Chapter Eight

Maintaining Health Records

Maintaining the health records of children in foster care is critical to providing and monitoring health care on an ongoing basis. When health records are maintained properly, they yield significant information on key health factors such as medical, mental health, and developmental conditions, signs of abuse or neglect, medications, immunizations, and overall health status. With current, up-to-date health records, the agency can evaluate and monitor the quality of care provided to the child; address health problems as they become known; enable caseworkers to make placement decisions that are in the best interests of the child; and develop a service plan that supports optimum health.

When children are placed in care, the first tasks necessary to create a health record are to (1) obtain consent to release past health records; (2) obtain the records; and (3) establish a health file for current and future health activities. This chapter discusses the policies and activities related to past and current records, setting up the health file, keeping the records up to date, using the information in the records effectively, and monitoring health information.

Sections in this chapter include:

1. Obtaining the child's health history
2. The health file
3. The medical home health file
4. Health information in CONNECTIONS
5. NYC ACS health passport
6. Documenting and monitoring health information
7. Resources

Note: The term "health record" is used in this manual to indicate all of the information related to the child's health, including the five assessments (medical, dental, mental health, developmental, and substance abuse). In practice, the term "medical record" is often used in the same way.

1 Obtaining the Child's Health History

At the time of placement (within 24 hours), or before placement if possible, the caseworker must seek consent from the child's birth parent/guardian to release the child's health history.[1] If the birth parent or guardian is unwilling to give consent or is unavailable, the local social services commissioner may authorize release of the child's prior health records.[2]

Health Care Coordination Activities

Upon receiving consent to release health records, health care coordination activities include:[3]

- Diligent efforts to obtain records of any previous medical, mental health, or dental treatment. This may include records maintained by the child's school (e.g., immunization records). Be aware that the Medicaid Unit at the local district can access records of claims paid on individual children through the Electronic Medicaid System of New York State (eMedNY). This will help identify past providers.

- Sending written requests with the attached consent for the child's treatment history and records to known health care providers (including hospitals) who have treated the child.

- For any preschool child, making diligent efforts to obtain the child's birth record from the hospital where the child was born or from another hospital in possession of the record.

Family Health History

If possible, interview the parents or guardians regarding the child's heath history. They could have a wealth of observations and knowledge that may not appear in the child's past medical records. The birth parents' health history should also be obtained, to the extent available. Many health conditions have a hereditary or genetic component. Disorders ranging from diabetes and high blood pressure to alcohol dependence and depression may run in families. It is important to obtain this information and provide it to the child's medical providers. This becomes particularly crucial if the child is later adopted, as the birth parents' health history must be provided upon request to the adopted former foster child and the adoptive parents.[4] *(See Chapter 6, Medical Consents; also Appendix A for a sample Health History Interview with Family form to assist in collecting this information.)*

[1] 18 NYCRR 441.22(e); 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.
[2] 18 NYCRR 441.22(e).
[3] Ibid.
[4] 18 NYCRR 357.3.

2 The Health File

Agency Records

For each child in foster care the authorized agency caring for the child must maintain a continuing individual medical history in the case record.[5] If the authorized agency is the LDSS (i.e., the child is in direct foster care), then the LDSS maintains the health record. If the child is in the care of a voluntary agency, that agency maintains the record. The contents of the health record are listed below. All relevant health information, past and ongoing, should be placed in the health file, which becomes the centralized health information resource for the agency.

If foster care services are provided by a voluntary agency, health information in the local social services district need not be so extensive. However, since the local district has ultimate responsibility for the child's welfare, they must maintain a health file adequate enough to properly monitor the child's care. In addition, the voluntary agency staff must send copies of additions to the health file to the local district whenever a *significant* change occurs in a child's health status or treatment but at least no later than the next six-month Service Plan Review.[6] Such changes might include hospitalization, emergency treatment, diagnostic testing, or necessity for extended follow-up care.

