medications Workgroup. Available at http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/teleconferences/Medication_Monitoring_Guidelines.doc

Coyle, J. (2000). Psychotropic Drug Use in Very Young Children. *Journal of the American Medical Association*, 283 (8) 1059-1060.

Engstrom, F., Hong, K. (1997). Psychotropic Drugs: Modern medicine's alternative to purgatives, straitjackets, and asylums. *Postgraduate Medicine*, 101 (3). Available at

http://www.postgradmed.com/issues/1997/03_97/psych.htm

Healthlink, Medical College of Wisconsin (2002). *Children, Mental Illness and Medicines*. Available at

<http://healthlink.mcw.edu/article/954384940.html>

Irwin, M. (2004). *Understanding the Use of Psychiatric Medication in Foster Care and Residential Treatment*. Saratoga Springs, NY: New York Public Welfare Association Summer Conference.

Irwin, M. (2002). *Usage of Psychiatric Medication in Onondaga County Foster Children: Follow Up 2002*

Malkin, M. (2005). *Psychotropic Medication for Children and Adolescents*. Los Angeles, CA: Los Angeles County Department of Mental Health, Juvenile Court Mental Health Services.

Manos, M. (2006). *Treating Severe ADHD in Very Young Children*. Available at <http://www.medscape.com/viewarticle/523542>

National Institutes of Mental Health (2000). *Child and Adolescent Bipolar Disorder: An Update from the National Institutes of Health*. Available at <http://www.nimh.nih.gov/health/publications/child-and-adolescent-bipolar-disorder/summary.shtml>

New York State Office of Mental Health. (2004) *Clinical Advisory and Issue Analysis Regarding Antidepressant Use in Children and Adolescents*. Available at <http://www.omh.state.ny.us/omhweb/advisories/clinicaladvisory.htm>

Ohio Legal Rights Service. (2002). *A Closer Look: A Review of Psychotropic Medication Practices in Children's Residential Facilities in Ohio*. Available at http://olrs.ohio.gov/ASP/pub_2_ChemicalRestraint.asp

Pennsylvania Department of Public Welfare. *Promoting Appropriate Use of Psychotropic Medications for Children and Adolescents*. Available at <http://www.dpw.state.pa.us/Child/BehavHealthServChildren/ChildAdolescentGuidelines/003670846.htm>

Rey, J., Walter, G., Hazell, P. (2000). Psychotropic Drugs and Preschoolers. *Medical Journal of Australia*. 173, 172-173. Available at http://www.mja.com.au/public/issues/173_04_210800/re/re.html

Roitman, N. (2004). *A Practitioner's Guide to the Use of Psychotropic Medication in Children*. NACC Children's Law Manual- 2004 Edition. Available at http://www.naccchildlaw.org/training/documents/PractitionersGuide_000.pdf

Streissguth, A., O'Malley, K. (1997). Fetal Alcohol Syndrome/Fetal Alcohol Effects: Secondary Disabilities and Mental Health Approaches. Available at <http://depts.washington.edu/fadu/Tr.today.97.html>

Texas Department of State Health Services. (2005). *Psychotropic Medication Utilization Parameters for Foster Children*. Available at <http://www.dshs.state.tx.us/mhprograms/PsychotropicMedicationUtilizationParametersFosterChildren.pdf>

Zima, B., Bussing, R., Crecelius, G., Kaufman, A., Belin, T. (1999). Psychotropic Medication Use Among Children in Foster Care: Relationship to Severe Psychiatric Disorders. *American Journal of Public Health*. 98 (11) 1732-1735.

ATTACHMENT

Working Together HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

Initial Mental Health Assessment

The initial mental health assessment must be conducted for children age 3 and older. It is recommended that this be completed within 30 days of placement. Although not explicitly required in NYS OCFS regulations, EPSDT [federal Early Periodic Screening, Diagnosis and Treatment standards] requires an assessment of mental health development for all Medicaid eligible children,¹⁴ and regulations specify that psychiatric and psychological services must be made available appropriate to the needs of children in foster care.¹⁵

The assessment includes (1) a mental health assessment conducted by a qualified mental health professional; (2) development of a mental health needs list; (3) list of child's strengths; and (4) development of a mental health treatment plan.

Health Care Coordination Activities

Before the mental health assessment takes place, you can help further the process by gathering records on the child's past mental health issues, diagnoses, and treatment, if any. After the assessment is completed, you will be involved in supporting the child's mental health treatment plan, including working with the child's caregivers, birth parents, and service providers.

