As-Is Assessment of the Foster Care Health Information Environment

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1 Overview

As part of its approved State Systems Interoperability and Integration Grant application, the New York State Office of Children and Family Services (OCFS) proposed the completion of six (6) major tasks designed to deliver a planning effort to support the implementation of a Children's Passport (CP) for the foster care population. OCFS envisions a Children's Passport that will aggregate Medicaid claims and health care encounter information as children enter care and while they receive ongoing care while in the foster care program.

These tasks and associated deliverables include:

1. As-Is Assessment of the Business Processes, Data Sources and Technical Architecture Supporting the Foster Child (FC) Health Information Environment
2. Alternatives Analysis
3. Cost Benefit Analysis
4. Finalization and Justification of the Selected Alternative
5. Definition of Benefits to Other States
6. Monthly Progress and Final Project Reporting

This document presents deliverable 1, an As-Is Assessment of the FC Health Information Environment, including: 1) Business Processes; 2) Data Sources; and 3) Technical Architecture.

This assessment will provide a baseline of information describing the current environment that will be used to define alternative approaches that best support the project's targeted outcomes to:

1. Reduce administrative costs by identifying and aggregating the most current health information for children in foster care, eliminating data redundancy and creating an electronic record so that care providers can efficiently and effectively manage health care services;
2. Improve the quality and coordination of health care services for the foster care population by building an interoperable electronic record, so care providers have the most current information available; and,
3. Improve the quality of foster care case management services by making an interoperable electronic record available to all care providers.

1.1 Project Scope

The project's scope as articulated in the Grant application is to complete a planning project to support the eventual DDI of the Children's Passport, an electronic record system that will store multi-agency medical health and mental health information for foster children.

This As-Is Assessment will utilize three (3) use cases to provide context to each As-Is domain: business processes, data sources and technical architecture. These use cases include:

1. Identifying the foster child;
2. Establishing the foster child's eligibility status, placement and location; and,
3. Gathering, recording and maintaining the foster child's health information.

1.2 Background

While the focus of this planning initiative is define an approach to the DDI of an interoperable electronic record aggregating health information for New York State's FC population, it is important to understand the structure of New York State's child welfare service delivery environment, IT systems, and the overall flow of supporting business processes where this information is gathered, processed and stored.

New York State's Child Welfare Environment: Agencies and Supporting IT Systems

Three (3) New York State government agencies support the delivery of child welfare services to the foster care population:

1. OCFS and the CONNECTIONS Child Welfare System;
2. The Office of Temporary and Disability Insurance (OTDA) and the Welfare Management System (WMS) and Child Care Review System (CCRS); and,
3. The Department of Health (DOH) supported by the eMedNY Medicaid Management Information System (MMIS), the Medicaid Data Warehouse (MDW) and the Medicaid Data Mart (MDM).

OCFS and CONNECTIONS

OCFS is responsible for the regulation and supervision of all child welfare services delivered in New York State, including child protective services (CPS), foster care (FC) and preventive services (PS). OCFS provides oversight and monitoring to make certain that appropriate program services are provided in compliance with relevant Federal and State laws and regulations.

Outside of New York City, there are fifty-eight (58) local Department of Social Services (LDSS) managing their county-based foster care and adoption programs. In New York City, this responsibility is managed by the Administration for Children's Services (ACS). Upon placement in foster care, the Family Court awards temporary custody of the child to the local DSS commissioner or ACS commissioner. While in temporary custody, the agency is responsible for addressing the children's needs as well as planning for their future.

The DSS or ACS commissioner has temporary custody of children whether they are: 1) placed directly by the local district in a foster home certified or approved by DSS, or 2) placed in a foster home certified or approved by a foster care agency. DSS sometimes arranges for placement in foster care and other services with private (non-public) foster care agencies (known as voluntary authorized agencies or local voluntary agencies (LVAs). In New York City, ACS *always* arranges for placement and services with private foster care agencies. Of the approximately 21,740 children in foster care in New York State, over 75% are cared for by the 86 non-public foster care agencies or LVAs in contract with local districts of social services.

Components of Foster Care Services and the Role of Caseworkers

The Foster Care Services program provides for the care of children who are placed in the custody of LDSS or ACS by the court so that their needs for safety, permanency and well-being can be met. The Foster Care Services program also provides rehabilitative services to parents, development and support of foster homes and residential settings, and processes for the achievement of permanency goals.

There are three (3) major components of Foster Care Services, including:

Foster Care Services Case Management: This function is the responsibility of the LDSS or ACS and includes authorizing the provision of preventive services, determining funding eligibility, approving client programmatic eligibility, approving family assessment and service plans (FASP), and approving payment for services. It begins at the time of assignment to foster care and continues through final discharge.

*Foster Care Case Planning***:** This function includes all processes, activities and services related to providing, coordinating and evaluating the provision of services to a child/family, including the development and implementation of the FASP.

Foster Care Casework: This function includes all processes, activities and services provided to a child/family by someone who has a role in the case, other than that of case planner or case manager.

District caseworkers coordinate the delivery of foster care program services required by Federal and New York State law and regulations. Caseworkers are responsible for developing service plans; maintaining a written case record to document case progress; contacting the children, parents and foster parents; and developing plans for the child's permanent placement that may result in reunification with his or her family or being freed for adoption

Role of CONNECTIONS

CONNECTIONS is a statewide system that maintains information on all children in foster care. The system tracks a wide variety of events associated with a child's stay in prior and current foster care placements. The system uses a common case identifier of CIN to uniquely identify each child. This identifier is generated by OTDA's WMS and will be described in greater detail, below. A Health Services data component, maintained by social work staff, is also provided in CONNECTIONS.

The Office of Temporary and Disability Insurance (OTDA), WMS and CCRS

OTDA supervises programs that provide assistance and support to eligible families and individuals. Major agency functions include: providing temporary cash assistance, assistance in paying for food and heating assistance; overseeing New York State's child support enforcement program; determining certain aspects of eligibility for Social Security Disability benefit; determining Medicaid eligibility; supervising homeless housing and services programs; and providing assistance to certain immigrant populations.

WMS is a statewide system of record for eligibility determinations for social services programs; including: Medicaid, Temporary Assistance to Needy Families (TAN-F), Supplemental Nutrition Assistance (SNAP, Child Support Enforcement/Title IV-D, and the Heating Assistance Program (HEAP). The system generates the unique identifier, or CIN, for each individual receiving social services benefits. WMS also maintains information on case composition (e.g., members of the household and their relationship) as well specific program eligibility and management of benefit payments, excluding Medicaid.

CCRS is a statewide system that tracks significant events as a child enters and leaves foster care. The system uses the same unique identifier generated by WMS and employed by CONNECTIONS. CCRS also authorizes medical services payments for a large segment of the foster care population.

The Department of Health (DOH), the eMedNY MMIS, MDW and the MDM

The New York State Department of Health (DOH) is responsible the delivery of public health services, including: the delivery of quality health care; disease prevention; scientific research; health related educational initiatives; maintenance of birth, death, marriage, and divorce records; publication of health and safety information; formulation of public health laws; and, maintenance of health and disease statistics for the state. DOH is also the single state agency responsible for the administration of the New York State Medicaid program. In conjunction with OTDA and OCFS, DOH administers this program providing medical services to the foster care population. In order to carry out these administrative duties, DOH relies on three major IT systems: the eMedNY Medicaid Management Information System (MMIS); the Medicaid Data Warehouse (MDW); and, the Medicaid Data Mart (MDM).

The MDM is housed at DOH and primarily stores Medicaid claims and encounter information. This data initially processed by the eMedNY MMIS via the MDW, is subsequently passed to the MDM. The MDM is unique in that it stores more historical information than the MDW: data back to 1996 versus 2005. While this information is constructed to support claims payment processing, it also represents a rich repository of clinically relevant data useful to foster care providers such as judges, doctors, case workers, and foster parents.

Section 3 Data Sources and Section 4 Technical Architecture will provide additional detail describing each of these IT environments.

2 Business Processes

Major Business Process Workflows

There are three (3) major business process workflows in the current child welfare operational environment that involve the gathering, processing and maintenance of foster child health information:

1. Identification of the Foster Child;
2. Establishing the Foster Child's Eligibility Status, Placement and Location; and,
3. Gathering, Recording and Maintaining Foster Child Health Information

2.1 Business Process Workflows

Business Process 1: Identification of the Foster child

There are four (4) major pathways for a child's entry into the foster care system, including three (3) involuntary avenues and one (1) voluntary. As illustrated in *Exhibit 2-1: Identifying the Foster Child* the majority of children foster enter care involuntarily, when evidence shows that child abuse or maltreatment has occurred and the child cannot remain safely at home. In this instance, the Family Court orders the placement. Children may also be placed in foster care through a Person in Need of Supervision (PINS) or Juvenile Delinquent (JD) petition placed before the Family Court. Children may also be placed in foster care voluntarily when parents refuse to care for the child and release them to the guardianship of the local DSS or ACS Commissioner, thereby surrendering them for adoption.

The standard for placement in foster care requires that the removal from the home must be essential to ensuring that the child receives proper care, nurturance or treatment. Placement may be considered essential when:

- It is necessary to ensure the health and safety of the child;
- The parents or caretakers refuse to maintain the child in the home or have voluntarily surrendered the child for adoption;
- The child's parents or caretakers are unavailable due to hospitalizations, arrest, imprisonment, or death;
- The child is placed at risk of serious physical or emotional harm due to an emotional, mental, or physical condition of the parent(s) or caretaker(s); and/or,
- The child has special needs for supervision or services that cannot be met adequately.

