CHAPTER 5
Initial Health Evaluation[1]

Certain initial medical activities are required and/or recommended when a child is placed in foster care. This is the time to gather as much medical history as possible on the child and family and to begin a comprehensive evaluation of the child's medical, dental, mental health, developmental, and substance abuse needs.

Whether a child in placement continues medications previously prescribed or continues a relationship with a specialized practitioner (or needs a referral to one) are crucial decisions. Health care coordination plays a vital role in seeing that (a) all necessary health-related services are provided in the specified time frames; (b) the caregiver supports the medical plan for the child; (c) information is shared appropriately among professionals involved in the child's care; and (d) the child's parents are involved in the planning and treatment.

Sections in this chapter include:

☑ **The New York State Office of Children and Family Services (OCFS) recommends that a full comprehensive health evaluation as described in this chapter be completed for each child in foster care. Footnote citations to a law or regulation indicate that an activity or component is required and provide the legal or regulatory source for the requirement. Use of the term "should" means that an activity is recommended by OCFS but is not required by law or regulation.**

[1] 18 NYCRR 441.22(f) ("periodic individualized medical examinations").

Health Services Time Frames

The chart below outlines the time frames for initial health activities, to be completed within 60 days of placement. The column labeled Mandated indicates whether an activity is required. The "**M**" in the time frame column indicates that the activity is required within a mandated time frame. Initial health activities include:

- Immediate screening of the child's medical condition, including assessment for child abuse/neglect.
- Immediate efforts to obtain medical consent.
- Immediate attention to HIV risk assessment.
- Comprehensive health evaluation: A series of five assessments provides a complete picture of the child's health needs and is the basis for developing a comprehensive problem list and plan of care.
- Follow-up health evaluation that incorporates information from the five initial assessments.
- Ongoing efforts to obtain child's medical records and document medical activities.

INITIAL HEALTH SERVICES TIME FRAMES

Time Frame		Activity	Mandated	Who Performs
24 Hours		Health screening/screening for abuse/neglect		Health practitioner (preferred) or caseworker health staff
5 Days	**M**	Initial HIV risk assessment for child under the age of 13[2]	**X**	Medical provider or designated staff
10 Days	**M**	Request consent for release of medical records and treatment	**X**	Caseworker or health staff
30 Days	**M**	Initial medical assessment	**X**	Health practitioner
30 Days	**M**	Initial dental assessment	**X**	Health practitioner
30 Days		Initial mental health assessment	**X**	Mental health practitioner
30 Days	**M**	HIV risk assessment for child with possible capacity to consent	**X**	Caseworker or designated staff
45 Days		Initial developmental assessment	**X**	Health practitioner
45 Days		Initial substance abuse assessment		Health practitioner
60 Days		Follow-up health evaluation		Health practitioner

New York State Immunization Information System

Bright Futures/American Academy of Pediatrics (AAP) has a comprehensive chart that is up to date, and a requirement of EPDST and C/THP includes specific physical and oral examination expectations and lead poisoning assessments https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

1. Initial Health Evaluation

To develop a full understanding of a child's health, a comprehensive health evaluation comprising five assessments takes place within certain time periods after the child's entry into foster care. These include:

[2] 18 NYCRR 441.22(b).

- Signs of abuse or neglect (If trauma is present, seek immediate medical attention.)
- Medical assessment (within 30 days)
- Dental screening (within 30 days)
- Mental health assessment (within 30 days)
- Developmental assessment (recommended within 45 days)
- Substance abuse assessment (recommended within 45 days)

The descriptions of each assessment provide guidance on the components involved and what health providers should take into consideration when performing the evaluation. Though there are five assessment domains, there need not be five different clinicians. Some providers are well qualified to conduct more than one assessment. For example, a pediatrician will routinely assess the developmental status as well as physical health of an infant.