Practitioners providing the assessment may include:

Physicians experienced in providing mental health services:

- Developmental/behavioral pediatricians for children under age 5.
- Child and adolescent psychiatrists or general psychiatrists with experience in the care of children and adolescents.

Licensed clinical psychologists with training and/or experience with emotional problems of children and adolescents.

Nurse practitioners with certification in child and adolescent psychiatry.

Certified psychiatric clinical nurse specialists.

Certified social workers (CSWs) or Masters of Social Work (MSWs) with training and/or experience with the emotional problems of children and adolescents.

Components of Mental Health Assessment

The purpose of the mental health assessment is to obtain a complete picture of the child who has just been placed in foster care and to identify any emotional and behavioral needs, issues, or problems or risk thereof arising from the child's situation. Removal from the home, a history of

¹³ 18 NYCRR 441.22(c)(2)(vii).

¹⁴ EPSDT 5123.2A.

¹⁵ 18 NYCRR 441.15.

abuse or neglect, separation from parents and siblings, changing schools, and changing foster homes are examples of stressors.

The practitioner derives this picture by obtaining the child's history, interviewing the child, caregivers, and birth parents and completing the following assessment components. It may take more than one interview to obtain the needed information and arrive at a diagnosis. Children are often traumatized by being removed from their homes and need time to adjust to their new situation.

1. Mental health/psychiatric history – obtained by interviewing the child, family, and caregivers, covering the following information:
 - Identifying information
 - Past psychiatric history
 - Past and current psychiatric medications
 - Identification of individual strengths/assets
 - Identification of individual deficits/liabilities
 - Developmental history
 - School history
 - Family history
 - Social and behavioral history
 - Medical history (including results of initial medical assessment)
 - Drug/alcohol history
 - Trauma and abuse history
2. Mental status examination – accomplished by interviewing the child and examining the child's appearance, behavior, feeling (affect and mood), perception, thinking, and orientation to time, place, and person.
3. Assess the circumstances of placement, family life events, and traumatic events, and observe for signs and symptoms:
 - Risks for suicide, self-mutilating behaviors, and/or violence
 - Substance exposure, misuse, abuse, and addiction
 - Maltreatment, including physical, sexual, emotional abuse and neglect
 - Risk of placement disruption
 - Risky sexual behavior
 - Risk of antisocial behavior
4. If clinically indicated, completion of diagnostic screening and assessment tools (behavior, mood, etc.) (*see section 7, Resources, for a list of assessment tools*).
5. If clinically indicated, psychological testing
6. Development of a mental health needs list or diagnosis (*see Chapter 2, Preventive and Ongoing Health Care, for information on the DSM-IV-TR Manual*).
7. Mental health treatment plan for the child's identified needs, consisting of treatment goals; treatment objectives; and treatment methods/interventions/services (types, frequency, specific providers).

Guidance for Caregivers

You have an important role in helping foster parents or childcare staff understand the mental health needs of the child placed in their care. If mental health information is available at the time of placement, discuss it with the caregivers so that they can be more aware of the child's needs. As the child becomes more comfortable in the placement setting, he or she may begin to exhibit certain different behaviors. This is a critical time to support caregivers and provide practical guidance and training to address these changes. Caregivers should be aware of this possibility, make note of the child's behavior, and pass the information on to the person conducting the mental health assessment. It is important to realize that the child may be reacting to feelings of separation, loss, or rejection, and his or her behavior may be more a reflection of the situation than an indicator of a genuine mental illness.

Some of the behaviors that caregivers should be alert to are:

- Angry outbursts.
- Excessive sadness and crying.
- Withdrawal.
- Lying or stealing.
- Defiance.
- Unusual eating habits, such as hoarding food or loss of appetite.
- Sleep disturbances.
- Sexual acting out, such as seductive behaviors toward caregivers.
- Change in behavior at school, including truancy.

Please note that if the child appears to be in crisis, immediate referral to a mental health provider should be made. If a foster parent identifies a child in crisis, he/she should contact the caseworker immediately.