Once the Family Court has ordered the foster care placement the assigned caseworker must first determine if the child is already known to New York State social welfare service programs via the Welfare Management System (WMS) and CONNECTIONS child welfare system. The caseworker conducts a search of WMS to locate the child's case record and unique identifier, or CIN. If the child is known to WMS and a CIN has been located, this information is transmitted to CONNECTIONS. If the child is not located in WMS, a new case is created,

Medicaid eligibility is determined, and this information is transmitted to CONNECTIONS and CCRS.

At this point the child has been identified to both IT systems and casework activities to develop a service plan and place the child in foster care proceed and are tracked in CONNECTIONS. With respect to health information, WMS has confirmed a Medicaid eligibility status and any data previously entered into the CONNECTIONS health module is available. While Medicaid claims data may also be available via the MDM, there is currently no electronic interface in place to support data gathering and evaluation.

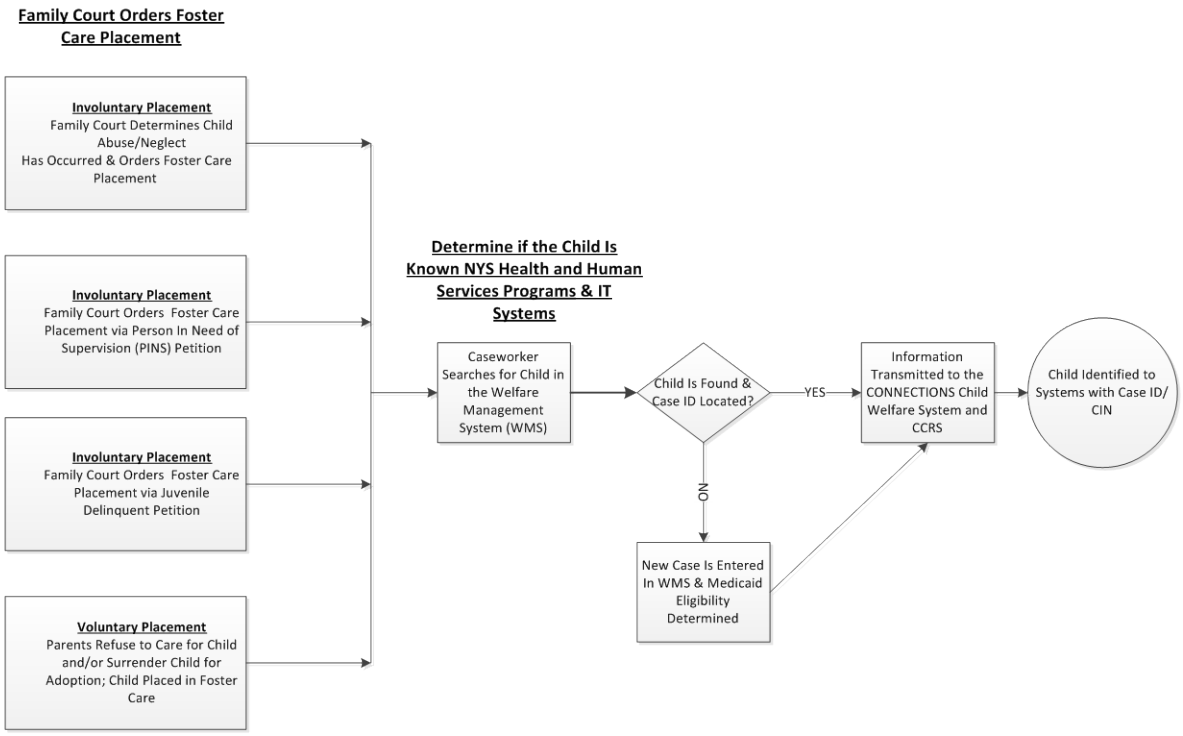


Exhibit 2-1: Identifying the Foster child

Business Process 2: Establishing the Foster Child's Eligibility Status, Placement and Location

In order to establish the child's eligibility status and proceed with casework activities necessary to confirm placement and physical location, caseworkers must rely on information stored in three (3) separate IT systems: the Welfare Management System (WMS), CONNECTIONS Child Welfare System and the Child Care Review System (CCRS). These systems have evolved over time to serve different purposes, resulting in an environment of information and functional "stove pipes".

As described in the previous sections, WMS is the statewide system of record for eligibility determinations for TAN-F, SNAP, Child Support and HEAP social services programs. WMS provides each child a unique identifier or CIN, critically important to support caseworker access to previously recorded information about the child, his/her family and Medicaid eligibility status. CONNECTIONS is the statewide system child welfare system, that maintains information on all children in foster care, identifying them via the CIN generated in WMS, tracking events associated with a child's stay in prior and current foster care placements. CCRS is a statewide system that tracks significant events as a child enters and leaves foster care, also employing the CIN generated by WMS and employed by CONNECTIONS. CCRS serves as the repository for the legal status of the child, including details of the foster care placement, and authorizes payments for medical services. To summarize the major function of these three systems:

- **WMS**: Assigns CIN and determines Medicaid eligibility;
- **CONNECTIONS**: Maintains foster child case information, tracks casework activities, stores medical information in its health services module, and extracts placement status from CCRS
- **CCRS**: Stores legal status per Family Court orders, placement and location information, and authorizes medical services payments.

As illustrated in *Exhibit 2-2: Establishing the Foster Care Child's Eligibility Status, Placement and Location*, the CIN generated by WMS is shared across all IT systems. Using this CIN, caseworkers proceed with service planning and case management activities, using CONNECTIONS to track their progress. They conduct an initial family assessment within 30 days of a child being considered for placement in foster care or if placed in foster care, whichever occurs first. This initial assessment and service plan is used to record the family's history and presenting problems, as well as their current level of functioning and the steps to be taken to meet their needs. Caseworkers continue to work with the family to assess the need for services and supports to achieve permanency, to ascertain the progress being made in meeting the desired outcomes, and to assist in the ongoing planning with the family. For every child placed in foster care, the following assessment and service plans must be developed:

- An initial family assessment and service plan must be completed and approved by the
- case manager within 30 days from the case initiation date;
- A comprehensive assessment and service plan must be completed and approved by
- the case manager within 90 days of the case initiation date;
- The first family reassessment and service plan must be completed no later than 210
- days from the case initiation date; and
- All subsequent family assessments and service plans must be completed 6 months from the due date of the previous reassessment and every 6 months thereafter.

Concurrent with foster care service activities completed by caseworkers and recorded in CONNECTIONS using the child's CIN, the CCRS is updated with the child's foster care placement and physical location information as well as details of the child's legal guardian per the Family Court order. CONNECTIONS extracts placement information for reference by caseworkers delivering foster care case management services. CCRS also authorizes payment of medical services and the MMIS makes the actual payments. For children receiving medical

services on a fee-for-service or managed care basis, the MMIS processes fee-for-service claims or processes a monthly capitation payment the child's Managed Care Organization. All payments for Medicaid services are made by the MMIS.

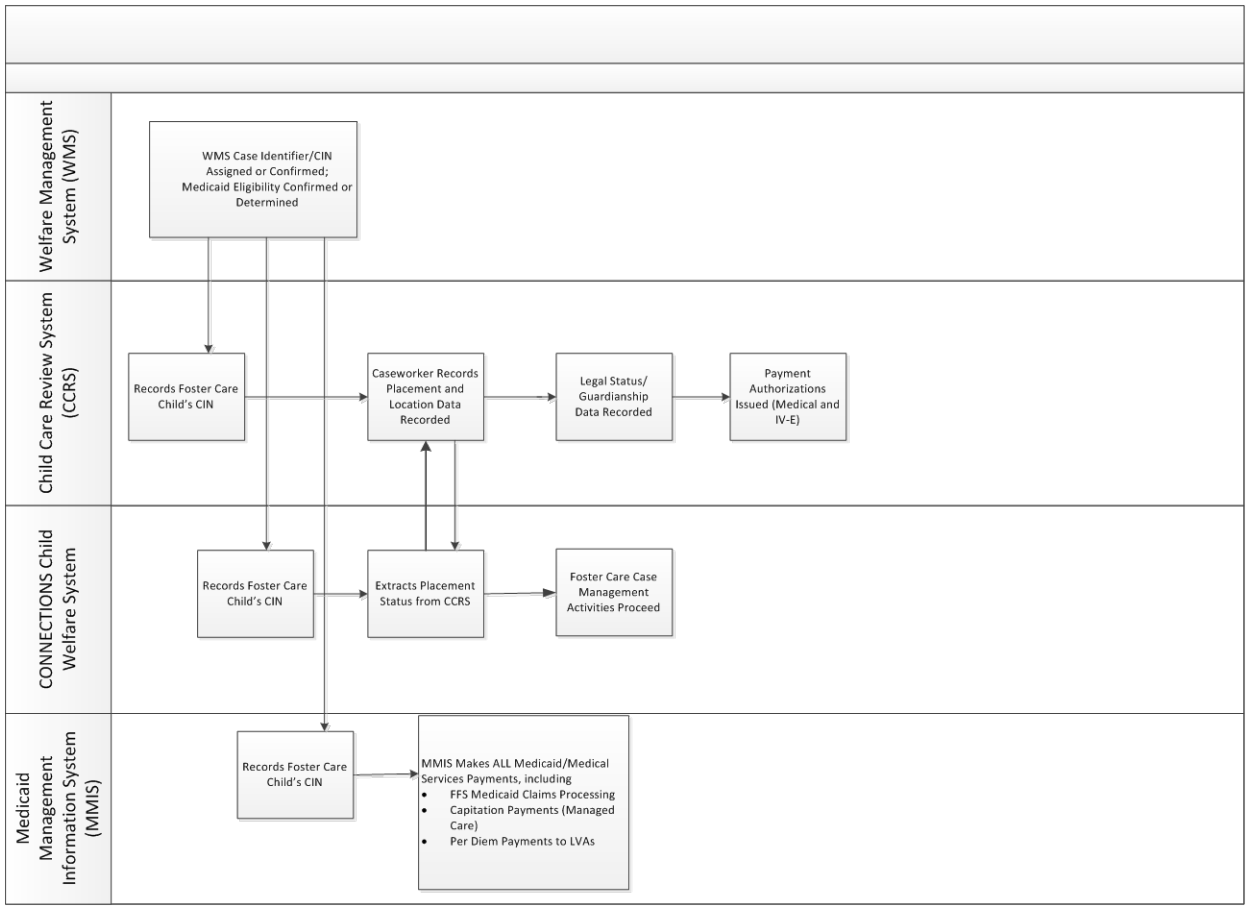


Exhibit 2-2: Establishing the Foster Child's Eligibility Status, Placement and Location

At this point, the child has been identified to all IT systems; Medicaid eligibility has been confirmed and/or determined; he/she is receiving foster care caseworker services and has been placed with a foster care provider; legal guardianship, placement and physical location details have been recorded; payment authorizations have been issued so that medical service payments can be made.