➔ The following staff activities are provided to support the completion and needed follow-up for the health assessments:[3]

- Scheduling the examination for the child or helping the foster parent schedule it within the required time frame.
- Offering to provide or arrange for transportation as needed.[4]
- Providing the practitioner with the child's available medical history at the time of the exam or as soon as possible thereafter.
- Making sure that the practitioner is familiar with the requirements of a comprehensive examination for children in foster care.
- Following up to make sure that the examination is completed and appropriate actions are taken, including filling prescriptions.
- Making sure that the results of the initial medical assessment and any referrals for follow-up care are filed in the health tab in CONNECTIONS or Family Assessment Service Plan (FASP) and documented electronically, as required.

Initial Medical Assessment

Each child entering foster care must receive an initial medical assessment within 30 days of placement.[5] If it is documented that the child has had such an assessment within 90 days before placement and the results are available, the examination does not need to be repeated unless medically indicated or if there are allegations of abuse or maltreatment that require medical attention. In this case, obtain a copy of the assessment to determine if appropriate treatment and follow-up have occurred for identified issues.

Practitioners providing this assessment may include:

- Physicians
- Nurse practitioners
- Physician assistants

The qualified practitioner should be experienced in providing comprehensive primary care for infants, children, and adolescents in foster care.

Institutional regulations require – and quality practice would dictate – that all providers be licensed, certified, and registered in New York State to practice their profession.[6] For the child, receiving health care in the context of a well-coordinated, high-functioning team of trauma-informed professionals can help with consistency and developing caring relationships.

[3] 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.
[4] 18 NYCRR 441.22 (j) (2).
[5] 18 NYCRR 441.22(c) (1) ("comprehensive medical examination").
[6] 18 NYCRR 442.18.

Medical Home

When feasible, children should receive all their health care, including routine preventive, acute illness, and chronic illness, from the same provider while in foster care. In this model of care, every child has an established, ongoing relationship with a primary health care provider, so that health problems can be identified, treated, and documented early to improve outcomes and reduce the likelihood of disease, disability, and hospitalization. Ideally, the child will continue with the health care provider the child had prior to entering foster care.

Health providers outside the medical home should consult with the primary care provider and share their findings (with appropriate consent) to facilitate comprehensive, coordinated care. This is particularly important when the child is referred to subspecialists for diagnostic evaluations and/or treatment and when services are ordered in other settings (e.g., occupational or speech/language therapy).[7] The medical home provides continuity of health care despite any changes in placement.

> A medical home is not a building, house, or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Children and their families who have a medical home receive the care they need from a pediatrician or physician (pediatric health care professional) whom they trust. The pediatric health care professionals and parents [or other caregivers] act as partners in a medical home to identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential. The American Academy of Pediatrics believes that all children should have a medical home where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective.
>
> Low income is often associated with a higher childhood incidence of inadequate nutrition, exposure to environmental toxins, poor-quality child care, dangerous living conditions, chronic stress, substance abuse and physical abuse. The impact of any one of these factors on the physical, emotional, and social well-being of a child can be overcome to a great degree by the provision of health services that are accessible, continuous, comprehensive, family centered, coordinated and compassionate. All these factors, again, define a medical home.
>
> *(American Academy of Pediatrics)*

Components of Medical Assessment

The initial medical assessment[8] must include (1) a medical and developmental history; (2) a physical examination by a qualified medical professional; (3) screening tests; (4) preventive services; and (5) development of a problem list and treatment plan.[9]

1. Medical history – building on the information from the 24-hour health screening, if available:

- Identify past providers and seek records.[10]
- Obtain information from parent or guardian whenever possible.
- Obtain immunization records.
- Review all available medical information.
- Obtain developmental history.
  - Birth family history of developmental problems.
  - History of psychosocial issues prior to placement.
  - Previous developmental assessments and treatments, if any.

Having this information at hand will be helpful for the primary care provider when conducting the initial medical assessment.

[7] EPDST/CTHP Provider Manual for Child Health Plus A (Medicaid) (2005) p. 19.
[8] 18 NYCRR 441.22 (c) (2).
[9] 18 NYCRR 441.22(c)(2)(i)-(viii).
[10] 18 NYCRR 441.22(c)(e).