Informed Consent for Non-Routine Health Care

Even if consent for routine evaluation and treatment has been obtained, medical providers will generally look for a higher level of consent – known as “informed consent” – for non-routine or elective medical or mental health care not generally provided as part of primary health care. Local districts that have obtained consents from a parent or guardian should evaluate the scope of such consent to determine whether it addresses both routine and non-routine medical care and treatment. For procedures or interventions that are not emergency in nature but call for informed consent, the health care provider should always contact the caseworker or the health care coordination staff at the agency. It is then the agency’s responsibility to facilitate the consent process.

Informed consent is required for:

Any hospitalization.

Dispensing of any psychiatric medication (*see Chapter 5, Medication Administration and Management*).

Any procedure that requires anesthesia.

Any surgery.

Any invasive diagnostic procedure or treatment.

“Informed consent” implies that the person giving consent has had the opportunity to ask questions, understands the risks, benefits, and alternatives of the treatment, and has been informed of the following types of information:

Diagnosis and symptoms being treated.

How the procedure/therapy fits with the treatment plan.

Nature of the procedure/treatment.

Benefits, risks, and side effects.

Projected course and duration of therapy.

Alternative approaches to treatment.

Assurance of monitoring for complications and side effects.

How to contact the clinical provider of the proposed procedure/treatment.

Location where the procedure/treatment will be performed.

Necessity, type, and risks of anesthesia, if any.

Proposed length of hospitalization, if any.

It is best to give this type of information to the person (birth parent or guardian, adolescent) orally and to be available to answer questions. If requested, follow up the discussion with information in writing.

If the birth parent or guardian objects to signing the consent, take the following steps:

- Set up a meeting with the practitioner to educate the parent.
- Obtain a second opinion, if requested.
- Pursue any reasonable treatment options that the parent may suggest.



George E. Pataki
Governor

NEW YORK STATE
OFFICE OF CHILDREN & FAMILY SERVICES
52 WASHINGTON STREET
RENSELAER, NY 12144

John A. Johnson
Commissioner

Informational Letter

Transmittal:	04-OCFS-INF-05
To:	Local District Commissioners Executive Directors of Voluntary Agencies
Issuing Division/Office:	Strategic Planning and Policy Development
Date:	June 18, 2004
Subject:	Smoking in Foster Homes
Suggested Distribution:	Directors of Services Foster Boarding Home-Finding Staff
Contact Person(s):	See Page 3
Attachments:	none
Attachment Available On – Line:	N/A

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		Part 443		NYS Foster Parent Manual	

I. Purpose

The purpose of this Informational Letter is to recommend that local social services districts and voluntary agencies with foster boarding home programs review their current policy and practices concerning foster parents and foster children and the smoking of tobacco, if such a review has not been undertaken in the last few years. This review is recommended to support the good health of foster children residing in foster homes and to take necessary steps to avoid the dangers caused by a child smoking tobacco or being exposed to second-hand smoke.

II. Background

In Chapter 5, “Daily Life” of the NYS Foster Parent Manual (dated September 2002), there is a short section entitled “Smoking.” The following is stated therein:

“Foster parents have the right to forbid or allow smoking in their own home, but given the known health risks, they should discourage foster children from starting or continuing smoking. Foster parents should not purchase tobacco products for any foster child, and it is illegal in New York State for children under 18 to purchase cigarettes.”

“Foster parents who smoke should do so in an area where foster children are not subjected to second-hand smoke. Smoking should never be allowed in the foster child’s sleeping area.”

Since then, the New York State Health Department has issued an on-line publication entitled, “Second-hand Smoke – It Takes Your Breath Away.” For your information, the link to the publication is

<http://www.health.state.ny.us/nysdoh/smoking/second/second.htm>.

The publication indicates that:

“Each year, an estimated 3000 American non-smokers die from lung cancer caused by second-hand smoke.”

A paragraph pertaining to children states:

“While second-hand smoke is dangerous for nonsmoking adults, it is even more dangerous for babies and children whose lungs are still developing. Infants and young children of parents who smoke are more likely to have lower respiratory tract infections, such as pneumonia and bronchitis. They are more likely to suffer from middle ear infections, sore throats and colds. And, second-hand smoke can cause youngsters with asthma or allergies to have longer and more severe attacks.”

III. Program Implications

There is extensive information that points to the danger associated with smoking and second-hand smoke, particularly concerning infants, young children and children with asthma and other allergies. As such, it is suggested that local districts and voluntary agencies with foster boarding home programs review their policies and practices pertaining to smoking, if such a review has not been undertaken in the last few years.

