	GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES CHILD WELFARE POLICY MANUAL			
	Chapter:	(10) Foster Care	**Effective Date:**	August 2014
	Policy Title:	Medical, Dental, and Developmental Needs		
	Policy Number:	10.11	**Previous Policy #:**	1011.2, 1011.3, 1011.4, 1011.6

CODES/REFERENCES

O.C.G.A. § 49-5-12(c)
Title IV-E of the Social Security Act Section 475(5)(D)

REQUIREMENTS

The Division of Family and Children Services (DFCS) shall arrange appropriate and timely medical and dental care for each child in foster care, including, but not limited to:

1. Working with the caregiver and the Amerigroup Care Coordination Team (CCT) to establish a medical and dental home for each child that will provide diagnostic, preventive, and emergency care through childhood.
2. Ensuring each child has a physical examination **at least** once a year in addition to all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) consistent with the recommendations for preventive pediatric health care posted at: http://brightfutures.aap.org/clinical_practice.html
3. Ensuring routine dental care is initiated by three years of age, and each child has a dental cleaning and examination at least every six months, as recommended by the American Academy of Pediatrics.

DFCS shall ensure every child who enters foster care receives a Health Check within 10 calendar days from the date of removal.

As part of the Health Check, DFCS shall refer all children in foster care from birth to five years of age to Children 1st for developmental screening, assessment and services within 10 calendar days of the child entering foster care (See Children 1st and Babies Can't Wait Services [BCW]). **NOTE:** Youth birth to three years old may have already been referred as part of a Child Protective Services (CPS) Investigation. In such instances, a new referral is unnecessary.

DFCS shall ensure a child who has signs or symptoms consistent with HIV infection, or whose health history places the child at risk, is evaluated by a physician to determine if testing is necessary and appropriate.

DFCS shall monitor children's health and medical care on an ongoing basis directly with medical/dental providers and the CCT to ensure each child receives appropriate care.

a. For children with ongoing medical/dental conditions requiring regular care, DFCS staff shall follow up each month to ensure treatment is being provided and to obtain regular updates on the child's condition.
b. For children without health conditions requiring them to be under the care of a

medical/dental provider or receive frequent care, DFCS staff shall follow up within two business days of a child's visit to the provider (e.g., office visit, annual physical, etc.)

c. All medical documentation received during this process must be uploaded into the Statewide Automated Child Welfare Information System (Georgia SHINES) and kept current.

DFCS shall invite parents to attend all of their children's medical and dental appointments, unless prohibited by court order or child safety concerns.

DFCS shall identify children determined to have "high risk" medical conditions and collaborate with Regional Well-Being Specialists (RWBS) and CCT to ensure each child is closely monitored on a regular basis, to include follow up with the caregiver and treating physician(s).

DFCS shall require all medication prescribed to children in foster care to be administered only as directed by the prescribing physician, to be administered only by authorized adults, and to be transported in the original containers. The signed consent of the DFCS County Director or designee is required for any new prescribed medication.

DFCS shall ensure a child's health records are reviewed and updated, and a copy of the record is supplied to the foster parent or foster care provider with whom the child is placed, at the time of each placement of the child in foster care.

DFCS shall ensure a child's health records are supplied to the child at no cost at the time the child leaves foster care if the child is leaving foster care by reason of having attained the age of majority under State law.

PROCEDURES

At the time of removal, the Social Services Case Manager (SSCM) will engage the parents, birth family, child, and collateral contacts and do the following:

1. Obtain information about the child's health/medical and dental status:
    a. Birth information (name & address of the hospital, circumstances surrounding the birth, complications, etc.);
    b. Current medications and/or any medical equipment (name, dosage, how and when to administer, reason it is being taken, and the prescribing physician);
    c. Medical history, including known medical problems, allergies (i.e. foods, drugs, etc.), seizures, serious accidents or injuries, surgeries, or hospitalizations;
    d. Immunization history (types of immunizations and date obtained);
    e. Developmental history;
    f. Location of medical and dental records (including name and addresses of all medical and dental providers).
2. Determine if a child has "high risk" medical needs and collaborate with the RWBS and CCT.
3. Complete the Emergency Intake (Medical Form) for all children entering foster care. Share the form with the relative placement, foster parent or other placement provider, CCFA provider, CCT, the local public health department and/or medical provider.
4. Collaborate with the CCT to ensure each child has a Health Check within 10 days of the child's placement that includes developmental screening (as prescribed by EPSDT guidelines or BCW/Children 1st) and a dental examination.

a. If the developmental screen indicates the presence of any developmental delay, submit a referral to Children 1st district coordinator for a full developmental assessment within five business days.
b. If the dental screen identifies any concerns or need for dental treatment, ensure the CCT coordinates follow up treatment with an approved dental provider within five business days.
c. If vision screening yields any concerns, ensure the CCT obtains an ophthalmic assessment and treatment for prescribed corrective devices within five business days.