2. Complete unclothed physical examination in accordance with current recommended medical practice, considering age, environmental background, and development of the child.

The examination must include observation for child abuse and neglect, which, if suspected, must be reported to the State Central Register of Child Abuse and Maltreatment (see Section 5, Child Abuse and Neglect Health Evaluation).

The exam must also include observation for dental problems in children under 3 years old and referral to a dentist if problems are found.[11]

3. Screening tests appropriate for age, identified risks, and identified conditions as recommended by the AAP and/or due to higher risk of children in foster care.

4. Preventive services, such as immunizations, health education, and anticipatory guidance appropriate for the child's age.

5. Development of a problem list and treatment plan.

Additional Time Frames for the Medical Assessment

An initial medical assessment must be completed within 30 days after a child returns to foster care following discharge, trial discharge, or absence without consent that lasted more than 90 days. At the discretion of the agency, the examination may be completed if there are concerns about a child's health when:

- The child returns to care *within* 90 days following discharge, trial discharge, or absence from care without consent.
- The child is transferred to the care of another agency and the receiving agency determines that a comprehensive medical examination may be necessary to help formulate the child's service plan.
- There are allegations of abuse or maltreatment.[12]
- There are concerns that the child has been involved with alcohol, drugs, or sexual activity during an absence without consent.

Initial Dental Assessment

An initial dental assessment must be conducted within 30 days of placement. If it is documented that the child has had such an assessment within 90 days before placement, and the results are available, the assessment does not need to be repeated unless medically indicated. In this case, obtain a copy of the assessment to determine if appropriate treatment and follow-up have occurred for identified issues.

The assessment includes:

- Dental history and screening.
- For children under age 3, referral for dental care when a medical provider finds problems upon examining the child's mouth.
- For children aged 3 and older, diagnostic examination by a dentist. [***Note:*** *NYC Administration for Children's Services (ACS) requires an exam by a dentist at age 2.*]

The following is recommended:

- Dental x-rays as indicated for diagnostic examination.
- Routine prophylaxis consistent with current dental practice for age:
  - Cleaning
  - Topical fluoride
  - Oral hygiene instruction to the child and caregiver

[11] 18 NYCRR 507.1 (c) (3) (vii); 17-OCFS-ADM-12, Provision of Dental Services for Children and Youth in Foster Care.
[12] 18 441.22(c) (4).
[13] 18 441.22 (f) (2) (viii).

- Sealants on permanent molars.
- Dental problem list and treatment plan.

Referral to a dentist and establishment of a dental home is recommended no later than 6 months after the first tooth erupts, or by 12 months of age, whichever comes first. This practice allows the dentist to assess risk and recommend interventions. It also provides an opportunity for the dentist to intervene in the oral hygiene habits of the primary caregivers to reduce the risk of colonization of the infant by the bacteria that cause tooth decay.

The State Newborn Hearing Screening Program

The New York State hearing screening law requires hospital administrators to implement their own newborn screening programs or in some cases to provide newborns with a referral for screening once they leave the hospital, most hospitals in the state provide an inpatient hospital screening and have mechanisms in place to follow up with newborns who need further testing. A few hospitals provide parents with a prescription to have their babies screened in the community following discharge from the hospital. Primary care providers should be aware of newborn hearing screening and follow-up programs conducted by facilities in their area. Infants who fail screening tests must be referred to audiological evaluation as soon as possible.

