CHAPTER 8

Maintaining Health Records

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

As a reminder, when children are placed in care, the first tasks necessary to create a health record are to (1) obtain consent to release past health records; (2) obtain the records; and (3) establish a health file for current and future health activities.

This chapter discusses the policies and activities related to past and current records, maintaining the health module in CONNECTIONS, keeping the records up to date, using the information in the records effectively, and monitoring health information.

Sections in this chapter include:

1. *CONNECTIONS Health Module*
2. *Documenting and monitoring health information*

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

1. The CONNECTIONS Health Module

Agency Records

For each child in foster care, the authorized agency caring for the child must maintain a continuing individual medical history in the case record.[1] If the authorized agency is the LDSS (i.e., the child is in direct foster care), then the LDSS maintains the health record. If the child is in the care of a voluntary authorized agency (VA), that agency maintains the record. The contents of the health record are listed below. All relevant health information, past and ongoing, should be placed in the health module in CONNECTIONS, which becomes the centralized health information resource for the agency.

Foster parents must receive a summary of health information for each child placed in their home. When a child is placed on an emergency basis, this information must be provided within 30 days of placement. This information must include:

- the health of the child,
- the procedure to be followed in obtaining consent for emergency medical treatment,[2] and
- the child's medical history.[3]

➔ The authorized agency must also facilitate communication between the VA and the LDSS so that the LDSS has the right amount of information to understand the child's health concerns and properly oversee safety and well-being. The agency must monitor the entry of data into the CONNECTIONS Health Services Module.

The level of information in the health module in CONNECTIONS will vary according to the model of health care provision (i.e., how and where the child obtains health care). If the child is in the care of an agency that provides health care and serves as the child's medical home, the records will be extensive and detailed. In this situation, the health module in CONNECTIONS may serve the dual role of agency health file and provider health file so long as the information is accessible to casework staff.

The health module in CONNECTIONS includes:

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

[1] 18 NYCRR 428.3(b)(2) (ii) & 441.22 (k).
[2] 18 NYCRR 443.2(e)(3)(ii) & 507.5.
[3] 18 NYCRR 357.3 & 443.2(e)(3)(ii).

Provider Records

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

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

➔ The information contained in a foster child's health file is confidential (see Chapter 3, Confidentiality of Health Information).

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

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

Required Fields:[4]

1. Designate health responsibility
2. Child Health Info tab

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

Required fields on this tab are:

- Current allergies, medications, and durable medical equipment with start and end dates, as applicable.
- All overnight hospitalizations while the child is in foster care.

[4] 08-OCFS ADM-01.

- To the extent known, overnight hospitalizations prior to foster care which are related to chronic health conditions or conditions that led to the child's removal.
- After-hours agency health contact, as applicable.
- Primary care/medical home provider.

3. Clinical Appointments tab

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

The following information must be entered into this tab:

- Initial assessments in five domains (physical/medical, dental, developmental, mental health, and substance use for children 10 years of age and older) for any child who entered foster care within the 90 days prior to the date the district implements the health services module, and every child who enters foster care there after.
- Periodic well-child care (physical/medical domain).
- Periodic preventive care (dental).
- "Immunizations up to date" indicator for initial and well-child physical/medical appointments.
- Discharge exam (use the "Well Child" appointment type).
- The initial diagnosis of a chronic health condition. If diagnosed prior to entry into care, use the "Diagnosis at Intake" appointment type.
- All "Emergency Care" and "Crisis Intervention" appointments.
- Provider name and address for all appointments entered.

4. Early Intervention tab

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

The following information must be entered into this tab:

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

5. Bio Family Health tab

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

The following information must be entered into this tab:

- Hereditary conditions and allergies of the child's biological family.
- Information on the biological family's health history that could impact the child's current or future health.

- Information on the biological mother's pregnancy for this child.
- Parent's cause of death, if applicable. If the parent died as a result of HIV/AIDS, record the exact illness (e.g., pneumonia) if known, or a general term such as infectious disease, if unknown.

6. HIV Risk Assessment

All children under the age of 13 in foster care must be assessed for HIV risk,[5] and the results of that assessment must be recorded on the HIV Risk Assessment tab. This tab is used for children in foster care ***only***.

The following information must be entered into this tab:

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

7. Health Narrative

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

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

Documenting and Monitoring Health Information

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

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

[5] 18 NYCRR 441.22(b).