5. Document results of all screenings and assessments on the child's Person Detail page and Health Information page in Georgia SHINES.
6. Obtain health information on the child's family and record it in the Family Medical Section of Form 419, Background Information on State Agency Child.

On an ongoing basis, for each child in care, the SSCM will:

1. Ensure each child receives preventive health maintenance including:
   a. Regular well checks;
   b. Immunizations;
   c. Dental cleaning and exam at least every six months.
2. Communicate directly with medical and dental providers each month to ensure treatment is being provided and to obtain regular updates on the child's condition. This applies to youth under the care of a physician for treatment of a health condition. For other youth, communicate directly with the medical/dental provider within two business days of a visit (e.g. office visit)
3. Collaborate with the CCT to follow through with recommendations made by medical and dental providers within five business days for non-emergency issues. Emergency issues require immediate follow up.
4. Share the child's medical information with the placement provider and document that it was shared.
5. Obtain written information on the child's diagnosis, treatment, medications, etc. and enter it in the child's Health Information page under the Person Tab in Georgia SHINES.
6. Consult with the child's parents to determine if they are in agreement with any medication prescribed to their child. Document the parental response.
7. Provide timely notification of any injuries, accidents, major illnesses, or death involving a child in out of home care.
   a. Immediately notify the Supervisor and County Director.
   b. Immediately notify the child's parents (mother and father) and caregivers (if they are not aware).
   c. Notify child's siblings (if appropriate).
   d. If the child is seriously injured or dies, prepare a case summary to assist in preparation of the Child Fatality/Serious Injury Report.
8. If a child dies due to medical complications, obtain copies of all medical documentation related to the circumstances surrounding the death (e.g., EMT report, ER records, etc.).
9. Make every effort to contact the parent and obtain parental permission prior to any surgery. When a parent cannot be located, or refuses to provide permission despite documented medical opinion of the need for surgery, obtain authorization from the court.

To ensure a child's developmental needs are adequately addressed, the SSCM will:

1. Communicate monthly with the Babies Can't Wait (BCW) Service Coordinator, therapist, and others to ensure a child eligible for BCW receives the appropriate services to reach his/her developmental potential.
2. Share the results of a child's initial Health Check with the BCW service coordinator as well as the most recent court order.
3. Work collaboratively with the child's birth parents and placement provider to meet the child's developmental needs, including self-esteem, cultural identity, positive guidance/discipline, social relationships and age-appropriate responsibilities.
4. Collaborate with the CCT and RWBS to ensure a referral is made to a diagnostic/treatment provider for further evaluation of any developmental delays, disabilities, etc., within five business days of the developmental assessment if the need for further evaluation is indicated.

To collaborate with the Regional Well-Being Specialists (RWBS), the Social Services Supervisor (SSS) or SSCM will:

1. Staff all cases involving children identified as having behavioral health, serious medical or developmental needs with the RWBS. The staffing should include the child's current caregiver when applicable.
2. Immediately notify the RWBS once a child has been approved for a determination of Maximum Watchful Oversight (MWO).
3. Provide the contact information of the Core Providers of each child placed in a MWO level Child Caring Institution (CCI).
4. Notify the RWBS of all treatment team meetings held for children placed in a CCI or receiving treatment in a Psychiatric Residential Treatment Facility (PRTF) and provide copies of treatment team notes or treatment plans. The RWBS will participate in treatment team meetings to the extent possible.
5. Invite the RWBS to all Permanency Roundtables held for children identified as "high risk" and add the RWBS as a secondary worker on the case.