Initial Mental Health Assessment

The initial mental health screening must be conducted for children aged 3 and older. It is recommended that this be completed within 30 days of placement. Although not explicitly required in OCFS regulations, early periodic screening, diagnosis and treatment (EPSDT) requires an assessment of mental health development for all Medicaid eligible children,[14] and AAP recommends a psychosocial/behavioral assessment at each checkup.[15] OCFS regulations specify that psychiatric and psychological services must be made available appropriate to the needs of children in foster care.[16]

Developmental and emotional screening in the primary care office is complicated by changes in caregivers, but foster parent reports and instruments should be reasonably accurate after four to eight weeks in a new home. Validated developmental and mental health screening instruments can be useful in triaging children for further evaluation when resources are limited, although ideally every child and teenager in foster care should eventually receive a mental health and developmental or educational evaluation conducted by an appropriately certified/licensed mental health professional. For younger children in foster care, developmental and behavioral conditions are best identified in the context of a full developmental evaluation.

If the screening identifies the need for further assessment, it will include (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.

➔ 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. It is a good idea to arrange for mental health providers to share appointment information with you to better monitor attendance at appointments.

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.

[14] EPDST 5123.2A.
[15] http://practice.aap.org/content.aspx?aid=1599.
[16] 18 NYCRR 441.15.

- Licensed clinical psychologists with training and/or experience with emotional problems of children and adolescents.
- Nurse practitioners with certification in child and adolescent psychiatry.
- Licensed clinical social workers (LCSWs) or licensed master social workers (LMSWs) with training and/or experience with the emotional problems of children and adolescents.

Note: LMSWs may only provide clinical social work services under supervision.

Components of Mental Health Assessment

Most children in foster care have experienced multiple trauma, such as abuse or neglect, witnessing domestic violence, or parental absence due to mental illness or substance abuse. Factors such as removal from the home, separation from parents and siblings, changing schools, and changing foster homes can also place additional stress on the child's emotional stability.

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 determine if the child has a mental health disorder or need for treatment.

Components of Psychiatric Evaluation in the Primary Care Office Setting

Office practitioners should conduct their own psychiatric evaluation of a child or adolescent who presents with emotional, psychological, or behavioral problems. The following are some tips for conducting the psychiatric evaluation (and a checklist for caseworkers):

- Schedule sufficient time to conduct the evaluation.
- Use a framework or structure (see outlines below) to facilitate gathering and organizing relevant information.
- Take time to establish rapport and lessen anxiety or defensiveness with the child, teen and parents.
- Meet with child/teen and parents together to gather information and understand the problem(s).
- Meet with child/teen alone to explore problem areas and assess their mental status - note any differences (information provided, behavior, etc.) from when parent(s) were present.
- Obtain information from other relevant sources (e.g., school, caseworker, etc.).
- When the assessment is completed, meet with the child/teen and parents together to discuss the formulation of the problem and any recommendations for intervention, treatment and/or referral.

The following is an outline of the components that should be included in the psychiatric evaluation conducted by a primary care physician:

- Psychiatric history
- Identifying data
- Presenting problem
- Past psychiatric history
- Early development
- School performance
- Family history
- Social history
- Medical history
- Drug/alcohol history

[14] EPDST 5123.2A.
[15] http://practice.aap.org/content.aspx?aid=1599.
[16] 18 NYCRR 441.15.

- Mental status exam
- Appearance
- Behavior
- Doctor-patient relationship
- Mood and affect
- Perceptual processes
- Thought content
- Thought processes
- Orientation
- Intellectual function (estimate)
- Insight and judgment
- Impulse control and frustration tolerance
- Assessment/formulation
- Strengths/assets of child and family
- Problems/needs of child and family
- Probable psychiatric diagnoses (DSM-IV)
- Recommendations (e.g., referral, treatment, etc.)

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, including reports and assessments
- Family history
- Social and behavioral history
- Medical history (including results of initial medical assessment and prenatal exposure to alcohol or drugs)
- History of drug/alcohol use by the child
- 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.).

5. If clinically indicated, perform psychological testing.

6. Identification of mental health symptoms and/or diagnosis that must be addressed (see Chapter 6, 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 child care staff understand the mental health needs of the child placed in their care. If information regarding the trauma experienced by the child and any mental health symptoms or diagnosis are known at the time of placement, discuss these 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, the child 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 the child's 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 the mental health provider should be made. If a foster parent identifies a child in crisis, the foster parent should contact the caseworker immediately.