Case planners and foster parents should actively discourage foster children from smoking or continuing to smoke. They must not assist the foster child in purchasing or obtaining cigarettes. It is illegal for a child under 18 to purchase cigarettes. In a relationship between a foster parent or a case planner with an older foster child, there are numerous matters to attend to in terms of supporting the youth’s optimal development, promoting a desired permanency outcome and promoting independent living skills. It is not suggested that attention to smoking prevention necessarily be a top priority for the foster parent or the case planner. However, given the known health risks associated with smoking, it would be appropriate to attempt to educate the foster child about the potential negative health impact of smoking. Additionally, foster parents are on firm ground in preventing a foster child from smoking in their home.

In suggesting that counties and agencies review their policies as they pertain to foster parents smoking, please understand that it is not recommended that you establish any steps that are likely to reduce your

cadre of foster parents to an insufficient level to meet your projected need for foster homes. An alternative to establishing absolute restrictions may be to establish a policy wherein training and education are directed at both existing and new foster parents. Such training and education could spell out the risks associated with second-hand smoke, as described earlier in this Informational Letter and in the publications referenced earlier. In addition to outlining the risks associated with second-hand smoke, the following suggestions should be made to foster parents:

- attempt to limit smoking in their homes to the extent practicable
- in particular, avoid smoking where a foster child sleeps, eats and/or spends a lot of time
- avoid smoking in vehicles when transporting foster children
- be extra diligent in avoiding exposing young, allergenic and asthmatic children to second-hand smoke.

Given the known health risks, local districts and voluntary agencies should avoid placing very young, allergenic and asthmatic foster children in homes where one or more of the residents smoke. Where such a placement needs to occur because it is in the child's best interests or due to a lack of alternative foster homes, or happens inadvertently (i.e., it is learned after the placement that the child is allergenic or asthmatic) the local district or voluntary agency should especially educate the foster parents about the potential dangers to the child.

IV. Contact Information

Any questions concerning this Informational Letter should be directed to:

BRO – Linda Brown (716) 847-3145
User ID: Linda.Brown@dfa.state.ny.us
RRO – Linda Kurtz (585) 238-8201
User ID: Linda.Kurtz@dfa.state.ny.us
SRO – Jack Klump (315) 423-1200
User ID: Jack.Klump@dfa.state.ny.us
ARO – Bill McLaughlin (518) 486-7078
User ID: William.McLaughlin@dfa.state.ny.us
YRO – Pat Sheehy (914) 377-2080
User ID: Patricia.Sheehy@dfa.state.ny.us
NYCRO -- Fred Levitan (212) 383-1788
User ID: Fred.Levitan@dfa.state.ny.us

Nancy W. Martinez s/s

Issued By:

Name: Nancy W. Martinez

Title: Director

Division/Office: Strategic Planning and Policy Development



George E. Pataki
Governor

NEW YORK STATE
OFFICE OF CHILDREN & FAMILY SERVICES
52 WASHINGTON STREET
RENSSELAER, NY 12144

John A. Johnson
Commissioner

Local Commissioners Memorandum

Transmittal:	04-OCFS-LCM-04
To:	Local District Commissioners
Issuing Division/Office:	Strategic Planning and Policy Development
Date:	June 29, 2004
Subject:	Referrals of Young Children in Indicated CPS Cases to Early Intervention Services
Contact Person(s):	BRO – Linda Brown (716) 847-3145 User ID: Linda.Brown@dfa.state.ny.us RRO – Linda Kurtz (585) 238-8201 User ID: Linda.Kurtz@dfa.state.ny.us SRO – Jack Klump (315) 423-1200 User ID: Jack.Klump@dfa.state.ny.us ARO – Bill McLaughlin (518) 486-7078 User ID: William.McLaughlin@dfa.state.ny.us YRO – Pat Sheehy (914) 377-2080 User ID: Patricia.Sheehy@dfa.state.ny.us NYCRO -- Fred Levitan (212) 383-1788 User ID: Fred.Levitan@dfa.state.ny.us
Attachments:	See links http://www.einy.org/policy.html http://www.einy.org/directory.html
Attachment Available On – Line:	yes

I. Purpose

The purpose of this Local Commissioners Memorandum (LCM) is to establish standards and procedures for referring a child under the age of three to early intervention services when the child is the subject of an indicated report of child abuse or maltreatment.