Health Care Coordination Activities

Facilitate communication between the voluntary agency and the LDSS so that the district has the right amount of information to understand the child's health concerns and properly oversee safety and well-being. Monitor the entry of data into the CONNECTIONS Health Services Module.

The level of information in the health file will vary according to the model of health care provision (i.e., how and where the child obtains health care). If the child is in the care of an agency that provides health care and serves as the child's medical home, the records will be extensive and detailed. In this situation, the health file may serve the dual role of agency health file and provider health file so long as the information is accessible to casework staff *(see section 3, The Medical Home Health File)*. If the agency does not provide health care, the agency health file will be separate from the file maintained by the child's primary health care provider, described below in "Provider Records."

[5] 18 NYCRR 441.22(k); 18 NYCRR 428.3(4)(ii).
[6] 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

Each agency will be responsible for deciding the format and details of the content of the health file. The health file should at least contain:[7]

- Names and addresses of the child's primary and specialist provider(s).
- Original consent forms authorizing medical treatment for the child and the release of medical records to the agency.
- Family health history, including chemical dependency, mental illness, and hereditary conditions or diseases.
- Alcohol, drugs, or medications taken by the child's mother during pregnancy.
- Immunizations received by the child while in care and prior to placement in care (type and dates).
- Medications prescribed for the child while in care and prior to placement in care, and Medication Administration Records.
- Child's allergies (environmental, food, medicine).
- Significant acute, chronic, or recurring medical problems; illnesses; injuries; and surgical operations. Date and place of hospitalization, including psychiatric.
- HIV risk assessment documentation and any HIV-related information.
- Results of laboratory tests, including tests for HIV.
- Durable medical equipment/adaptive devices currently used or required by the child (e.g., wheelchair, feeding pump, mechanical breathing supports, eyeglasses, hearing aids).
- Copies of exam reports from primary providers and specialists while child is in care, including results of diagnostic tests and evaluations in the five assessment domains.
- Updated plan of care that addresses all five assessment domains, including follow-up or continuing treatment provided to, or still needed by, the child.
- Summaries of health care planning meetings.

In addition, required forms are listed in section 7, Resources.

[7] 90 ADM-21 Foster Care: Medical Services for Children in Foster Care; 18 NYCRR 357.3.

Provider Records

The primary health care provider serving as the child's medical home will keep detailed records in accordance with accepted professional standards and practices. The records should contain pertinent information about the child in care, such as: name, health history, diagnosis, procedures, observation and progress notes, report of treatment and clinical findings, dates of service, and reports on referrals to other providers. The records should be available to the child caring agency or its authorized representatives for inspection, audit, reproduction, excerpts, and/or transcriptions, consistent with consent standards. Specialists will also keep records documenting their assessments, diagnoses, and recommendations for treatment.

Although community providers keep their own health records on the child, they should also record the results of any assessment in a brief and understandable format for use by the agency. This includes the date of the visit, name of the provider, problems identified, plan for further evaluation or treatment, and date of follow-up appointments. Copies of the results should go to the caseworker to be placed in the health file and to the caregiver and birth parent or guardian, if appropriate. Findings and recommendations for follow-up services that result from the visit should be incorporated into the child's case plan and reviewed at each Service Plan Review.

Health Care Coordination Activities

Consider developing a "Health Care Provider Summary" sheet for the person accompanying the child to a medical appointment *(see Appendix A for sample summary sheets)*. On the summary sheet, the health care provider lists his/her identifying information, the reason for the visit, the findings, and recommended treatment and follow-up, including return date. After the visit, the foster parent or child care staff accompanying the child should give the sheet to the caseworker or agency health staff. If this information is provided immediately in a concise manner, it will not be necessary to send the provider a request for the record of the visit.