Initial Developmental Assessment

An initial developmental assessment must be conducted for children entering foster care. It is recommended that this be completed within 45 days of placement. Although not explicitly required in OCFS regulations, EPSDT requires a developmental assessment for all Medicaid eligible children,[17] and regulations require a developmental history.[18]

The assessment includes (1) a developmental history; (2) a clinical assessment; and (3) an individual service plan.

The purpose of the initial developmental assessment is to examine the child's growth and development in relation to the child's age and expected milestones. Adequate knowledge about a child's development supports better placement, custody, and treatment decisions. Many children in foster care have not grown up in an environment that supports the achievement of developmental milestones. Negative environmental conditions, including lack of stimulation, child abuse, or violence within the family, impact and may impair brain development, particularly in very young children.

[17] EPDST 5123.2A.1.
[18] 18 NYCRR 441.22(c) (2).

Practitioners providing this component may include:

- Professionals with formal training and experience evaluating child development appropriate to the age of the child (see above section on mental health assessment).
- The same professional performing the medical examination if appropriately qualified.

Initial Substance Use Disorder Assessment

An initial substance use disorder assessment should take place within 45 days of placement for children aged 13 and older, and younger if indicated. Although not explicitly required in OCFS regulation, the OCFS health services guidelines recommend this assessment be considered for children aged 10 and older, as either an independent activity or a component of the mental health assessment. Standards for services to Medicaid eligible adolescents require an assessment of psychosocial adjustment, including use of drugs, alcohol, and tobacco.

The purpose of the assessment is to determine whether the child is currently using drugs, alcohol, or tobacco or is at risk of using them. A thorough assessment also considers substance use in the child's family.

Note: "Substance" or "drug" includes all alcohol and chemicals, including prescribed pharmaceuticals, improperly used either by inhalation, smoking, ingestion, or injection.

Practitioners providing this component may include:

- Qualified health professionals with adolescent development and addiction training and experience.
- Certified alcohol and substance abuse counselors (CASAC) practicing in an approved work setting.[19]
- Psychologists with MSWs with adolescent development and addiction training and experience.
- LCSWs or LMSWs with adolescent development and addiction training and experience.

Based on the assessment and any identified problems, a treatment plan will be developed that includes recommendations for counseling and other services for the child and family.

2. HIV Risk Assessment

Assessment and testing of children under the age of 13 in foster care for HIV infection[20]

Each child under age 13 in foster care must be assessed for risk factors related to HIV infection. Youth, ages 13 and older, must be offered an HIV test as part of their periodic medical assessments.

Within five business days of a child under the age of 13 entering foster care, the authorized agency must complete an initial assessment of the child's risk for HIV infection based on the risk factors set forth in this subdivision.

The assessment of a child's risk for HIV infection must be made by a medical provider or by designated agency staff with basic information and training regarding HIV and AIDS, knowledge of the risk factors associated with HIV infection, the HIV-related testing available, and the confidentiality provisions regarding HIV-related information. The assessment of a child's risk for HIV infection must be appropriate for the age and developmental stage of the child and must include a review of the medical and psychosocial history available at the time to determine whether one or more of the following risk factors related to HIV infection exists.

(A) Risk factors in the medical and psychosocial history of the family related to an infant or child and associated with direct perinatal transmission of HIV infection at birth include:

[19] 14 NYCRR 853.3 (d).
[20] NYCRR 441.22(b).

- that this child had a positive drug toxicology or symptoms of drug withdrawal at birth.
- that this child had a positive test for syphilis at birth;
- that a sibling of this child 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;
- that this child has symptoms consistent with HIV infection;
- that this child was abandoned at birth and no risk history is available; or
- that the biological mother of this child has or had a positive HIV status.