II. Background

Recent revisions to the federal Child Abuse Prevention and Treatment Act require states to establish standards and procedures for referral of young children to early intervention services. Article 25, Title II-A, of the Public Health Law establishes the Early Intervention Program in New York State and makes the New York State Department of Health the lead agency for the program. The Early Intervention Program is a voluntary program that identifies infants and toddlers with disabling conditions; evaluates their needs for a range of early intervention services; and develops individualized family service plans to address such needs. The Early Intervention Program offers a variety of therapeutic support services to eligible infants and toddlers with disabilities, and their families. Each of the 57 counties and New York City offer Early Intervention services.

On December 11, 2003 the Office of Children and Family Services issued 03-OCFS-LCM-25, *Protocol on Children in Foster Care Who Participate in the Early Intervention Program*, which provides additional information about the state's Early Intervention Program, as well as how to access services for foster children. This LCM links readers to <http://www.einy.org/policy.html>, the section of the website for the New York Association of Counties that includes policies for the Early Intervention Program. A directory of the Department of Health's regional office contacts and of county Departments of Health can be found at this link, <http://www.einy.org/directory.html>.

A growing body of evidence suggests that children involved in tumultuous or neglectful family situations may experience developmental delays. The impacts on young children often manifested themselves in later attachment disorders; behavioral problems; and social, emotional, motor and cognitive delays. The Early Intervention Program offers screening and services as necessary and appropriate.

III. Program Implications

Section 424(13) of the Social Services Law requires that each child protective service coordinate, provide, arrange, and monitor rehabilitative services for children and families. Accordingly, local social services districts must inform parents of children under the age of three who are subjects in an indicated report of child abuse or maltreatment of the Early Intervention Program, and refer them to the county's Early Intervention Program. A directory of lead agencies in each county may be found at the website cited above, under "Early Intervention County Connections." Direct contacts with this resource in the county will assist parents in accessing needed services.

Nancy W. Martinez s/s

Issued By:

Name: Nancy W. Martinez

Title: Director

Division/Office: Strategic Planning and Policy Development

TO: Local District Commissioners, Medicaid Directors, Services Directors

FROM: Mark Kissinger, Deputy Commissioner
NYS Department of Health, Office of Long Term Care

SUBJECT: Bridges to Health Waivers (B2H) for Children in Foster Care

EFFECTIVE DATE: January 01, 2008

CONTACT PERSONS: Department of Health: Priscilla Smith (518)486-6562
Office of Children and Family Services:
Mimi Weber 518-408-4064

The purpose of this GIS is to inform Local Social Service Districts (LDSS) that the New York State Department of Health (DOH) and the Office of Children and Family Services (OCFS) are authorized by the federal Centers for Medicaid and Medicare Services to implement a new Medicaid program, "Bridges to Health" (B2H) for children in foster care up to 21 years of age, beginning January 1, 2008.

B2H will provide community based services to children who are in the care and custody of a LDSS or OCFS and who have significant mental health care needs, developmental disabilities or medical fragility and who require an institutional level of care.

Administered as three separate targeted 1915(c) Medicaid waivers, the program will be phased in over a three year period, with a total 3,305 participant slots distributed between the three waivers by 2010: 2,688 serious emotional disturbance (B2H/SED); 541 developmentally disabled (B2H/DD); 76 slots medically fragile (B2H/MedF).

The services listed below will be available to participants in each waiver. Detailed descriptions can be found in the B2H Program Manual that is available on the OCFS website at <http://www.ocfs.state.ny.us/main/b2h>.

- Health Care Integration
- Skill building
- Family care giver supports and services
- Day habilitation
- Prevocational services
- Supported employment
- Planned respite
- Special needs community advocacy and support
- Crisis avoidance, management and training
- Immediate crisis response services
- Intensive in-home supports crisis respite
- Accessibility modifications
- Adaptive and assistive equipment

Initially, children must be in foster care and categorically eligible for Medicaid to be considered for enrollment in the B2H waivers. B2H participants who are discharged from foster care may remain in the B2H waiver if they meet the waiver and Medicaid eligibility criteria. A B2H participant who has been discharged from foster care will have her/his Medicaid eligibility determined based on a household of one, and her/his own income and resources will be compared to the Medically Needy level. If a child's income and/or resources exceed the Medically Needy level, s/he may spenddown. Either ADC-related budgeting or SSI-related budgeting may be used, whichever is most beneficial to the child. However, if SSI-related budgeting is used, a disability review must be completed. Medicaid and waiver eligibility must be renewed annually.

