Fostering Health NC · Best Practices for School Nurses

Building and Strengthening Medical Homes for Infants, Children, Adolescents and Young Adults in Foster Care

www.ncpeds.org/fosteringhealthnc

What is Fostering Health NC? There are approximately 10,000 children in foster care in North Carolina. These children have special health care needs. Often because of the circumstances that led them to be placed into foster care, their physical, developmental, mental/social-emotional and oral health care has been inconsistent and sometimes impacted by crisis or injury. Fostering Health NC, a project of the North Carolina Pediatric Society, is focused on building and strengthening medical homes for infants, children, adolescents and young adults in foster care through integrated communications and coordination of care through a unique partnership among local Departments of Social Services, CCNC Networks, the pediatric care team, the child and the child's family.

A. Standards of Care for the Foster Care Population

Because children in foster care are at high risk for significant health problems, the American Academy of Pediatrics (AAP) has designated them as Children and Youth with Special Healthcare Needs. As such, the AAP strongly recommends the medical home model for children in foster care. Further, the AAP recommends an enhanced well-visit schedule for children in care. These standards are available in the Fostering Health NC Online Library or the AAP website. [See www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Health-Care-Standards.aspx]

Summary of the AAP Standards:

- **0-6 months of age:** Should be seen every month
- **6-24 months of age:** Should be seen every 3 months
- **2-21 years and times of significant change:** Should be seen every 6 months

AAP standards call for an ***Initial Visit*** with a primary care provider within 72 hours of placement into foster care (NC Division of Social Services standard for completing this visit is within seven days). The *Initial Visit* should be an assessment of acute care needs and an opportunity to get releases of information from additional providers in preparation for a second visit, the ***30-day Comprehensive Visit.*** The *Comprehensive Visit* should occur within 30 days of placement and should include a care plan, appropriate referrals, and instructions for professionals and caregivers supporting the child.

Follow-up Well-Visits should start within 60 to 90 days of placement, and additional health evaluations (mental health, developmental, educational, and dental) should occur based on the child's age.

B. Care Coordination

Children entering foster care are in the custody of the local county Department of Social Services (DSS). These children may reside with a family member, foster parent, or in a residential setting. DSS is responsible for collecting medical history about these children, sharing the information with a primary care provider, and ensuring that medical needs are met. To facilitate this information sharing and care alignment with the AAP standards discussed in Section A, the NC Division of Social Services released a set of standard forms for local DSS offices and medical homes to use.

For each child entering DSS custody, **DSS should complete a Health History Form (DSS-5207)**. This form is to be shared with the designated primary care provider/medical home approximately one week prior to the child's 30-day Comprehensive Visit.

Primary care providers serving as medical homes for children in foster care are asked to complete Health Summary Forms after each of the recommended visits:

- Health Summary Form—Initial Visit (DSS-5206)
- Health Summary Form—30-day Comprehensive Visit (DSS-5208)
- Health Summary Form—Well Visit (DSS-5209)

These forms can be found on the DHHS forms website and on the Fostering Health NC Online Library: www.ncpeds.org/fosteringhealthNC

It is best practice for school nurses to coordinate with the county DSS who has custody of the child in order to share information as needed and in accordance with the guidance provided in Section C.

School nurses may also work with other professionals such as Care Coordination for Children (CC4C) or

Community Care of North Carolina (CCNC) care managers assigned to a child's case. CC4C care managers focus on children birth – 5 years; CCNC care managers focus on the population over 5 years old.

Because children in foster care spend a significant amount of time in school, school nurses are uniquely positioned to support care plans and monitor well-being. For example, school nurses may be the first to observe troubling symptoms or behavior associated with trauma (see list in gray box on page 3). By getting in touch quickly with a child's social worker, school nurses can facilitate a fast response to these issues and prevent more serious crises. Furthermore, school nurses, in partnership with teachers and other school-based professionals, can share information about a child's academic progress to help assess the child's overall functioning.

C. Sharing Information

Entities serving children in the foster care system are sometimes reluctant to share information with each other. While federal and state laws protect the privacy of health, education, and social services records, individuals who are responsible for coordinating and delivering healthcare for this population are generally able to share information.

Health Records

DSS social workers, in coordinating care for children in DSS custody, are permitted to share protected health information (PHI) about children on their caseloads with school nurses—just as they can with physicians or other health care providers—for treatment, payment, or healthcare operations without the authorization of the student or student's parent. DSS staff who work in an agency with a Technology-Enabled Care Coordination Agreement (TECCA) with CCNC, allowing them to view Medicaid Claims information (which includes PHI), are required to comply with the HIPPA Privacy Rule as described in the CCNC Participation Agreement. [See US Department of Health and Human Services, Frequently Asked Questions—FERPA and HIPAA: www.hhs.gov/hipaa/for-professionals/faq/ferpa-and-hipaa]

School nurses, in turn, can share health information about students in foster care with DSS social workers. Sharing these records is covered by FERPA rather than HIPAA, and are therefore specifically excluded from the definition of PHI. In most cases, the HIPAA Privacy Rule will not apply to elementary or secondary schools because they are generally not HIPAA covered entities. Similarly, school nurses may share records regarding the student's medical care with health care providers under FERPA provided there is an existing relationship through implied consent (e.g. a current prescription). Otherwise, explicit consent is required from the DSS legal guardian.