Business Process 3: Gathering, Recording and Maintaining Foster Child Health Information

Caregivers can now proceed with completing an initial evaluation of the child's health, and establishing a schedule for any additional assessments required, along with routine preventive and ongoing health care services. As the child's health needs are addressed, a tremendous volume of health data is gathered and recorded in a variety of disparate formats and systems. Much of this information is manually recorded in physical files maintained by health care providers and the responsible LVAs. The information most critical to the immediate care of the child can be recorded in the CONNECTIONS child welfare system, but is done so inconsistently. A complete discussion of the health information gathering, recording and maintenance processes follows.

Obtaining Medical Consent

Medical consent is required for routine evaluation and treatment of a child in foster care. This includes consent for initial assessment, follow up and treatment, and ongoing periodic re-evaluation, as well as emergency medical or surgical care in the event that the parent or guardian cannot be located at the time such care becomes necessary.

Giving medical consent is agreeing to and understanding the risks and benefits of the services to be provided. It includes:

1. Consent for release of prior health records;
2. Consent/authorization for routine evaluation and treatment; and,
3. Informed consent for non-routine health care.

Since foster children are placed outside the home - often moving from one placement to another and having agency staff as well as health care providers involved with their care – they require special oversight and consideration regarding medical consent. As a result, the law generally requires that consent from the parent or guardian be obtained and documented for key medical activities and conditions. Appendix A provides a complete listing of all applicable State and Federal laws and regulations governing consent and other medical rights of children in foster care.

Caseworkers make every effort to obtain the parent's or guardian's signature on the agency's consent for release of information form as early as possible. This is critical to make certain that efforts to obtain the child's medical history, complete initial evaluations and provide treatment can begin within 24 hours of placement. When consent cannot be obtained from the birth parent/guardian, it is necessary to obtain the either the consent of the local social services or a Family Court order.

Informed Consent

Even if consent for routine evaluation and treatment has been obtained, medical providers will generally look for a higher level of consent – known as "informed consent" – for non-routine or elective medical or mental health care not generally provided as part of primary health care. Local districts that have obtained consents from a parent or guardian should evaluate the scope of such consent to determine whether it addresses both routine and non-routine medical

care and treatment. For procedures or interventions that are not emergency in nature but call for informed consent, the health care provider contacts the caseworker or the health care coordination staff at the agency. It is then the agency's responsibility to facilitate the consent process.

Informed consent is required for:

- Any hospitalization;
- Dispensing of any psychiatric medication;
- Any procedure that requires anesthesia;
- Any surgery; and,
- Any invasive diagnostic procedure or treatment.

Informed consent implies that the person giving consent has had the opportunity to ask questions, understands the risks, benefits, and alternatives of the treatment, and has been informed of the following types of information:

- Diagnosis and symptoms being treated;
- How the procedure/therapy fits with the treatment plan;
- Nature of the procedure/treatment;
- Benefits, risks, and side effects;
- Projected course and duration of therapy;
- Alternative approaches to treatment;
- Assurance of monitoring for complications and side effects;
- How to contact the clinical provider of the proposed procedure/treatment;
- Location where the procedure/treatment will be performed;
- Necessity, type, and risks of anesthesia, if any; and,
- Proposed length of hospitalization, if any.

Health Insurance Portability and Accountability Act (HIPAA) Compliance

The Federal Health Insurance Portability and Accountability Act (HIPAA sets forth procedures and guidelines for maintaining the privacy and security of individually identifiable health information and outlines penalties for failure to protect this information. HIPAA also includes provisions designed to increase the efficiency of the health care system by creating standards for the use and dissemination of health care information. The CONNECTIONS child welfare system includes safeguards to protect this information that include role based security protocols based on providing access to only those workers that absolutely must review this data in order provide services. Since the LVAs provide foster care services to over 75% of the State's foster care population, additional HIPAA safeguards are provided at the local level.

Gathering Health Information: Initial Evaluation of Foster Child's Health

Once the child has been placed in foster care, there are a number of medical activities required by regulation and child welfare policy that are completed via the collaborative efforts of medical practitioners and caseworkers. Medical histories of the child and his/her family are gathered and a comprehensive evaluation of the child's medical, dental, mental health and substance abuse is initiated. These activities result in the compilation of a comprehensive needs/problem list and plan of care addressing all identified health needs.

Each child receives a health screening within 24 hours of placement. The purpose of this screening is to identify active health problems, any needs for immediate care and continuation of medications. Ideally a qualified health care practitioner (RN, LPN, nurse practitioner or physician's assistant) conducts this screening. If this is not possible, OCFS maintains a screening tool that can be used by caseworkers to identify the child's immediate needs.

The most critical items to identify and document are:

- Signs of abuse or neglect;
- Active medical/psychiatric problems;
- Obvious illnesses, injuries, or disabilities;
- Current medications;
- Allergies to food, medication, and environment;
- Upcoming medical appointments;
- Need for eyeglasses, hearing aids, or other durable medical equipment; and,
- For infants: delivery history (e.g., where, when, how, toxicology screen, complications).

Obtaining a Comprehensive Medical History

At the time of placement, caseworkers make every effort to obtain a complete medical history of the child by interviewing the birth parents, the child, health care providers, other service providers (e.g., school nurse, day care center), and existing medical records. Ideally, caseworkers gather medical information at the time of the child's removal from the home.

Critical elements of the medical history include:

- Prior and current illnesses and behavioral health concerns;
- Immunization history;
- Medications (prescription and over-the-counter);
- Allergies (food, medication, and environmental);
- Results of diagnostic tests and assessments, including developmental and psychological tests;
- Results of laboratory tests (including HIV antibody screening);
- Family history of hereditary conditions or diseases;
- Details of pregnancy, labor, and delivery (for children age 5 and under, and as available for other children);
- Results of the infant's Newborn Screening;

- Names and addresses of the child's health and medical provider(s), with details of illnesses, accidents, and previous hospitalizations, including psychiatric hospitalizations;
- Durable medical equipment/adaptive devices currently used or required by the child (e.g., wheelchair, feeding pump, glasses); and,
- Needed follow-up or ongoing treatment for active problems.

Exhibit 2-3, below, details the major components and timeframes for initial health evaluation activities, including:

- 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; and,
- Ongoing efforts to obtain child's medical records and document medical activities.