PRACTICE GUIDANCE

Health Check

The initial Health Check consists of a comprehensive unclothed physical examination, dental examination, mental health assessment, and developmental assessment. The physical examination must be completed by a primary care physician. Children will receive well-child checks based upon EPSDT standards. A dental examination is also included in the Health Check and must be completed by a licensed dentist. The mental health assessment (Trauma Assessment, Psychological Evaluation, Psychiatric Evaluation, Psychosocial Evaluation, Substance Abuse Evaluation, etc.) must be completed by a licensed behavioral health provider. Development assessments are performed on children from nine to 36 months of age by the primary care physician according to the EPSDT periodicity schedule. Babies Can't Wait (BCW) also conducts Developmental Assessment Screening on children from birth to age three. Copies of the BCW assessments should be maintained in the case record. Many medically fragile children are under the care of medical specialists. Special services, equipment needs, medical supplies, etc., may be recommended by the physician as medically necessary due to a child's medical condition or diagnosis.

Medical/Dental Coverage at Initial Entry into care
Children in foster care should be seen by Georgia Medicaid providers. The Medicaid program provides funds to the state for the costs of providing medical and some dental services to Medicaid eligible recipients. DFCS must utilize these funds for services to children entering DFCS custody in order to conserve state funds for those children not eligible for Medicaid (See Applying for Medical Services at Initial Entry and Exit).

Georgia Families 360˚
On March 03, 2014, DFCS transitioned from a standard fee-for-service Medicaid program to a statewide Medicaid Care Management Organization (CMO) through Amerigroup Georgia Managed Care Company. The transition impacted children in DFCS custody and children receiving AA as they became members of a new program called *Georgia Families 360˚* which is separate from *Georgia Families*, the general Medicaid program administered by the Georgia Department of Community Health (DCH). *Georgia Families 360˚* is designed to provide coordinated care across multiple services and focus on the physical, dental, and behavioral needs of member children. The program is designed to ensure each member has a medical and dental home, access to preventive care screenings, and timely assessments. It also seeks to ensure medical providers adhere to clinical practice guidelines and evidence-based medicine.

Amerigroup Care Coordination Teams (CCT) and Care Managers
Each *Georgia Families 360˚* member is assigned to a regional Care Coordination Team with a specified Care Manager. The CCT members are Masters level staff, the majority of whom hold a professional license to practice in their respective field. The CCT completes a Health Risk Screening (HRS) on youth in care to identify medical and/or behavioral needs. They ensure each child is assigned to a Primary Care Physician (PCP) and Primary Care Dentist so every child has a medical and dental home. The CCT is responsible for coordinating the health components of the Comprehensive Child and Family Assessment (CCFA), including the initial physical assessment, dental screening, and trauma assessment. Care Managers are the primary partner of the SSCM for identifying and making referrals for needed services. Care Managers ensure each youth has an individualized care plan that addresses both physical and behavioral health needs. They work with community agencies to ensure appropriate services are provided.

Any services not authorized by the CCT will not be paid for out of Medicaid. Therefore, it is imperative that all medical/dental, behavioral health and developmental care be coordinated with the CCT to avoid any uncovered expenses. See the COSTAR manual for an explanation of the “Unusual Medical/Dental” funding source for children who are not Medicaid eligible or who receive a service not covered by Medicaid. For youth covered by other forms of Medicaid (i.e., Fee-for-Service) or health coverage, the SSCM should utilize known providers in the community and contact the assigned Regional Well-Being Specialist for further support or assistance.

Amerigroup Notification Form (E-Form)
DFCS communicates with Amerigroup, Rev Max, and DCH utilizing an electronic notification form (E-Form). It is the primary means for communicating information about a member enrolled in Georgia Families 360˚. The E-Form must be completed and sent to Amerigroup, Rev Max, and DCH within 24 hours of a youth entering foster care. It should be completed thoroughly to include demographic information, medical information, placement information, the identified

CCFA provider and other referrals (e.g., Babies Can't Wait). The E-Form is also used to report updates such as placement changes, a youth exiting care, etc. If there is information not available at the time of the initial referral to Amerigroup, submit an E-Form (update) as soon as the information is obtained. Accurate and timely communication with Amerigroup and Rev Max is vital to the Medicaid eligibility determination and the assignment of a CCT and service providers. Important decisions regarding the assignment of primary care providers and referrals are made based upon the information submitted on the E-Form.

