	GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES CHILD WELFARE POLICY MANUAL			
	Chapter:	(10) Foster Care	**Effective Date:**	April 2020
	Policy Title:	Medical, Dental, and Developmental Needs		
	Policy Number:	10.11	**Previous Policy #:**	N/A

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:

1. Arrange appropriate and timely medical and dental care for each child in foster care, including, but not limited to:
   a. 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.
   b. 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
   c. Ensuring each child under 12 months of age undergoes dental screening, with subsequent dental cleaning and examination at least every six months thereafter (as recommended by the American Academy of Pediatrics).
   d. Ensuring each child 12 months of age and over has a dental examination, with subsequent dental cleaning and examination at least every six months thereafter (as recommended by the American Academy of Pediatrics).
   e. Ensuring each child has an annual eye examination or vision screening.
2. Ensure each child receives a Health Check within 10 calendar days of entering foster care.
3. As part of the Health Check, refer all children in foster care under five years of age to Children 1st for developmental screening, assessment and services within 10 calendar days of entering foster care (see policy 19.28 Case Management: Children 1st and Babies Can't Wait).
   NOTE: Children three years of age and younger may have already been referred as part of a Child Protective Services (CPS) Investigation. In such instances, a new referral is unnecessary, however, follow up is needed with Children 1st to obtain the results of the screening.
4. Share the results of the developmental screening with the birth parents and foster caregivers.
5. 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.
6. Monitor the child's health and medical care on an ongoing basis directly with

medical/dental providers and the Amerigroup 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 ten business days of a child's visit to the provider (e.g., office visit, annual physical, etc.)
7. Be available and responsive to any hospital or other entity providing hospitalization or treatment to manage the medical/dental needs of children in foster care.
8. Invite parent(s) to attend all of their child(ren)'s medical and dental appointments, unless prohibited by court order or child safety concerns.
9. Collaborate with the Wellness, Programming, Assessment, and Consultation (WPAC) Unit to secure appropriate services for children with high risk medical needs.
10. Require all medication prescribed to children in foster care to be administered only as directed by the prescribing physician.
    a. All medication shall be administered only by authorized adults and transported in the original containers.
    b. The signed consent of the DFCS County Director is required for any new prescribed medication.
11. *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.*
12. *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 due to having attained the age of majority under State law.*
13. Make every effort to contact the parent(s) and obtain parental permission prior to any surgery when a child is in the temporary custody of DFCS. When a parent cannot be located or refuses to provide permission despite documented medical opinion of the need for surgery, authorization shall be obtained from the court or DFCS County Director or a designee with the same or higher level of authority within DFCS (i.e. County Director, Region Director, District Director).
14. Obtain authorization from the DFCS County Director prior to any surgery when a child is in the permanent custody of DFCS. When the County Director is unavailable, authorization shall be obtained from a designee with the same or higher level of authority within DFCS (i.e. County Director, Region Director, District Director).
15. Require all consent forms for surgical procedures to be signed by the County Director or a designee with the same or higher level of authority within DFCS (i.e. County Director, Region Director, District Director).
16. Maintain current medical documentation in Georgia SHINES.

PROCEDURES

When a child enters foster care, the Social Services Case Manager (SSCM) will:

1. Engage parents, birth family, children, and collateral contacts to obtain information about a child's health/medical and dental status including:
   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. Share known information regarding a child's health and medical status with the foster caregiver, CCFA provider, Amerigroup CCT, and the local public health department or other medical provider (see policy 10.1 Foster Care: Placement of a Child).
3. Collaborate with the WPAC Unit and the Amerigroup CCT when a child has high risk medical needs to ensure the child receives appropriate services.
   a. Staff the case with the WPAC Unit. Include the child's current caregiver when applicable.
   b. Provide the contact information of the Core Providers if a child is placed in a MWO level Child Caring Institution (CCI).
   c. Notify the WPAC Unit of any Transitional Roundtable, Permanency Staffing or Cold Case Staffing.
   d. Invite the regional WPAC specialist to Permanency Roundtables.
4. Collaborate with the Amerigroup CCT to ensure each child has a Health Check within 10 days of entering foster care that includes developmental screening (as prescribed by EPSDT guidelines or BCW/Children 1st) and dental screening for children under 12 months of age or a dental examination for children 12 months of age and over.
   a. If the developmental screening indicates the presence of any developmental delay, submit a referral to Children 1st district coordinator for a full developmental assessment within five business days or sooner if indicated.
   b. If dental screening of a child under 12 months of age identifies any concerns or need for dental treatment, ensure the Amerigroup CCT coordinates follow up treatment with an approved dental provider within five business days of receipt of results, or sooner based on the treatment needed.
   c. If vision screening yields any concerns, ensure the Amerigroup CCT obtains an ophthalmic assessment and treatment for prescribed corrective devices within five business days or sooner based on treatment needed.
5. Document the results of all screenings and assessments on the child's Person Detail page and Health Information page in Georgia SHINES within 72 hours of receipt.
6. Review the results of developmental screening with birth parents during the next purposeful contact that occurs after receiving the information.
7. Review the results of developmental screening with placement providers during the next purposeful contact that occurs after receiving the information.
8. Obtain health information on the child's family and record it in the Family Medical Section of the Birth Family Background Information for 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;
d. Annual eye examinations/vision screening.