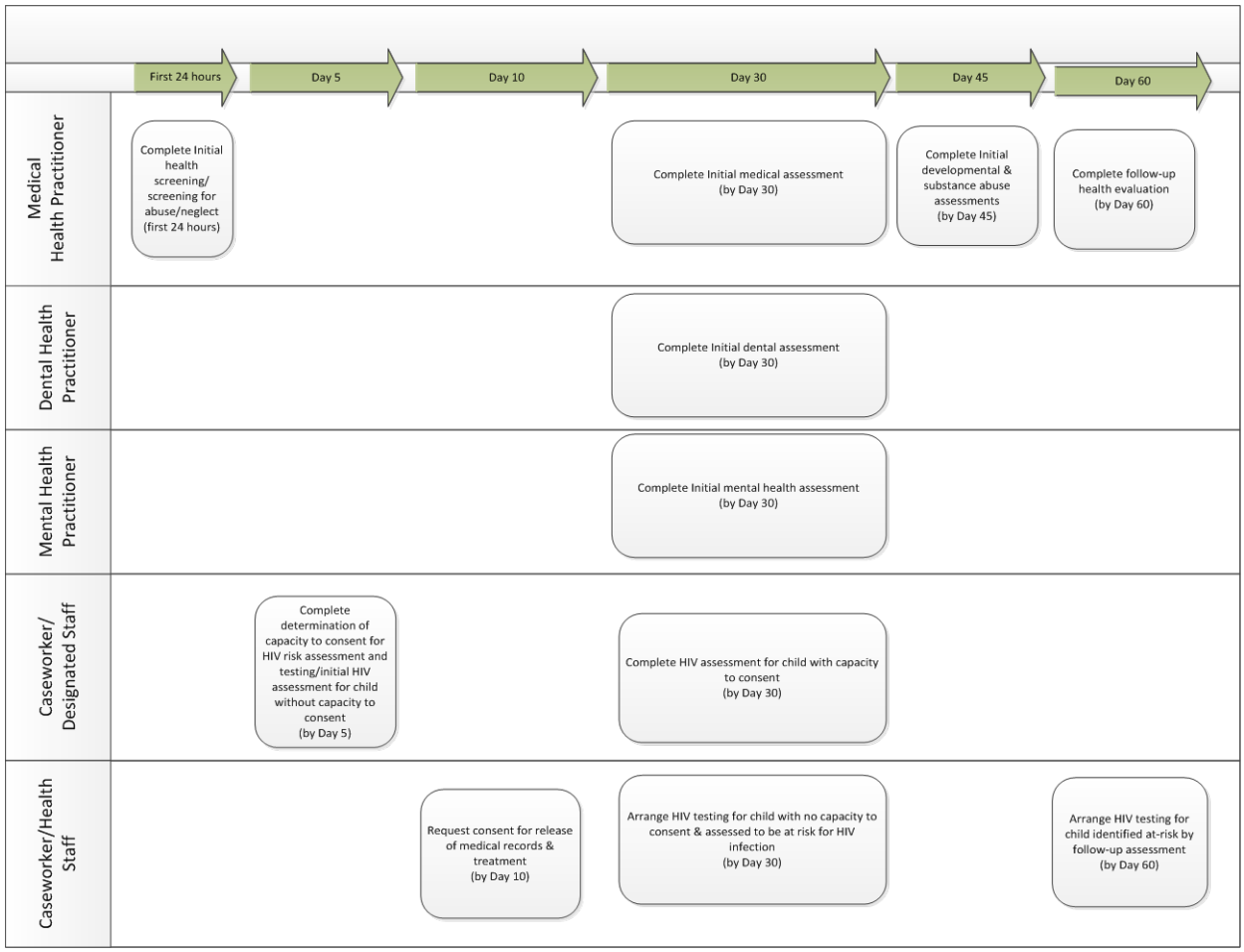


Exhibit 2-3: Initial Evaluation of Foster Child's Health

Comprehensive Plan of Care for Each Foster Child

Each initial health assessment (medical, dental, mental health, developmental, and substance abuse) included in the comprehensive health evaluation results in the development of a comprehensive plan of care for the foster child. This plan is designed to address specific needs identified in the initial assessments and includes recommendations for treatment, referral information, and follow-up appointments. It also includes information and tips for caregivers about healthy growth and development and be used in case planning activities to enhance service coordination and monitoring. By incorporating health information into case planning activities, caseworkers will make certain that all providers are aware of the child's various health care issues and that all medications are managed properly.

Gathering Health Information: Routine Preventive and Ongoing Health Care

Medical Services

The child's case plan also includes a schedule for routine preventive health and any ongoing care needed. Periodic comprehensive medical assessments known as well child visits are scheduled on an ongoing basis. *Exhibit 2*-4 summarizes this schedule, adopted by New York State in accordance with current American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care. Due to the greater health needs of children in foster care, OCFS has incorporated additional well-child visits for children under the age of 6.

Well child visits include:

- Clinical examination by a primary care provider who is a pediatrician, family physician, physician's assistant, or nurse practitioner with pediatric training and experience – preferably, the same provider who conducted the initial medical assessment;
- Administration of immunizations consistent with current DOH recommendations for age and special conditions that may be present such as HIV infection, sickle cell, asthma, or diabetes;
- Periodic screening tests consistent with the current AAP well child visit schedule and DOH regulations for age and current professional standards for specific conditions (e.g., blood tests for lead poisoning);
- Health education and guidance consistent for caregivers; and,
- Review and updating of the problem list and treatment plan at each well child visit.

Dental Health Services

Comprehensive dental care for children in foster care includes routine restorative care and ongoing dental examinations, preventive services, and treatment as recommended by the dentist.

Mental Health Services

Psychiatric, psychological, and other essential mental health services for children in foster care include:

- Diagnosis and treatment of all needs identified during the initial assessments;
- Medically necessary psychiatric and psychological services;
- Care, services, and treatment to ameliorate defects, physical and mental illness, and conditions discovered by Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings and,
- School supportive services, including occupational therapy and physical therapy.

Developmental Services

Developmental services for children in foster care include:

- Timely access to services identified in the initial medical or developmental assessments and age-appropriate assessment at routine periodic medical visits.
- Assessment of the child's developmental, educational, and emotional status based on an interview with the foster parents, standardized tests of development, and/or review of school progress at each well-child visit; and,
- Diagnosis and treatment of all developmental delays and deficits identified and developmental treatment services such as speech and language therapy; occupational therapy; physical therapy; and services for the hearing and visually impaired.

Substance Abuse Services

Screening for substance abuse is incorporated in the initial comprehensive health evaluation for all children age 13 and older. Youth of any age who are identified as having alcohol or/other drug related problems will receive professional services that include a comprehensive assessment for alcohol and substance abuse disorders. Treatment and services for any alcohol or drug abuse problem identified as part of the screening and assessment process is provided in accordance with the current standard of care for adolescents

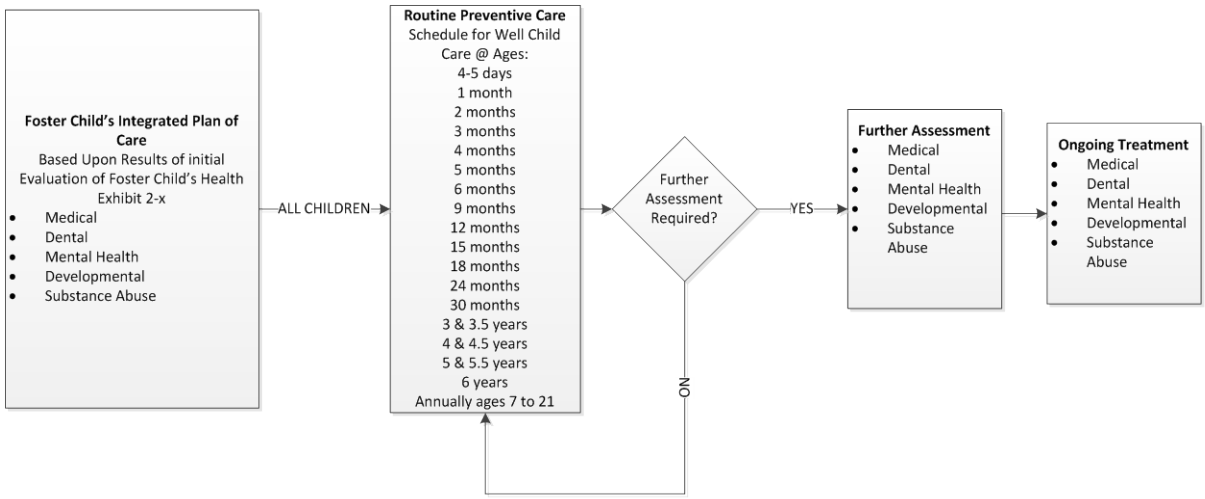


Exhibit 2-4: Preventive and Ongoing Health Care for Foster Children

Recording and Maintaining Foster Child Health Information

The preceding business process descriptions detail the extensive amount of health information gathered as a child moves through the foster care system. As the child's health needs are addressed, health data is gathered and recorded in a variety of disparate formats and systems. Much of this information is gathered, stored and maintained manually in physical files managed by a wide variety of caregivers, including health care professionals, caseworkers, the courts and foster parents. While the CONNECTIONS child welfare system provides a capability to electronically record and maintain a limited set of the most critical data elements required to manage a foster child's case, it is not intended to represent a comprehensive electronic health record. This section describes the business processes in place to support the maintenance of physical records as well as electronic records in CONNECTIONS.

Hardcopy Health Care Case 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. 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 agency, 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 file, which becomes the centralized health information resource for the agency.

If foster care services are provided by a voluntary agency, health information in the local social services district need not be so extensive. However, since the local district has ultimate responsibility for the child's welfare, they must maintain a health file adequate enough to properly monitor the child's care. In addition, the voluntary agency staff must send copies of additions to the health file to the local district whenever a *significant* change occurs in a child's health status or treatment but at least no later than the next six-month Service Plan Review. Such changes might include hospitalization, emergency treatment, diagnostic testing, or necessity for extended follow-up care.

The level of information in the health file 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 file may serve the dual role of agency health file and provider health file so long as the information is accessible to casework staff. If the agency does not provide health care, the agency health file will be separate from the file maintained by the child's primary health care provider.

At a minimum, the health file should at least contain:

- 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;
- 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 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 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; and,
- Summaries of health care planning meetings.

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 birth 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.

CONNECTIONS Health Services Module

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. Section 3, page 3-3 provides a detailed description of this data.

3 Data Sources

3.1 Background

Data flows through the principal legacy IT systems described previously and each of these systems supports major events associated with the use cases. The common denominator that links the individual foster child to lifecycle events is the common identifier or CIN. This section provides the data attributes for each use case and the associated relationship with each of the IT systems, as appropriate.

3.2 Data Sources Supporting Major Business Processes

Data Sources Supporting Business Process 1: Identification of Foster child

Welfare Management System (WMS)

The identity of a foster child will be shared among the various legacy IT via the CIN. Initial identification of a child in the general social services environment is managed in the Welfare Management System (WMS).