The LDSS will approve children for a B2H waiver based on their qualifying diagnosis. Each B2H waiver will be identified by separate restriction/exception (R/E) codes: • SED - R/E code 72; • DD - R/E code 73; • MedF - R/E code 74. Districts must enter the appropriate R/E code for each B2H participant as Medicaid claim payments will be made only for those with appropriately assigned codes. Training for specific claim procedures will be scheduled upon provider request.

The three year phase-in plan is designed to permit steady development of the needed administrative and service infrastructure for the waiver program, including the Health Care Integration Agencies (HCIA) and Waiver Service Provider (WSP) networks. The HCIA's are voluntary child care agencies responsible for the operational and administrative functions of the B2H waivers. The WSP networks will operate throughout the State to ensure the delivery of comparable B2H services—regardless of the location of a child's residence. Details regarding the phase-in plan, and other information regarding the program, are posted on the OCFS website at the above mentioned address.

The existing OCFS regions form the basis for the B2H regional designations. The B2H and OCFS regional designations are identical, with one exception: OCFS Region V is divided into the Lower Hudson Valley and Long Island B2H regions. Please refer to the website above for specific information regarding the OCFS and B2H regions.

An Administrative Directive (ADM) will be forthcoming with more detailed instructions regarding implementation and administration of the B2H program. OCFS will notify LDSS staff of upcoming training on administering the B2H program through the Statewide Training Automated Registration System (STARS). Topics will include B2H eligibility determination, data system entry and program monitoring. In addition, detailed information regarding the B2H program, including the phase-in plan, B2H eligibility determination rules and billing instructions, can be found in the B2H Program Manual posted on the OCFS website at the above mentioned address.

WGIUPD

GENERAL INFORMATION SYSTEM
DIVISION: Office of Medicaid Management

10/27/05

PAGE 1

GIS 05 MA/041

TO: All Local District Commissioners, Medicaid Directors, Service Directors

FROM: Betty Rice, Director
Division of Consumer and Local District Relations

SUBJECT: Categorical Eligibility for Children in Foster Care

EFFECTIVE DATE: Immediately

CONTACT PERSON: Medicaid - Local District Liaison
Upstate (518)474-8887 NYC (212)417-4500

The purpose of this GIS is to inform local departments of social services (LDSS) of Medicaid categorical eligibility for both Title IV-E and Non Title IV-E children in foster care. In the past, children in foster care who met the eligibility criteria under Title IV-E of the Social Security Act were deemed eligible for Medicaid, while those who did not meet the Title IV-E eligibility criteria, and those awaiting Title IV-E determination, had their Medicaid eligibility determined separately using a specific budgeting methodology for non Title IV-E children in foster care.

The Department submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to provide Medicaid categorical eligibility for children who are in foster care. CMS has approved the State Plan Amendment. This change in policy is effective immediately, retroactive to January 1, 2005. Children in foster care identified as eligible for Medicaid with a spenddown, or who were either denied Medicaid or on Child Health Plus B due to excess income during the retroactive period, are now categorically eligible for Medicaid, if they are citizens or meet satisfactory immigration status. Changes to these cases should be made as they are identified by either Services staff or Medicaid staff or at next recertification, whichever comes first.

Therefore, all children who are in the care and custody of the local district commissioner, and who are citizens or have satisfactory immigration status, are eligible for Medicaid. In addition, children adjudicated as juvenile delinquents pursuant to Article 3 of the Family Court Act and placed into the custody of the Office of Children and Family Services, pursuant to Section 353.3 of the Family Court Act, and who are citizens or have satisfactory immigration status, are eligible for Medicaid. Districts are no longer required to do an eligibility determination for non Title IV-E children in foster care.

Upstate Title IV-E cases will remain Case Type 13 and Upstate non Title IV-E cases will remain Case Type 20. The Upstate categorical code for children in foster care will remain 07 "Removed by Court Order".

New York City procedures for authorizing Medicaid on SERMA for children in foster care remain the same. There are no changes to categorical codes for children in foster care in New York City.

As is current policy, an infant born to a woman eligible for and receiving Medicaid on the date of a child's birth, including a pregnant woman in foster care, is eligible for Medicaid until the end of the month of the infant's first birthday.

An Administrative Directive will be forthcoming. If you have any questions, please contact your Local District Liaison.