(B) Risk factors related to the child and associated with the child's behavior or other means of direct transmission of HIV infection after the child's birth. The assessment of these risk factors may include discussions with the child, when appropriate for the age and developmental stage of the child, in addition to the required review of the medical and psychosocial history available at the time. These risk factors include:

- that this child has been sexually abused;
- that this child has engaged in high-risk sexual activity, such as behavior that includes, but is not necessarily limited to, unprotected anal, vaginal or oral sex;
- that this child has a history of sexually transmitted diseases, such as syphilis, chlamydia, gonorrhea, hepatitis B, or genital herpes;
- that this child is known or reported to have had multiple sex partners or known, reported to or suspected to have been sex trafficked;
- that this child is known or reported to inject illegal drugs or share needles, syringes or other equipment involved in drug use or body piercing; or
- that this child is known or reported to use non-injection illegal drugs, such as crack cocaine.

(C) Risk factors for HIV in the medical and psychosocial history of the family related to the child's biological parent, or sexual partners of the child's biological parent. These risk factors are relevant generally to an infant or young child if they occurred before the child was born and placed the child at risk of HIV infection through perinatal transmission at birth. Risk factors include the biological parent's diagnosis of HIV infection, symptoms consistent with HIV infection, or death due to HIV-related illness; and for biological parents not diagnosed with HIV, one or more of the following occurring since their last HIV test:

- condomless anal or vaginal intercourse without HIV pre-exposure prophylaxis with partners whose HIV status is unknown, who have untreated HIV, or who do not have an undetectable viral load while on treatment for HIV;
- at least one bacterial STI in the previous 12 months;
- injecting substances for purposes not prescribed, including hormones, or having sexual partners who report injecting substances for purposes not prescribed;
- transactional sex, or history or risk of sex trafficking, such as sex for money, drugs, housing, or other goods, or having sexual partners who report transactional sex;
- multiple or anonymous sexual partners, or having partners who report multiple or anonymous sexual partners;
- sexual activity at sex parties or other high-risk venues, or having partners who report sexual activity at sex parties or other high-risk venues; or
- recreational use of mood-altering substances during sex, such as but not limited to alcohol, methamphetamine, cocaine, and ecstasy.

(D) Risk factors for HIV related to the child and associated with the child's behavior or other means of direct transmission of HIV infection after the child's birth. The assessment of these risk factors may include discussions with the child, when appropriate for the age and developmental stage of the child, in addition to the required review

[19] 14 NYCRR 853.3 (d).
[20] NYCRR 441.22(b).

of the medical and psychosocial history available at the time. Risk factors for the child include one or more of the following occurring since their last HIV test:

- condomless anal or vaginal intercourse without HIV pre-exposure prophylaxis with partners whose HIV status is unknown, who have untreated HIV, or who do not have an undetectable viral load while on treatment for HIV;
- at least one bacterial STI in the previous 12 months;
- injecting substances for purposes not prescribed, including hormones, or having sexual partners who report injecting substances for purposes not prescribed;
- transactional sex, or history or risk of sex trafficking, such as sex for money, drugs, housing, or other goods, or having sexual partners who report transactional sex;
- multiple or anonymous sexual partners, or having partners who report multiple or anonymous sexual partners;
- sexual activity at sex parties or other high-risk venues, or having partners who report sexual activity at sex parties or other high-risk venues; or
- recreational use of mood-altering substances during sex, such as but not limited to alcohol, methamphetamine, cocaine, and ecstasy.

The risk factors set forth in (A) and (B) above are not applicable to a child born in New York or any other jurisdiction that conducted a newborn screen that included a HIV test.[21]

Procedures related to HIV-related testing

If a child is determined through the required assessment to have one or more risk factors for HIV infection, designated agency staff must refer the child to an appropriate medical provider prior to the child's initial comprehensive medical examination for the purpose of offering HIV testing in accordance with applicable HIV testing standards. The referral to the appropriate medical provider must include information on the risk factors identified in the risk assessment.