WMS contains the following key information attributes:

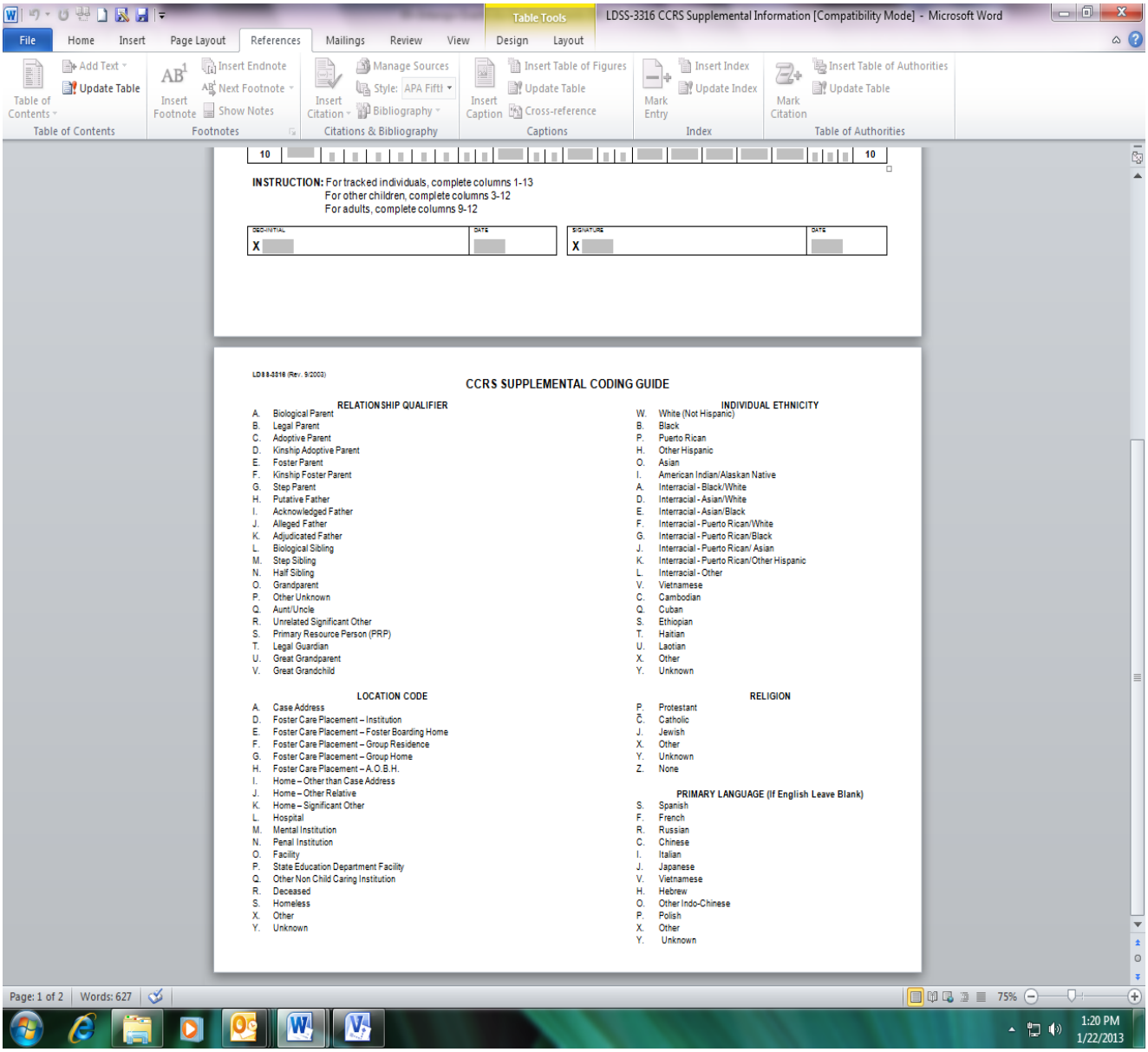
- Name
- Sex
- Date of Birth (DOB)
- Primary Address
- Case Composition (typically the relationship of the significant individual involved in a case; e.g., the mother, father and siblings in the home)
- CIN
- Eligibility History

CONNECTIONS

The CONNECTIONS child welfare system continues to utilize the foster child's CIN along with the basic demographic information provided by WMS. This information is updated during the lifecycle of foster care services prior to and after placement.

CCRS

CCRS continues to utilize the CIN to identify the foster child and maintains his/her legal status. CCRS data is shared with CONNECTIONS and the MMIS. Exhibit 3-1, below, provides a listing of all CCRS data elements.



10 10

INSTRUCTION: For tracked individuals, complete columns 1-13
For other children, complete columns 3-12
For adults, complete columns 9-12

DEC-INITIAL	DATE	SIGNATURE	DATE
X		X	

LDSS-3316 (Rev. 9/2003)

CCRS SUPPLEMENTAL CODING GUIDE

RELATIONSHIP QUALIFIER

A. Biological Parent
B. Legal Parent
C. Adoptive Parent
D. Kinship Adoptive Parent
E. Foster Parent
F. Kinship Foster Parent
G. Step Parent
H. Putative Father
I. Acknowledged Father
J. Alleged Father
K. Adjudicated Father
L. Biological Sibling
M. Step Sibling
N. Half Sibling
O. Grandparent
P. Other Unknown
Q. Aunt/Uncle
R. Unrelated Significant Other
S. Primary Resource Person (PRP)
T. Legal Guardian
U. Great Grandparent
V. Great Grandchild

LOCATION CODE

A. Case Address
D. Foster Care Placement – Institution
E. Foster Care Placement – Foster Boarding Home
F. Foster Care Placement – Group Residence
G. Foster Care Placement – Group Home
H. Foster Care Placement – A.O.B.H.
I. Home – Other than Case Address
J. Home – Other Relative
K. Home – Significant Other
L. Hospital
M. Mental Institution
N. Penal Institution
O. Facility
P. State Education Department Facility
Q. Other Non Child Caring Institution
R. Deceased
S. Homeless
X. Other
Y. Unknown

INDIVIDUAL ETHNICITY

W. White (Not Hispanic)
B. Black
P. Puerto Rican
H. Other Hispanic
O. Asian
I. American Indian/Alaskan Native
A. Interracial - Black/White
D. Interracial - Asian/White
E. Interracial - Asian/Black
F. Interracial - Puerto Rican/White
G. Interracial - Puerto Rican/Black
J. Interracial - Puerto Rican/ Asian
K. Interracial - Puerto Rican/Other Hispanic
L. Interracial - Other
V. Vietnamese
C. Cambodian
Q. Cuban
S. Ethiopian
T. Haitian
U. Laotian
X. Other
Y. Unknown

RELIGION

P. Protestant
C. Catholic
J. Jewish
X. Other
Y. Unknown
Z. None

PRIMARY LANGUAGE (If English Leave Blank)

S. Spanish
F. French
R. Russian
C. Chinese
I. Italian
J. Japanese
V. Vietnamese
H. Hebrew
O. Other Indo-Chinese
P. Polish
X. Other
Y. Unknown

Exhibit 3-1: CCRS Data Elements

MMIS and MDM

The MMIS continues to use the CIN to identify the foster care child for purposes of claims processing, encounter processing and per diem payments.

The MDM is a repository of all claims paid on behalf of Medicaid insured individuals, such as foster, are children using the CIN as the primary identifier. Data is available back to 1996.

Data Sources Supporting Business Process 2: Establishing the Foster Child's Eligibility Status, Placement and Location

Welfare Management System (WMS)

WMS is the primary eligibility system for all major social services programs. Given that a high percentage of the foster care population is Medicaid insured prior to placement, initial eligibility is typically established in WMS. Upon placement in a foster care setting, Title IV-E eligibility is established in WMS.

CONNECTIONS and CCRS

CONNECTIONS and CCRS share information on the foster care child's specific placement, including the type; legal status; foster care case management services provided supporting the progress towards achievement of permanency goals; and, the foster child's specific location (family foster care or LVA).

MMIS and MDM

The MMIS processes payments for health services covered by Medicaid and maintains the information detailing the foster child's physical location, including the address of either the foster family or LVA placement. It also stores the foster child's eligibility status.

Data Sources Supporting Business Process 3: Gathering, Recording and Maintaining Foster Child Health Information

CONNECTIONS

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, authorized agency, 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.