3 The Medical Home Health File

In some situations, the child may receive his or her medical care directly from the voluntary agency. If this is the case, the agency is in fact the child's medical home. The health file will be more comprehensive, similar to the provider record described above. The health file should be maintained by qualified health staff and organized in such a way that the information is easily accessible and useable. It is important that documentation be timely, comprehensive, and accurate. Since the health file is the legal record for all health services provided to children in foster care, it must be legible and available for continuity of care, monitoring, and oversight. Encourage staff who enter information to use ink, write legibly, document at the time of service, and date all entries.

Note: The information contained in a foster child's health file is confidential *(see Chapter 7, Confidentiality of Health Information).*

Although there is no prescribed method of organization, the medical home health file may be stored in a loose-leaf three-ring binder with tabbed dividers including sections such as:

- Face Sheet*
- Consents
- Medical documentation from hospital/clinic visits
- HIV Risk Assessment
- Medications
- Medical Assessment/Immunizations
- Dental Assessment
- Mental Health Assessment/Psychiatric Medications
- Developmental Assessment
- Substance Abuse Assessment
- Laboratory Reports
- Past Health Records
- Health Education
- Health Care Coordination Activities (includes required notices and other communications)

*The Face Sheet, containing critical information at a glance, can be very useful to staff reviewing a child's health file. Include the child's name, current placement, name of primary provider, any active problems, allergies and other chronic health problems, blood type, durable medical equipment, recent hospitalizations (with dates), insurance information, and emergency contact number.

Congregate care: The health file should include:

- Face sheet
- Nurse triage form
- Nursing progress notes
- Medication Administration Form
- Medical documentation from hospital/clinic visits

- Physician referral, if necessary
- Child's available record (immunizations, screening results)
- Consultation forms

To organize the health file, consider the functions it serves of collecting, recording, and conveying information. Be sure to file records in chronological order within each section.

4 Health Information in CONNECTIONS

The Health Services Module in CONNECTIONS allows the child's case manager, case planner, agency nurse, or health care coordinator easy access to the most critical health information for the child. It 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 described in the previous two sections. Because it is not necessary to enter all of the child's medical appointments or services into the system, the external health file will be the more complete record. The child's medical providers will have the most comprehensive record of all.

Entering and updating the following health-related information in the Health Services Module is required for all children in foster care and all children in OCFS custody placed in an authorized agency. Required fields should be completed as soon as the documentation is received from the provider.

Required Fields[8]

1. Designate health responsibility

2. 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 CONNECTIONS Job Aid http://www.ocfs.state.nyenet/connect/jobaides/jobaides.asp. 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.

[8] 08-OCFS-ADM-01.

- 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.

3. Clinical Appointments tab

   To support the accuracy of critical health information, records from health care 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.

4. 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.

5. Bio Family Health 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.

6. 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 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.

7. 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.

5 Health Passport

Foster parents must receive a summary of health information, such as a health passport or its equivalent, for each child.[9] A health passport is an abbreviated health record that accompanies the child from placement to discharge *(see section 7, Resources)*. Foster parents should take the passport to all health appointments and ask the provider to fill in the information. They should also take it to any Emergency Room visits. When the child is discharged from foster care, remember to give the health passport to the discharge resource (birth parent, guardian, adoptive parent, or child if appropriate).

Information to be collected for the health passport should include:

- Child's health status before placement.
- Documentation of medical, dental, and mental health services provided while in care.
- Names and addresses of past and current medical, dental, and mental health care providers, such as physicians, pharmacies, or opticians.
- Parents' names and their medical histories.
- Child's current medications and serious medical conditions such as allergies.
- Durable medical equipment/devices required, such as glasses, hearing aid, braces, wheelchair.
- Child's health history, including date of birth, hospital of birth, birth weight and condition, childhood diseases, chronic health problems, hospitalizations, immunizations, educational history, developmental history, functional history, and immediate family health history.

Information should be entered onto the health passport as soon as it is available. Review the health passport at least once every six months to assure that appropriate entries have been made. *To be useful, the health passport must be kept up to date.*

Caseworkers, caregivers, and health providers should be trained in and familiar with the use of the health passport, emphasizing its importance to the well-being of the child.