Trauma Assessments

Trauma can affect many aspects of a child's life and may lead to secondary problems that negatively impact safety, permanency, and well-being (e.g., peer relationships, problems in school, health related problems).The Administration for Children and Families (ACF), a federal agency in the Department of Health and Human Services, has informed state child welfare agencies of the need to implement trauma-focused screening, assessment and treatment for children in foster care. The emotional well-being of our children is of the utmost importance and is directly correlated to their ongoing safety and success of permanency plans. Children five years of age and over are referred for a comprehensive trauma assessment after the completion of the medical evaluation and after the results of the hearing and vision screening have been received. The trauma assessment identifies all forms of traumatic events experienced directly or witnessed by a child to determine the best type of treatment for that specific child. In addition to the trauma history, trauma-specific evidence-based clinical tools assist in identifying the types and severity of symptoms the child is experiencing. Examples of evidence-based, trauma-specific clinical tools include:

1. UCLA PTSD Index for DSM-IV
2. Trauma Symptom Checklist for Children (TSCC)
3. Trauma Symptom Checklist for Young Children (TSCYC)
4. Child Sexual Behavior Inventory

The trauma assessment must provide recommendations and actions to be taken by DFCS to coordinate services and meet a child's needs. Behavioral health providers who conduct a trauma assessment will provide a report which includes:

1. Trauma history, which informs the agency of information concerning any trauma the child may have experienced or been exposed to, as well as how they have coped with the trauma in the past and present
2. A standardized trauma screening tool
3. Summary and recommendations for treatment (if needed)

The inclusion of a trauma assessment as part of the CCFA does not mean there will not be situations in which other specialized assessments (e.g., psychological evaluations, psycho-sexual evaluations, psychiatric evaluations, neuropsychological evaluations, substance abuse assessments, psycho-educational evaluations, etc.) will be warranted. The decision to refer a child for additional assessments must be made on a case-by-case basis in coordination with the CCT after an overall assessment of the child's needs has been completed. If it is determined that a psychological evaluation is needed, prior authorization must be obtained from the CCT in order for Medicaid to pay for it.

Children 1st
Children 1st was created by the state of Georgia in an effort to improve the health conditions of children from birth through five years of age. Children 1st is the "Single Point of Entry" to a statewide collaborative system of public health, prevention-based programs and services, school, and community-based organizations to identify children at risk for poor health or developmental outcomes. Children 1st identifies and screens children and links them to programs such as:

1. Babies Can't Wait (BCW)
2. Children's Medical Services (CMS)
3. Universal Newborn Hearing Screening and Intervention (UNHSI)
4. Georgia Newborn Screening Program
5. 1st Care
6. Women, Infants, and Children Program (WIC)

Referrals are submitted to the local Children 1st District Coordinator. A list of Children1st District Coordinators is available at http://dph.georgia.gov/children-first.

Physical Impairment
A physical impairment is defined as a dysfunction of the musculoskeletal and/or neurological body systems that affects the ability of an individual to move or coordinate movement. This includes one or more of the following body systems: neurological; musculoskeletal; sensory organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic, skin; and endocrine. A physical impairment on its own does not make a child eligible for BCW services. However, if there is a significant developmental delay due to the physical impairment, then the child may be eligible.

Developmental Needs
A developmental assessment is completed as part of the Health Check for children under four years of age who enter foster care. The assessment determines whether there are factors that may result in a developmental delay for a child or place a child at risk of delay. Any child in care [***under the age of three***] who has a suspected developmental delay, physical impairment or diagnosed disability must be referred to BCW via Children 1st for assessment. DFCS cannot provide consent for BCW services. Consequently, a surrogate parent or other appropriate adult may be needed to act on behalf of the child and provide necessary consents. (See Children 1st and Babies Can't Wait Services)

Developmental Delays
A developmental delay is a chronological delay in the appearance of normal developmental milestones achieved during infancy and early childhood, adjusted for prematurity in one or more of the following areas: cognitive, physical (including vision and hearing), communication, social/emotional and adaptive. Such delays may be caused by organic, psychological, or environmental factors. **Example:** If most children crawl by eight months of age and walk by the middle of the second year, then a child five or six months behind schedule in reaching these milestones may be classified as developmentally delayed regarding mobility.

Significant Developmental Delay
A delay is considered significant when it interferes with the child's ability to interact within his/her natural environment (relative to expected developmental sequences of cognitive, communication, adaptive, physical, and social-emotional development) to such a degree that ongoing development is compromised. In addition, secondary delays relative to the initial delay are likely to occur (e.g., significant delays in expressive communication may lead to compromised social skills with peers). Criteria for a significant delay include identification of deficits in skills which are instrumental in accomplishing later developing skills or functional tasks that would be expected of peers who are developing typically.