Health care providers may share information with school nurses or DSS under HIPAA without patient consent or authorization for treatment, payment, or health care operations.

Education Records

In most cases, health records kept on students at public schools are considered "education records." An exception to FERPA under 20 U.S.C. § 1232g(b)(1)(L) permits local education authorities and schools to disclose information from the education records of a student in foster care to child welfare agencies or tribal organizations. [See US Department of Education, Family Policy Compliance Office--FERPA Frequently Asked Questions: http://familypolicy.ed.gov/faq-page?src=ferpa#t86n434]

The FERPA exception allows schools/school nurses to share information from a child's education record (including health information and academic records) with DSS when the child is in DSS custody. To share the information with entities ***other than DSS*** (e.g., CC4C, CCNC), schools/school nurses must obtain a signed and dated consent for disclosure to those entities from a parent or legal guardian.

Importantly, FERPA requires schools to keep a record of requests for access to and disclosures of information from the education records of each student. While written agreements do not have to be in place between a school and local DSS in order to share information, the US Department of Education recommends such agreements to ensure participants understand their responsibilities.

Social Services Records

The North Carolina Juvenile Code authorizes local DSS offices to share child welfare case information that is necessary for the assessment and treatment of the child with health care providers—including school nurses--working with children in DSS custody. [See N.C.G.S. 7B-505.1(e)]

Exceptions for Certain Information
Schools and DSS offices should be aware that certain *types* of information are governed by special regulations (e.g., substance abuse treatment records subject to 42 CFR Part 2, and psychotherapy notes). For more information about these regulations, see *Sharing Health Information for Treatment* on the Fostering Health NC Online Library: http://bit.ly/2jgCLR
Note: Schools and DSS offices are advised to contact their attorney if they are uncertain about sharing information about a particular child in foster care.

D. Supporting the Child's Environment

Partner with your local DSS office. Contact your local DSS office to discuss information sharing protocols and who to contact with concerns about a child in foster care. Consider requesting a copy of each child's Health Summary Form—30-day Comprehensive Visit (DSS-5208).

Educate teachers and other school-based professionals. Help teachers and administrators understand the impact of trauma and multiple transitions on children in foster care. Share applicable care plan instructions with those who will be working with the child.

Monitor and report. Share relevant observations (positive and negative) with the DSS social worker and know who to call in the event of a crisis. If sharing information electronically, ensure you are doing so in a secure manner. [See NC Department of Public Instruction—Transmitting Private Information Electronically: http://www.ncpublicschools.org/docs/data/management/best-practices.pdf]

Symptoms and Behaviors That May Be Observed in Children in Foster Care

These symptoms may indicate that a child is not coping well and having problems related to social-emotional development and mental health. See Suggested Resources in the next section for more information.

- Sleep problems
- Feeding and Eating issues
- Toileting issues (i.e., constipation, encopresis, enuresis, regression of toileting skills)
- Self-regulation issues (inability to console or soothe or calm self, impulsive actions)
- Frequent severe temper tantrums
- Self-abuse (such as biting or hitting self)
- Aggressive with other children
- Defiance/arguing
- Frequently in trouble at school and with peers for fighting and disrupting
- Hypervigilance, anxiety, or exaggerated response
- Excessive crying or worrying
- Flat affect, withdrawn, not smiling, resists cuddling in infants (problems with attachment)
- Dissociation (detachment, numbing, compliance, fantasy)
- Difficulty acquiring developmental milestones in infants
- Difficulty with school skill acquisition and keeping up in school
- Trouble keeping school work and home life organized
- Losing details can lead to fabrication, viewed by others as lying
- Inappropriate sexual behaviors or gestures

E. Suggested Resources

Contact Information for Local County DSS Offices
www.ncdhhs.gov/divisions/dss/local-county-social-services-offices

Early Brain Development
AAP: Early Brain and Child Development www.aap.org/ebcd
www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Documents/EBCD_Well_Child_Grid.pdf

Center on the Developing Child at Harvard University www.developingchild.harvard.edu

Data & Information Sharing
Legal Center for Foster Care & Education
http://www.fostercareandeducation.org/AreasofFocus/DataInformationSharing.aspx

Foster Care
AAP Healthy Foster Care America www.aap.org/fostercare

Mental Health
AAP Mental Health Initiatives www.aap.org/mentalhealth

Transition Guidance from Pediatric to Adult Care
Got Transition http://www.gottransition.org/

Trauma
AAP's Parenting After Trauma
www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FamilyHandout.pdf
Spanish: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FamilyHandoutSpanish.pdf

AAP's *Helping Foster and Adoptive Families Cope With Trauma: A Guide for Pediatricians*
www.aap.org/traumaguide
Spanish: www.aap.org/en-us/Documents/hfca_foster_trauma_guide_spanish.pdf

National Child Traumatic Stress Network
www.nctsn.org

Child Trauma Academy
www.childtrauma.org

AAP Medical Home for Children and Adolescents Exposed to Violence - The Resilience Project:
www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence/Pages/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence.aspx

Best Practices for School Nurses was developed by the Fostering Health NC State Advisory Team, with contributions from the North Carolina Department of Health and Human Services, Community Care of North Carolina (CCNC), UNC School of Government, and the North Carolina Office of Attorney General.