[9] 18 NYCRR 443.2(e).

6 Documenting and Monitoring Health Information

To monitor health services and staff activities regarding health of children in foster care, agencies should have procedures specifically related to health records and information. Procedures should reflect the following goals:

- Document all health services provided.
- Maintain health records in a fashion that encourages their use.
- Protect the confidentiality of health records.
- Track caseworkers' activities in meeting the health needs of children on their caseload.
- Review health records and health care plans regularly and incorporate them into the Family Assessment and Service Plan (FASP) for the ongoing service needs of the child.
- Collaborate between and among service providers to integrate their contributions with the child's health plan.
- Support health care coordination activities to abstract, summarize, and review health care plans; recommend health-related policies and procedures; consult with caseworkers on an individual case; and monitor the health status and quality of health care being provided to children in care.
- Facilitate data collection and record-keeping procedures so that health histories are accessible and available, current health status and health plans can be easily reviewed, and overall system-wide health data can be examined.

7 Resources

Health Passport

The New York City Administration for Children's Services (ACS) provides its foster parents with a medical passport for each child in care. The passport documents the child's name, date of birth, Social Security number, name and address of parent/guardian, doctors' names, addresses, and telephone numbers, type of insurance, CIN number, name of agency, date of placement, foster parent's name, etc. Medical information includes prenatal history, family history, immunizations, and screening tests.

On the inside front cover of the passport is a message from ACS to foster parents:

> The goal of the medical passport is to capture pertinent health information about your child that would assist health care providers to understand the health history and status of your child for appropriate intervention. It is meant to enhance communication among those responsible for his/her care (including caregivers, medical providers, and agencies) and promote continuity and coordination of health care. This is a lifetime health record that belongs to your foster child summarizing critical health information.
>
> - Please bring this passport with you every time your foster child visits a doctor or any medical provider, including mental health providers. Ask them to record the visit and their findings here.
> - Your child will need this record for the future.
> - Make sure it accompanies the child if he/she moves to a new foster boarding home (FBH).
> - As a foster parent, you do not have the right to consent for treatment. Consent should be sought from the agency.
> - Information on this passport is confidential and should not be shared with anyone other than providers responsible for the health care of your children, the foster care agency staff, and ACS staff.
> - Keep this passport in a safe place.

Agency Forms and Notices

The health record should also include the following required information and notices:

Form DSS-711, Child's Medical Record, or copies of a comparable medical record form. This form is no longer in wide use, 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 assessments given the child.

Medical Report on Mother and Infant. A request for all prenatal and birth information available for each preschool child placed in foster care must be submitted to the appropriate hospital or physician. A consent release must be attached. Diligent effort must be made to obtain such information, which should be retained in the case file.

Progress Notes. Progress notes related to health may be entered into CONNECTIONS. Use the Health Narrative for confidential information, as described in section 4 above. Notes may also be maintained in the health file. Activities to 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.

Consent forms. Signed consent forms for release of prior health history, for routine medical or psychological assessment and treatment, and for emergency medical or surgical care (when the parent or guardian cannot be located at the time the care is necessary) must be kept in the child's health file *(see Chapter 6, Medical Consents)*.

Family planning notices to foster parents. A copy must be kept in the child's health 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.[10]

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 adolescents in foster care within his or her jurisdiction of family planning services, a copy of the information provided to the youth must be kept in the health file *(see Appendix A for a sample notice.)* The availability of these services may be discussed orally with the youth but must also be offered in writing. If your district has this policy, it must be implemented across the entire county.

Notice of C/THP services. Within 60 days of entry into foster care, if the child is Medicaid eligible, the local district 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

[10] 18 NYCRR 463.2.

copy of the notice must be kept in the child's health history file. This written notice must also be provided to the caregivers of the child at least annually.[11]

CONNECTIONS Enter required data on each child in foster care into the Health Services Module, as outlined in section 4 above.[12]

[11] 18 NYCRR 507.1.
[12] 18 NYCRR 466.3