If the use of standardized diagnostic measures is deemed appropriate, a score of two (2) standard deviations below the mean (average) in one of the five developmental domains, **or** at least one and a half (1.5) standard deviations below the mean in two or more of the five developmental domains constitutes a significant delay. The determination of whether or not a child has a significant developmental delay must be made by a qualified clinician.

Sexual Health Needs
Sexual and reproductive needs of youth in foster care are addressed through the initial and follow-up health screening. Youth in foster care may receive health education and risk prevention services through Georgia's Personal Responsibility Education Program (GA-PREP), which provides high risk youth (ages10-19) free access to evidence-based teen pregnancy prevention programs and supplemental adult preparation subjects. Youth in care access PREP services through the agency's partnership with the Department of Public Health (DPH) Adolescent Health and Youth Development (AHYD) Program. GA-PREP is federally funded by the Administration for Children and Families' (ACF) Family and Youth Service Bureau (FYSB).

HIV Antibody Testing
If a child has signs or symptoms that may be consistent with HIV infection or whose health history places the child at-risk, the child must be evaluated by a physician to determine if testing is necessary and appropriate. Minors may receive HIV prevention counseling and testing services with or without parental consent. Whenever possible, parents should be involved in the counseling and testing. Local public health facilities with knowledgeable specialists in HIV may be contacted for consultation and information. The SSCM must recognize and understand the risk factors for HIV which may need to be brought to the attention of health care providers such as:

1. The child was sexually abused by a person(s) from a high risk group;
2. The child has been engaged in sexual activity with high risk group partners;
3. The child has a history of intravenous(IV) drug usage;
4. The child was born to a parent from a high risk group;
5. The child is a hemophiliac.

Almost all children who have become infected with HIV are infected prenatally by their mother. The maternal HIV antibody is present in children up to 18 months of age, resulting in a "false positive." ***A "true negative" finding can only be made 18-24 months following birth***, at which time seroconversion may have occurred. In other words, the child's body would have begun to produce specific, detectable antibodies in response to the presence of the virus. Primary health care providers should be able to care for HIV-exposed children and for most asymptomatic HIV-infected children with normal immune systems. As children become

symptomatic, they will need the care of a pediatric infectious disease specialist.

Since a child with a depressed immune system is at greater risk of suffering severe complications from routine childhood illnesses such as chicken pox and measles, the physician needs to be consulted when determining the setting that is best for the child and the degree to which that setting should be restricted. Usually, the benefits of an unrestricted setting outweigh the risks of the child acquiring harmful infections. More often than not, the infected child can be served in a foster home and attend school and/or day care. The results of HIV testing are confidential and may be released only to the following individuals:

1. The child's parents/guardian/custodian (unless child is in the permanent custody of DFCS, then a decision is made on a case by case basis);
2. Placement provider; and
3. Any health care provider who has a legitimate need to know such information.

Regional Well-Being Specialists (RWBS)

The Regional Well-Being Specialist acts as an educator, advocate, mentor, and role model in multiple areas of permanency and well-being, including:

1. Training
2. Engaging partners
3. Data tracking and analysis
4. Roundtable or staffing of high end cases
5. CCI/CPA treatment team semi-annual reviews
6. Waiver requests
7. Transitional & discharge planning
8. Psychotropic medication monitoring

Staffings with the RWBS are used for information sharing, resolution of case management issues, decision making regarding the selection of service providers, transitional/discharge planning, and assessing diagnosis/treatment plans.

High Risk: Medical

"High risk" youth are those with significant medical conditions or illnesses. Medical issues that contribute to children being considered as "high risk" include:

Down Syndrome
Cerebral Palsy
Multiple Sclerosis
Spina Bifida
Fragile X Syndrome
Von Willebrand Disease
Sickle Cell
Osteogenesis Imperfecta
Rickets
Cancer
Diabetes
Hypoxia
Neurological disorders
Epilepsy
TBI

Respiratory Illness
Respiratory Failure
Asthma
Gastrointestinal Illness
Short Gut Syndrome
Failure to thrive
Feeding disorders
Birth defect to organs
Organ failure
Organ transplants
Mechanically/Technology dependent…G-tube dependent
Trach and/or Vent dependent
Portacaths
Physically disabled children

FORMS AND TOOLS

Babies Can't Wait: http://dph.georgia.gov/Babies-Cant-Wait
Children 1st: http://dph.georgia.gov/children-first
Department of Behavioral Health and Developmental Disabilities (DBHDD):
http://dbhdd.georgia.gov/
http://www.ada.org/sections/about/pdfs/doc_policies.pdf