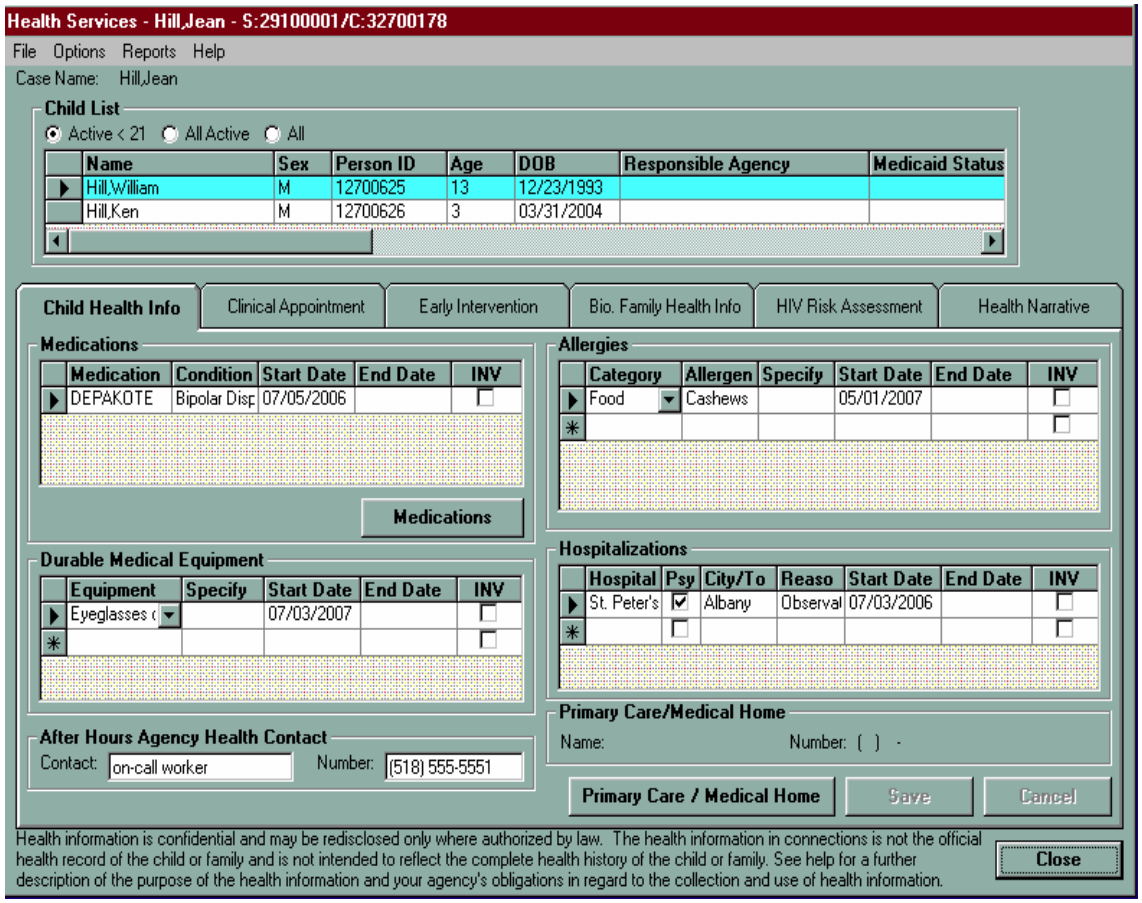


Exhibit 3-2: CONNECTIONS Health Services Module

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 an authorized agency.

Required fields are completed upon receipt of hardcopy documentation from the provider and include the following:

1. **Designate Health Responsibility Field**
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.

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;
- 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; and,
- 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 abuse 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 thereafter;
- 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; and,
- 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 age 3 in an indicated Child Protective Services (CPS) case;
- All other fields as applicable for referred children; and,
- 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 should ***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; and,
- 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 in foster care must be assessed for HIV risk, 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; and,
- 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 abuse provider's reports or notes;

- Quotes from mental health provider's reports or notes; and,
- Confidential reproductive health services, including sexually transmitted diseases (STDs).

MMIS and MDM

The MMIS stores Medicaid claims and encounter information and the MDM stores claims history dating back to 1996. Major data classifications include:

- Labs, X-rays;
- Medications;
- Dental;
- Medical;
- Residential Treatment;
- Mental Health; and,
- Hospitalization (defined as one or more overnight stays).

4 Technical Architecture

4.1 Background

As discussed in the previous section, in order to establish the child's eligibility status and proceed with casework activities necessary to confirm placement and physical location, caseworkers must rely on information stored in three (3) separate IT systems:

- The Welfare Management System (WMS);
- CONNECTIONS Child Welfare System; and,
- The Child Care Review System (CCRS).

These legacy systems have been serving New York State for many years; WMS and CCRS are over thirty years old and CONNECTIONS is almost twenty years old. Due to their age the systems are "siloed", meaning they are vertically integrated, each providing a narrow range of services. Although over the years there has been modifications and enhancements the lateral integration issue has not been addressed. Disparate system have been patched so that some data can be retrieved online, but the viewpoints promoted by the interoperability architectures of today (i.e., NHSIA) have not been addressed

In this section we will discuss the current technical architectures of these systems and how these systems currently support the three (3) business processes.

Welfare Management System (WMS) & Child Care Review System (CCRS)

The primary vehicle in New York State for providing technology support at the enterprise level – across all major social service program areas – is the legacy-based WMS and related applications, including Benefit Issuance Control System (BICS), Child Support Management System (CSMS) and Child Care Review Service (CCRS). WMS and its related applications support aspects of application, eligibility, and budgeting for Temporary Assistance (TA), Food Stamps (FS), Medical Assistance (MA), the Home Energy Assistance Program (HEAP), and family and adult services

WMS has served the State and Local Departments of Social Services (LDSS) since mid–1970, supporting the benefit and service delivery model in the Local Departments of Social Services (LDSS) and New York City. Currently, New York State supports and maintains two separate Welfare Management Systems (WMS), one for the five counties in NY City (NYC) and one to handle the rest of the state's population. However, over the last several years, the increase in system changes resulting from Federal and State legislation, have highlighted the need to consolidate the upstate and downstate WMS systems into one statewide WMS to achieve agility and efficiency.

Two Unisys ClearPathPlus Dorado 780 Enterprise Servers support the OTDA Bureau of Information Technology and the legacy systems. On the primary system, there are two production partitions: one that services the 'upstate' legacy application and network (57 counties) and a second partition that services the 'WMSNYC' legacy application and network (5 NYC Boroughs). A third partition on this primary system serves as a statewide end-user systems for application development, testing and quality assurance. The second system serves as a

Disaster Recovery (DR) Platform and is an exact mirror of all OTDA partitions of the primary system. Each partition is switched over to its corresponding DR partition at least twice every calendar year where it runs live for at 2-3 weeks as a true test of Business Continuance viability for OTDA legacy applications.

Most mainframe data is stored in a Conference on Data System Languages (CODASYL) style, Unisys proprietary database, now known as UDMS-2200. Data is currently accessed for inquiry and update by both transaction interface processing (TIP) transactions and batch runs within the host partitions. This legacy data is also accessible to other platforms via a number of open transaction interfaces services such as Unisys Transaction Manager (TM2200/OSITP), OpenTI and Message Queuing (MQ Series) which allow open platforms to retrieve and process legacy data as well.

Statewide Automated Child Welfare Information System (SACWIS) CONNECTIONS

The Omnibus Budget Reconciliation Act of 1993 provided enhanced federal funding for states to build Statewide Automated Child Welfare Information Systems (SACWIS). The New York State SACWIS is CONNECTIONS. CONNECTIONS is a statewide effort to provide OCFS, LDSS, and Voluntary Agencies with an automated tool that would provide a uniform system to improve the quality and consistency of their efforts on behalf of children and their families. The system provides case management support for direct caseworkers, decision-making support tools for managers, and appropriate access to client information across the state. Through the statewide network, CONNECTIONS links child welfare caseworkers, supervisors, and other management and administrative staff.

The initial development of CONNECTIONS was undertaken in 1996 by transferring the Texas SACWIS system to New York and then modifying it to operate in this state's environment. The initial technical implementation consisted of a proprietary software development platform (Foundation for Cooperative Processing (FCP)) running in a "fat client" server environment.

As technology progressed the CONNECTIONS architecture continued to evolve over the years; initially with the introduction of the Citrix servers and then the movement of a more open platform using Microsoft based products. The current architecture reflects this evolutionary process by amalgamating the legacy technology (FCP) with the Microsoft Office Sharepoint Services (MOSS) architecture which introduces shared services into the architecture.

Authentication/Authorization

When an external user wants to connect to either the WMS or CCRS application they must traverse either the NYeNet and/or human services enterprise network (HSEN) networks that are operated by the New York State Office for Information Technology Services (ITS); the latter network being the original network of the now superseded New York State Department of Social Services.

Authentication to the network and authorization to the applications are accomplished by using two software products CentraPort and SiteMinder. Five NYS agencies worked together to

develop an Intranet portal designed to connect counties to New York State health and human service agencies so that they can exchange information and access commonly used applications and Web pages more efficiently. CentraPort, as the portal is named, links county social services departments to information and applications that they need from four different state agencies – the Office of Temporary and Disability Assistance (OTDA), the Office of Children and Family Services (OCFS), the Departments of Health (DOH), and the Department of Labor (DOL).

CentraPort co-locates access to related human services applications on a single Web site. Each individual's rights are assigned and managed by that person's employer and all participating organizations use the same rules and procedures. CentraPort co-locates both Web-based and older legacy systems. Users still need to sign on separately to the legacy systems, but they do not have to leave CentraPort to use them.

SiteMinder is the user authentication and authorization component of an access management suite from Netegrity. SiteMinder provides policy-based authentication as well as single sign-on for all Web-based applications. SiteMinder is used in conjunction with IdentityMinder, which manages detailed user profiles, and TransactionMinder, which provides access to Web services

CONNECTIONS does not use CentraPort or SiteMinder for authentication/authorization because of the Citrix implementation. Citrix users enter CONNECTIONS through the Citrix Web interface into the Zone Data Collectors (ZDC) which are Citrix servers that monitor and manage the Metaframe server farm. The ZDC send credentials to the HSEN Domain Controllers to validate userid/password. The ZDC also keeps track of the IP addresses for each server and the load on each of the servers and holds what groups belong to what published application.

If users want to access data from the legacy FCP portion of the application they access one of the twenty FCPinstances; if they want to access data from other parts of the application (e.g. the Visual Basic (VB) portion) the request is sent to the network load balancers to the cluster load balancers to the CONNECTIONS data base.

Exhibit 4-1 reflects the major components of Authentication/Authorization, WMS, CCRS and CONNECTIONS.

4.2 Technical Architecture Supporting Major Business Processes

Technical Architecture Supporting Business Process 1: Identification of the Foster child

A caseworker searches for a child in WMS by first authenticating and getting an authorization to use the WMS system. This is done by entering a userid/password, as illustrated in *Exhibit 4-1*.