Additional assessments of a child under the age of 13 in foster care

Each required periodic medical examination of a child must include an assessment of all HIV risk factors and annually thereafter to coincide with the child's annual periodic medical exam.

All other HIV risk factors will be addressed by the medical providers appropriately as and if they occur before the next periodic medical exam.

If it is determined at a service plan review or periodic medical examination of the child that referral to an appropriate medical provider for the offer of HIV-related testing of the child is recommended, the authorized agency must refer the child to an appropriate medical provider within five business days of the recommendation.

Medical services and counseling

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

- refer the child for appropriate medical services; and
- provide or arrange for appropriate psychological and other support services for the child and/or the child's family and/or the child's foster family, as applicable.

Documentation of HIV-related testing of a child in foster care

Information regarding any HIV-related testing of a child in foster care and the results of such testing must be documented in the medical history of the child within the CONNECTIONS Health tab.

[21] 18 NYCRR 441.22(b)(3)(v).

Access to HIV-related information concerning the foster child

Information regarding any HIV-related testing of a child and the results of such testing must be provided only to those persons or entities authorized to have access to HIV-related information concerning the foster child in accordance with 18 NYCRR 357.3 and PHL Article 27-F, including:

- the certified or approved foster parents or prospective adoptive parents of the child;
- the child, consistent with PHL Article 27; or
- the parents or guardian of the foster child; the child's written release for such disclosure must be obtained in accordance with 18 NYCRR 360-8.1 before any information concerning the HIV-related test is provided to the child's birth parents or guardian.[22]

3. Follow-Up Health Evaluation

A follow-up health evaluation with the primary care provider should take place when all assessments are completed, approximately 60 days after the child's entry into foster care.

Activities of the follow-up health evaluation include, at a minimum:

- Continue to update immunizations for age.
- Review results of all assessments and laboratory and other screening tests.
- Review new information emerging during placement (e.g., mental health issues, substance abuse) and update the treatment plan accordingly.
- Review compliance with appointments to make sure all planned follow-up has occurred.
- Plan continuing care.
- Review compliance with treatment recommendations, including medication.

➔ Make sure that the medical home (primary care provider) has received the results of each initial assessment. The follow-up health evaluation provides an opportunity for the primary care provider to review the child's strengths and needs as identified in the initial assessments and develop an overall plan of care for the child. Communicate this plan to the child's treatment team and all specialty providers.

4. Child Abuse and Neglect Health Evaluation

A child abuse and neglect health evaluation is a medical examination conducted by a health care practitioner for the purpose of identifying, documenting, and treating any signs and/or symptoms of abuse or neglect. This evaluation may be integrated into an initial or routine physical or mental health exam. It may also be a separate activity at any time that suspicions of abuse or neglect arise. A thorough evaluation addresses both the physical and emotional aspects of the child's well-being. Medically, the child will need treatment for injuries and other physical complaints. Just as important is the identification and treatment of the functional and emotional consequences of abuse or neglect. This should include referrals to skilled mental health providers. All health care providers involved in the child's treatment plan should know when the child's needs are related to suspected abuse or neglect, and the plan must address these needs.

Health care practitioners as well as caseworkers and caregivers need to be vigilant in observing the child for signs of abuse and neglect. Identification and documentation of child abuse and neglect should be an ongoing activity that begins with the initial screening (within 24 hours of placement) and must be a part of every medical contact.

If there is reasonable cause to suspect abuse or maltreatment of a child residing in a foster home or in the home of a parent or other person legally responsible, an immediate call must be made to the Statewide Central Register of Child Abuse and Maltreatment (SCR). Keep in mind that caseworkers, child care staff, and licensed health professionals are

[22] 18 NYCRR 441.22(b)(7).

mandated reporters under state law.[23] The telephone number for reporting suspected abuse and maltreatment to the SCR for mandated reporters is 1-800-635-1522, and the number for the general public is 1-800-342-3720. If the child is residing in a congregate care program, reports must be made to the Vulnerable Persons Central Register at 1-855-373-2122.