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 ten business days of a visit (e.g. office visit).
3. Collaborate with the Amerigroup 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. When a child is hospitalized, work continually and closely with hospitals during admission, treatment, and discharge to ensure full engagement throughout the child's stay (see policy 19.29 Case Management: Coordination of Care with Hospitals).
5. Share the child's medical information with the placement provider and document that it was shared.
6. 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.
7. Consult with a child's parents to determine if they agree with any medication prescribed to their child. Document the parental response.
8. 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 the child's siblings (if appropriate).
   d. Prepare a case summary to assist in completion or complete the Child Death/Near Fatality/Serious Injury Report, when applicable (see policy 6.7 Special Investigations: Reporting of Child Death, Near Fatality, Serious Injury).
   e. Make a report to the Child Protective Services Intake Communication Center (CICC) immediately, but no later than 24 hours, if there is known or suspected child abuse and/or neglect (see policy 3.24 Intake: Mandated Reporters).
9. 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.).
10. Make every effort to consult the parent(s) of a child in the temporary custody of DFCS prior to any non-surgical procedure. When a parent cannot be located or is not in agreement with a non-surgical procedure being performed, consult with the Social Services Supervisor for authorization.
11. Make every effort to contact the parent(s) of a child in the temporary custody of DFCS and obtain parental permission prior to any surgery.
    a. 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.
    b. If the court is unwilling to intervene, obtain authorization from the DFCS County Director or a designee with the same or higher level of authority within DFCS (i.e. County Director, Region Director, District Director).
    c. After consent is obtained granted the appropriate authority, ask the DFCS County Director to sign the medical provider's consent form.

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 and the most recent court order with the BCW service coordinator.
3. Work collaboratively with the child's 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 Amerigroup CCT and WPAC Unit 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).

PRACTICE GUIDANCE

Health Check

The initial Health Check consists of a comprehensive unclothed physical examination, a dental examination and a developmental assessment (as applicable). All children should undergo an initial physical examination performed by a primary care physician and receive well-child checks based upon EPSDT standards. Children 12 months of age and older should also undergo an initial dental examination performed by a licensed dentist. Children under 12 months of age should undergo dental screening instead of a dental examination. Dental screening may be performed by a pediatrician or primary care physician. However, once these children reach 12 months of age, they should undergo an initial dental examination performed by a licensed dentist. 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 (see policy 19.28 Case Management: Children 1st and Babies Can't Wait). Copies of 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 to conserve state funds for those children not eligible for Medicaid (see policy 9.2 Eligibility: Applying for Medical Services at Initial Entry and Exit).

Georgia Families 360˚

On March 03, 2014, the Georgia Department of Community Health (DCH) 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˚. The new program is separate from Georgia

Families, the general Medicaid program administered by 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 Amerigroup CCT members are Masters level staff, the majority of whom hold a professional license to practice in their respective field. The Amerigroup 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 Amerigroup CCT is responsible for coordinating the health components of the Comprehensive Child and Family Assessment (CCFA), including the initial physical, dental 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 Amerigroup 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 Amerigroup CCT to avoid any uncovered expenses. See Field Fiscal Services COSTAR Manual Section 3100 Family Foster Care 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 WPAC Unit for further support or assistance.

Amerigroup Notification Form (E-Form)

DFCS communicates with Amerigroup 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 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 is vital to the Medicaid eligibility determination and the assignment of an Amerigroup 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.

Children 1st

Children 1st was created by the state of Georgia 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 policy 19.28 Case Management: Children 1st and Babies Can't Wait.

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 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. Often, 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.

Wellness, Programming, Assessment, and Consultation (WPAC) Unit

The WPAC Unit provides practice support, consultation and quality monitoring of physical and moderate behavioral health needs of children and youth in foster care. Specific functions of intensive support and monitoring include:

1. Training and consultation;
2. Performance monitoring;
3. Review, assessment and programmatic recommendations;
4. Data tracking and trend analysis;
5. Coordination and partnering during case staffing and case planning; and
6. Strategic coordination with community partners.

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

Consent for Surgical and Non-Surgical Procedures

In general, DFCS can give permission or consent for medical care deemed appropriate or necessary by competent medical authorities. Moreover, some court orders contain language that explicitly gives DFCS the authority to provide consent for ordinary medical care. This usually involves non-surgical procedures or routine surgical procedures that are considered low-risk. However, when consent for extraordinary medical care (e.g. major surgery, potentially life-threatening procedures) is needed, it should be sought from a parent or the court. Even when DFCS has the legal authority to make medical decisions regarding children in DFCS custody, such authority must be exercised in a manner consistent with family-centered practice. Families should <u>always</u> be involved in the decisions affecting their lives. This applies to parents and the children. Decisions should always be based upon what is in the best interest

of the child.

FORMS AND TOOLS

Babies Can't Wait
Birth Family Background Information for Child
Children 1st
Department of Behavioral Health and Developmental Disabilities (DBHDD)
Medical Homes Ensure Better Health Care for Children