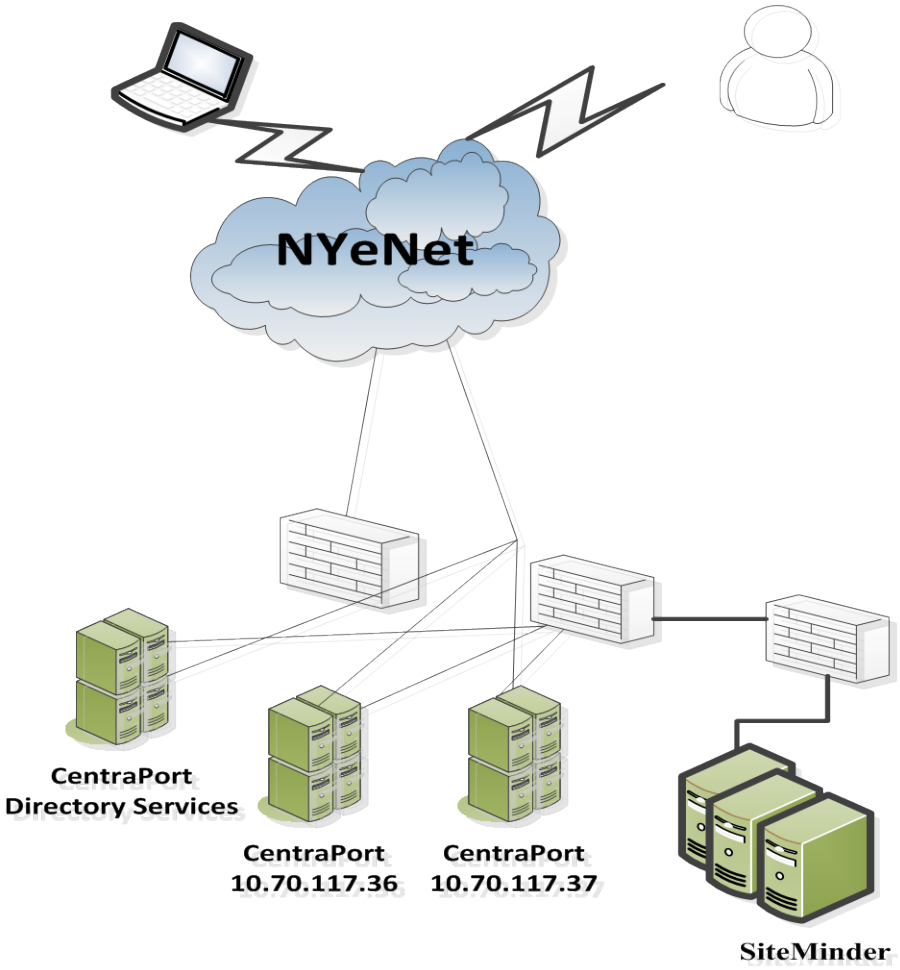


Exhibit 4-1: WMS Authentication and Authorization: Identifying the Foster Care Child

The caseworker then enters WMS to search for an existing CIN and enters information into Medicaid Budget Logic (MABEL) to make an eligibility determination.

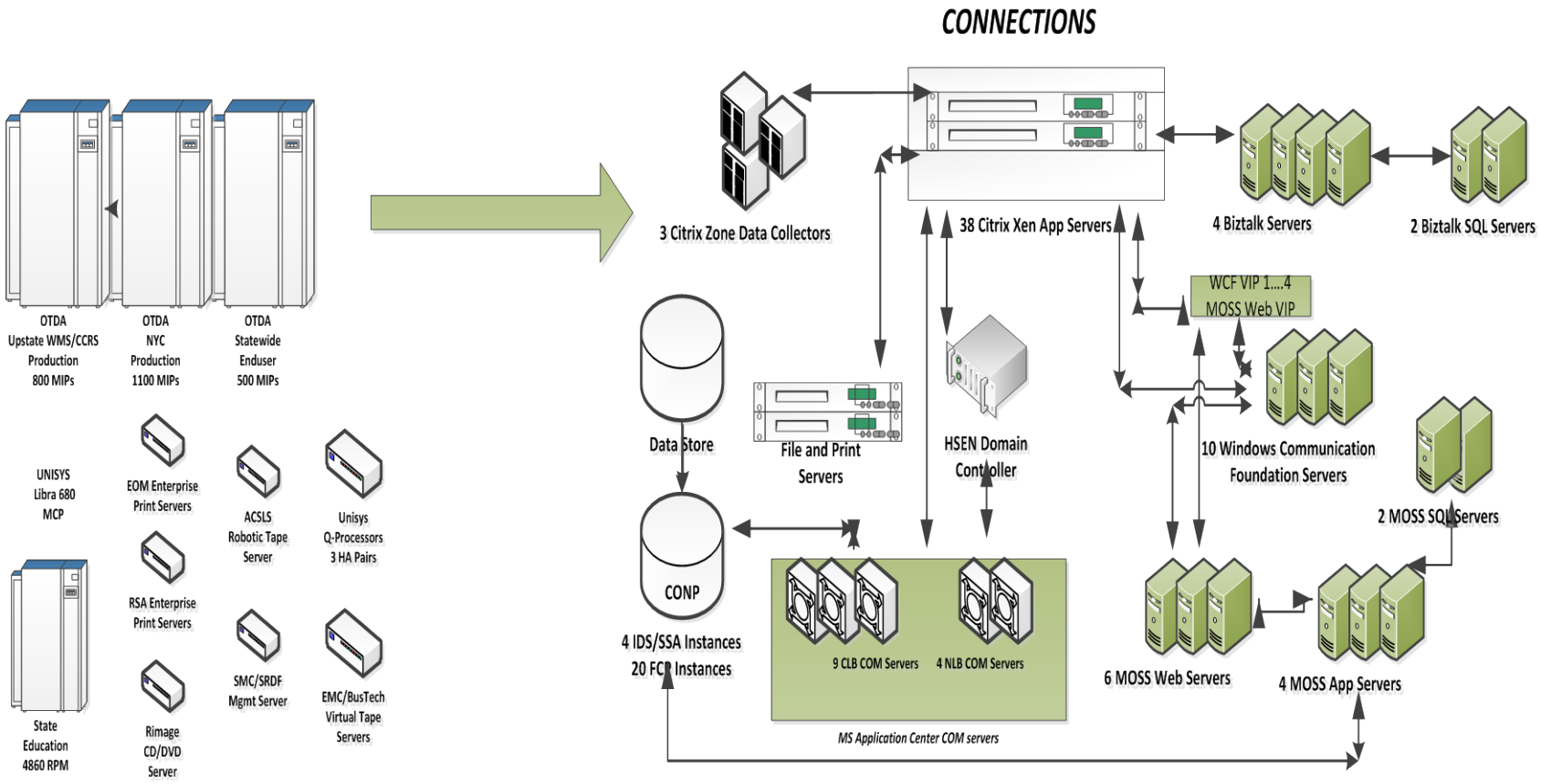


Exhibit 4-2: WMS Eligibility Determination and Communication with CONNECTIONS

Technical Architecture Supporting Business Process 2: Establishing the Foster Child's Eligibility Status, Placement and Location

A caseworker enters a child's CIN into WMS by first authenticating and getting an authorization to use the WMS system. This is done by entering a userid/password

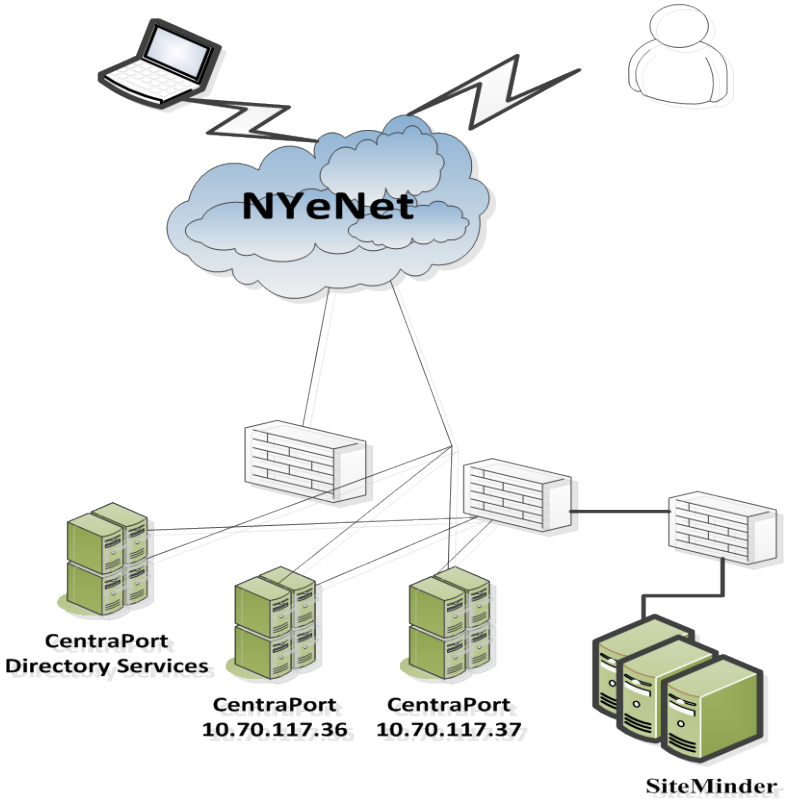


Exhibit 4-3: WMS Authentication and Authorization to Establish Eligibility Status, Placement and Location

Using the same user id/password, the caseworker records placement, location, legal guardianship and payment authorization information into CCRS. The payment and eligibility information is the passed to the State's fiscal agent so that Medicaid payments can be made to providers.

