8.3 Health Records
Effective 12/1/94 – Updated 2002

PURPOSE

Child and family health histories and documentation of preventive, acute, and chronic health care for children in the care or custody of the Department are gathered and maintained in order to assist in the assessment of the child's health status, to provide continuity of health care, to avoid duplication of services, and to carry out the Department's duties and responsibilities toward children in its custody.

LEGAL BASE

Both federal and state statutes address the health care of and health information about a child in the care or custody of the Department.

Federal Title IV-E, Section 475(1)(C) requires that the child's case plan include, to the extent available and accessible:

- The names and addresses of the child's health providers,
- A record of the child's immunizations,
- The child's known medical problems,
- The child's medications and,
- Any other relevant health information concerning the child determined to be appropriate by the state agency.

Section 475(5)(D) of Title IV-E requires that the child's health record as described in Section 475(1)(C) be reviewed, updated, and supplied to the foster parent or foster care provider with whom the child is placed at the time of each placement or the child in foster care.

State law requires the Department to "ensure that a child ordered into its custody receives an appointment for a medical examination by a licensed physician or nurse practitioner within 10 working days after the Department's custody of the child commences" (22 MRSA Section 4063-A.1.)

In addition, Title 22 MRSA 4063-A.2. states that "if the physician or nurse practitioner who performs a physical examination pursuant to subsection 1 determines that a psychological assessment of the child is appropriate, the Department shall ensure that an appointment is obtained of such an assessment within 30 days of the physical examination."

CHILD HEALTH HISTORY

Procedure

A history of the child's health and health care is to be sought prior to any out-of-home placement made by the Department of Human Services.

The Child Protective Services caseworker who files the petition for a child protection order, who informs the parent or legal custodian of a child protection order granting custody to the Department, or who negotiates and signs the agreement for voluntary care is responsible for gathering health and health care information and providing it directly to the foster parent or other child care provider at the time of the child's placement with them, or to the caseworker responsible for placing the child. Minimally this is to include:

a. Serious medical conditions
b. Allergies
c. Medications for chronic conditions
d. Medications for acute conditions
e. Assistive technologies, i.e. adaptive equipment which assists the child to function independently
f. Names and addresses of child's current physician(s)
g. Names and address of child's dentist
h. Record of immunizations
i. Names and addresses of child's current counselor or therapist
j. Names and addresses of other current health care providers

Additional child health information, including:

a. Pre-natal, birth, and post natal history
b. List of diseases and dates
c. Dates and reasons for hospitalizations/surgery
d. Other relevant information which might affect the child's health

is to be provided to the child's caseworker by the Child Protective Services caseworker within 10 days of the child's entry into care/custody if the information is known. A plan will be developed by the Child Protective Services caseworker and Children's Services caseworker for obtaining the remaining information and implemented so that the remaining history is gathered prior to the child's examination by a new physician and no later than 60 days after the child has entered care/custody. The child's caseworker updates this health record while the child is in care/custody.

The Child Health History, Form BCFSC-008, is filed in the Health Packet of the child's case record. The source of the child health information (e.g., mother's statement, physicians record, hospital record) is to be noted with the information. Certain health history information is also recorded in the child's portable health record.

FAMILY HEALTH HISTORY

Procedure

A family health history is to be obtained for each of the child's biological parents. This is to be sought along with the child's health history if possible, and if needed for diagnosis or treatment of the child, to the degree possible it will be sought immediately. Otherwise this is to be obtained upon request of the child's physician, within 30 days of a final protection order or the initial administrative case review, whichever occurs first.

Form BSSSC-009 Family Health History is used to record the information. For each medical condition listed on this form the parent is asked whether any biological relative has or has not had the condition, or whether the parent does not know. For each "yes" answer, the specific relative and the information requested on the form are recorded.

Specific attention is to be given to obtaining information on hemophilia, organ or tissue transplants or transfusions received by either biological parent between 1978 and 1986, use of injected drugs by either biological parent and the cause of death of either biological parent.

If a parent states she or he is HIV positive, the parent will be asked to sign a consent to permit the Department to release that information as needed for child protection proceedings and planning for and care of the child. Maintenance of this information is to be in compliance with confidentiality statutes for HIV status information.

If a parent records the information on the form, the parent signs after "Source of Information". If the caseworker records the information, the caseworker records the name of person providing the information and the caseworker's name after "recorded by". The date the information is obtained is also recorded.

If a parent refuses to provide family health information or to provide a release of this information from appropriate sources, various actions may be taken. If the parent refuses and the health history is determined to be necessary and relevant to the investigation of a report of suspected abuse or neglect or to a subsequent child protection proceeding, an investigative subpoena can be utilized to get the information from health providers. If the health care provider is not willing to provide the information absent a court order, the Department can apply to the District Court to enforce the subpoena. The Department may request that the court order release of this information as part of a preliminary protection order, final protection order or an order after judicial review. When and how to proceed in these circumstances should be discussed with the appropriate Assistant Attorney General.

These forms are filed in the Health Packet of the child's case record; if more than one child is in care or custody, a copy of the family health history form is to be filed in each child's case record.