All in-depth interviews related to abuse or neglect, especially sexual abuse, should be conducted by qualified and experienced professionals. It is not the role of the foster parents or caregivers to take on this task.

Time Frames

A child abuse and neglect observation should take place:

- Prior to or within 24 hours of placement.
- At the initial medical assessment.[24]
- At periodic health visits.[25]
- Immediately, when specific indicators of abuse or neglect are present.
- Within 24 - 48 hours of return when a child returns from trial discharge or has been absent without leave (AWOL).
- Within 24 - 48 hours before discharge.

Time Frames for a Sexual Abuse Evaluation

The timing of a sexual abuse health evaluation depends on when the suspected abuse occurred. If the sexual abuse occurred more than four days prior to the disclosure, it is more important to have the examination conducted in a child-friendly, non-threatening environment than to adhere to strict time frames for seeking the medical evaluation. The assessment and interview process should begin immediately, and medical attention sought as soon thereafter as possible and appropriate. If there are suspicions that a caregiver or someone with regular access to the child is the abuser, immediate action must be taken to protect the child regardless of when the abuse occurred. Involve child protective services as appropriate.

A medical exam should take place:

- On the same day if the sexual abuse occurred within the past 96 hours (4 days).
- On the same day if there is vaginal or rectal bleeding, pain, or signs of sexual trauma.
- If the sexual abuse took place more than 96 hours prior, seek the advice of a clinician as needed to determine the urgency of a medical examination on an individual basis. Examples of situations where an immediate exam may be indicated include: the child has vaginal discharge or there is suspicion of a sexually transmitted disease or pregnancy; the child lives in the same house as another child who has been sexually abused; or the child has specific behavioral or physical indicators of sex abuse.

The professional conducting the health evaluation should be trained and experienced in child abuse and child sexual abuse issues. Whether conducted by an individual or a child abuse team, the evaluation should be comprehensive to avoid multiple interviews and examinations, which may increase the trauma for the child. It is recommended that a sexual abuse evaluation take place within a multidisciplinary child abuse team (MDT) or child advocacy center (CAC). If no MDT/CAC is available, a qualified medical professional should conduct the evaluation.

The Child Abuse Evaluation and Treatment for Medical Providers website is a comprehensive source for child abuse information that offers tools and resources with which to diagnose and manage child and adolescent abuse victims: https://www.champprogram.com/doh-initiatives.shtml

[23] SSL Article 6 Title 6, 413-415.
[23] 18 NYCRR 441.22(c) (2).
[23] 18 NYCRR 441.22 (f) (2).

Components of Child Abuse and Neglect Health Observation

A medical evaluation for child abuse and neglect should include the following:

1. Interview with the child that is developmentally appropriate, sensitive, and completed in an unbiased and truth-seeking manner. The New York State Children's Justice Task Force Forensic Interviewing Best Practices Guidelines are recommended, although not required. With an allegation of sexual abuse, the interviewer also seeks to identify signs and symptoms of child sexual abuse, including but not limited to: nightmares, sexual knowledge inappropriate for the child's age, and sexualized behaviors inappropriate for the child's age (see Chapter 7, Special Health Care Services, for information on child sexual abusers).

2. Thorough directed physical examination: observation of verbal and nonverbal behaviors, affect, growth parameters (height, weight), skin, nails, hair, mouth, extremities, genitalia, anus.

3. Documentation, including detailed narrative, sketches, and photographs.

4. Imaging and laboratory studies as clinically indicated: If signs of physical abuse are present, a skeletal survey (x-ray) should be done to identify old and new fractures (e.g., a very young child with injuries in various stages of healing).

➔ If your county does not have access to a child advocacy center, identify and use health care practitioners who are experienced and trained in conducting a child abuse and neglect evaluation. Encourage them to reference guidance documents such as the ones noted above. To support a coordinated approach to child abuse and neglect in your LDSS or voluntary agency, establish a multidisciplinary child abuse team if one is not already present.