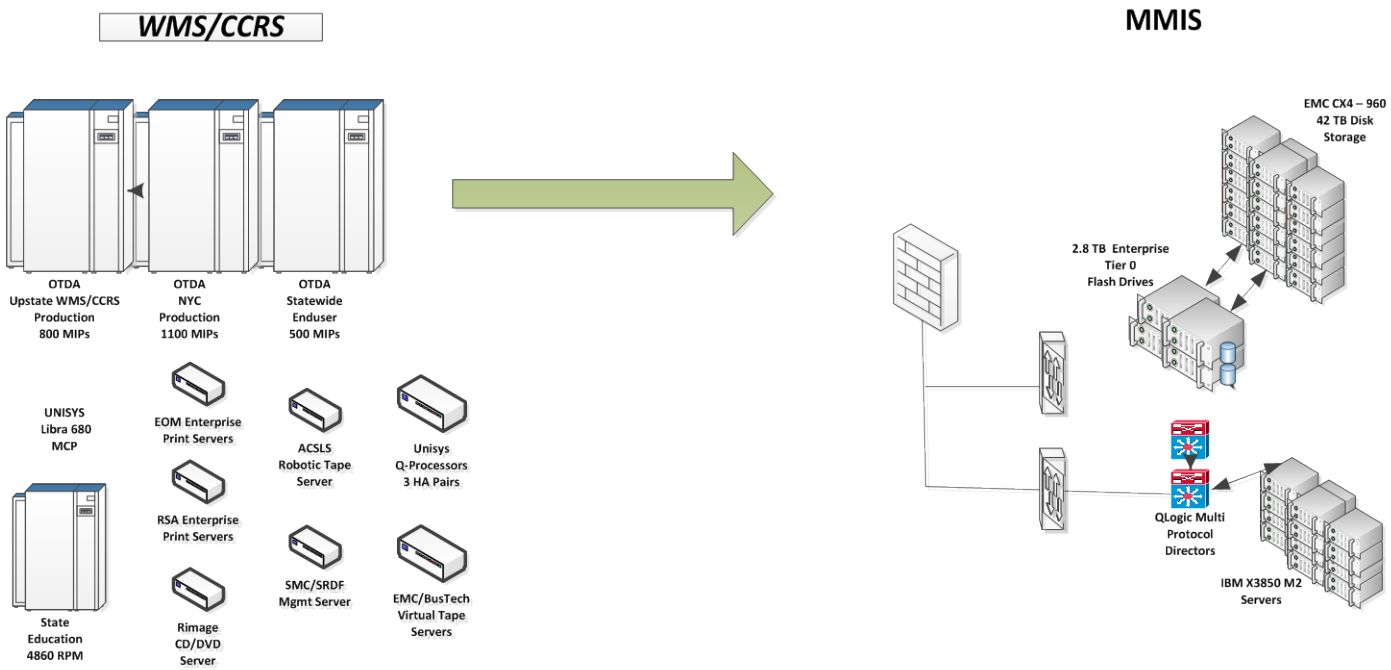


Exhibit 4-4: WMS Eligibility Determination and Communication with the eMedNY MMIS

Technical Architecture Supporting Business Process 3: Gathering, Recording and Maintaining Foster Child Health Information

Caseworker enters a limited set of health care information into CONNECTIONS' Health Services Module; at this time most data is kept in manual files.

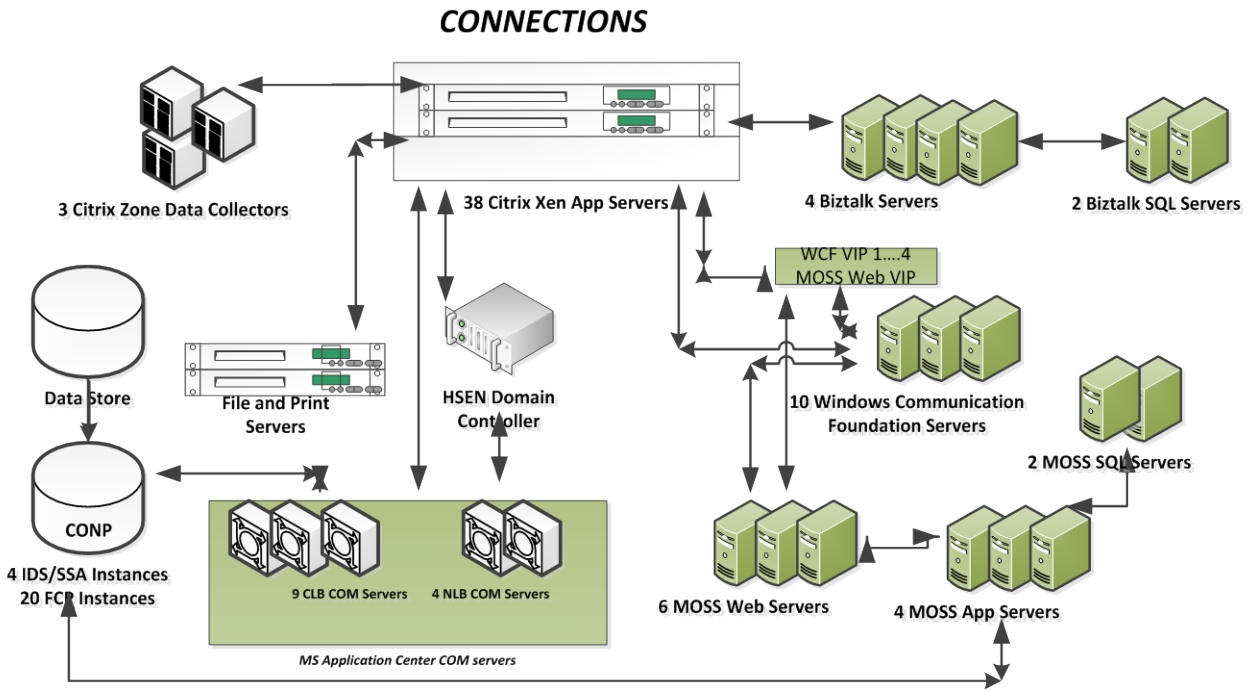


Exhibit 4-5: CONNECTIONS Health Services Module Data Entry

Appendix A: Laws and Regulations Governing Foster Care Health Information

Federal Law

431 U.S. 678: The U.S. Supreme Court in Carey vs. Population Services International – established the right of a minor to consent to reproductive health services and family planning services.

HIPAA (Health Insurance Portability and Accountability Act) – gives people certain rights regarding their Protected Health Information (PHI), including the right to keep their PHI confidential. HIPAA gives youth the authority to have control over certain categories of their own PHI.

You can find more information at: http://www.nyhealth.gov/nysdoh/hipaa/hipaa.htm More information about HIPAA and the rights of minors (under 18 years of age): http://www.cumc.columbia.edu/hipaa/policies/minors.html

New York State Law

Public Health Law (PHL) § 2504(1) – A person who is 18 years of age or older, or is the parent of a child, or has married, can give consent for medical care.

PHL § 2504(2) – Any person who has borne a child may give consent for that child's medical care.

PHL § 2504(3) – Any person who is pregnant may give consent for their own medical, dental, and hospital services relating to prenatal care.

PHL § 2504(4) – Emergency medical services can be provided to any person without consent.

PHL § 2305 – A health care provider may treat or prescribe for a person under the age of 18 for a sexually transmitted disease without the consent or knowledge of the parent or guardian.

PHL § 17 – Records concerning the treatment of a minor for a sexually transmitted disease or the performance of an abortion upon the minor shall not be released or made available to the parent or guardian of the minor without the minor's consent.

PHL § 2789(5) – Defines capacity to consent in regard to HIV testing.

PHL § 2782 – Lists who has the right to see confidential HIV-related information.

Mental Hygiene Law (MHL) § 22.11 – A minor may receive inpatient, residential, or outpatient substance abuse treatment without the consent of a parent or guardian in some cases.

MHL § 33.21 – A minor may receive mental health treatment

MHL § 33.21 – A minor may receive mental health treatment without the consent of a parent or guardian in some cases.

Social Services Law (SSL) § 384-a(2)(c)(ii) – A parent cannot be pressured or forced to sign a voluntary placement agreement, nor can the parent be charged with neglect for refusing to sign a voluntary placement agreement as long as the parent has a safe and appropriate plan for the child.

SSL § 373-a – The medical histories of a child in foster care and the child's parents must be provided to the foster parents, prospective adoptive parents, adoptive parents, and the former foster child upon request.

Family Court Act § 241 – Minors who are involved in family court proceedings will be represented by attorneys to protect their interests and to help them express their wishes to the court.

For the full text of New York State laws, visit http://public.leginfo.state.ny.us/ and click on "Laws of New York."

Foster Care Regulations

NYCRR is the official compilation of Codes, Rules, and Regulations of the State of New York.

18 NYCRR § 441.22(a); 507.1(a) – Every child in foster care is entitled to comprehensive medical and health services.

18 NYCRR § 441.15 – Psychiatric, psychological, and other essential services must be available for children in foster care.

18 NYCRR § 441.22(b)(4)(i)(e) – A youth in foster care who has the capacity to consent to an HIV test cannot have an agency-supervised,confidential HIV test without the youth's written permission.

18 NYCRR § 423.4(g)(2) – A foster care agency must provide services to keep an infant child and minor parent in foster care together, except when this arrangement would create an imminent risk of abuse or maltreatment.

18 NYCRR § 463.1 – Each social services district must provide reproductive health education and family planning services upon request to sexually active youth and youth of child-bearing age who are in foster care.

18 NYCRR § 507.1(c)(9) – The social services district must provide or arrange for family planning services within 30 days of the request.

A link to New York Codes, Rules, and Regulations can be found on the New York Department of State website at www.dos.ny.gov/info/nycrr. html.