PORTABLE HEALTH RECORD

This concise health record provides a health history to foster parents, residential child care facilities, and physicians; enhances communication among physicians, foster parents, and caseworkers; provides information in an emergency situation; provides documentation of health services received; and provides a permanent health record for the child, the child's physicians, and the child's parents or guardian following the child's discharge from the Department's care or custody.

Content

The portable health record contains

1. Information needed to reach the child's legal custodian and/or to obtain consent for emergency medical care. This includes:
    a. Name of the legal custodian(s) (if the Department is not custodian, this includes the custodian's address, and telephone number)
    b. Name and address of caretaker (e.g., of the foster parents or residential child care facility)
    c. Date family foster home or facility license expires or a statement that caretaker is not licensed
    d. Name of child's DHS caseworker, office address, and telephone number
    e. After-hours telephone number for the Department.

    The child's caseworker is to update the information as changes occur either by providing to the caretaker new sheet which contains accurate information (a., b., c.), or by asking the foster parent or caretaker to make the necessary changes on the existing sheet (d. e.).

2. A "Medi-Alert" section which readily identifies that the child has a serious medical condition(s), has allergies to a food, medication, insect, or other substances, uses or requires adaptive equipment or other assistive technologies, and/or requires medication(s) for chronic condition(s). The information in this section includes:
    a. The name of any serious medical condition which could require emergency treatment (e.g. seizures, diabetes, heart disease, bleeding disorder, asthma, epilepsy, etc.). HIV infection is not to be included on he portable health record.
    b. Any known allergies to food, insects, medications, or other substances, the child's reactions to the allergy and required treatment
    c. Assistive technologies (e.g. braces, hearing aid, corrective lens) and any other technologies which assist the child to function as independently as possible, or other equipment, such as an apnea monitor, used.

d. The name and strength of any medication for chronic conditions and how it is administered.
e. Medications for acute conditions are recorded as part of ongoing care under Medications and at the time of placement, as part of each case plan on the Health/Dental/Medical section of the Case Assessment and Case Plan.

This section is to be readily visible.

3. A brief birth and medical history of the child. This includes:
   a. Birth data (i.e. place, physician, birth weight, length)
   b. Any problems with pregnancy, delivery, post-natal care
   c. Developmental problems
   d. History of chronic health problems of the child
   e. History of trauma, sexual abuse, and/or ritualistic abuse
   f. Significant known health problems of child's biological parents and siblings
   g. Health care providers
   h. Hospitalizations/surgery
   i. Environment factors, including potential exposure to lead
   j. Use of tobacco, alcohol, or drugs
   k. Immunizations
   l. Screening for TB, lead, cholesterol, hearing, vision
   m. Medical illnesses/conditions not included in the Medi-Alert section.

   This is not to include HIV status information.

4. An on-going record of care sought and received while the child is in care or custody. This includes:
   a. Medical diagnosis, care, and treatment list (i.e. the date, nature of problem, action(s) taken, the name of the physician or other health care professional taking these actions, providing diagnosis or treatment)
   b. The full names and the addresses of all medical care providers and he date or period of time when they provided care to the child.
   c. Dental care (i.e. dates or spans of all dental care visits, care or treatment provided, and the name and address of dentist providing the care)
   d. Other Health Assessments/Care (e.g. eye care - dates, purpose for care, action(s) taken and name and address of optician, optometrist, or ophthalmologist; developmental assessments, speech or hearing evaluations, other screening services; physical therapy; occupational therapy).
      HIV testing or HIV status information is not to be included on the portable health record.

e. Psychiatric and psychological evaluations and treatment (i.e. date and type of evaluations, name and address of the provider)
f. Medications. Name, strength, dosage, frequency, start date, stop date. Medications for chronic conditions are also recorded on the Medi-alert section.

5. The Health/Dental/Medical section of the child's Case Plan Form, which contains information required by federal law to be provided to each foster parent or foster care provider at the time of the child's placement is placed in the center compartment if all of that information is not contained elsewhere in the portable health record.

6. Medical Assistance Card
The child's medical assistance card for the current month is also placed in the center compartment.

PROCEDURES

1. The caseworker responsible for placing the child arranges for the completion of the portable health record and providing it to the foster parent or other caretakers at the time the child is placed with them.
2. The foster parent or residential child care facility staff person is responsible for the updating of the information; preferably by requesting each health care provider to record his activity.
3. When the child moves, the foster parent or other child care provider returns the portable health record and the current medical assistance card to the caseworker. The information contained in the portable health record is reviewed. Any information not already recorded in the Health Packet of the child's case record will be added to that section. Any information not already recorded in the portable health record will be added to the relevant section of the portable health record.
4. The updated portable health record and current medical assistance card are then given to the next foster parent or residential child care provider. When he child is placed with a parent or legal custodian, a photocopy of the entire portable health record is made and filed in the child's case record, and the original portable health record is given to the parent or legal custodian.
5. While the child is in the Department's care or custody, the child's caseworker is responsible for adding medical information to the child's case record in order that the case record contain that included in the portable health record. This is to occur at the time of each placement or if there is no change in placement, at least every six months. This may be accomplished by photocopying the portable health record and filing the copy in the Health Packet in the child's case record.