Interim Policy in Effect

The City of New York
Administration for Children's Services

Policy and Procedure #2014/xx

Referral, Admission, and Monitoring Policy for Children Needing Nursing Homes or Skilled Nursing Facilities

<table>
<tr><td>Approved By:

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Commissioner</td><td>Date Issued:
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<tr><td>Related Laws:
Public Health Law §2801; 42 USC § 1395i-3</td><td>ACS Divisions/Provider Agencies:
Child Protection; Family Court Legal Services; Family Permanency Services; Family Support Services; foster care provider agencies</td><td colspan="2">Contact Office /Unit:
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<tr><td rowspan="2">Related Policies:
• Procedure 102/Bulletin 99-1 (Amended) - Guidelines for Providing Medical Consents for Children in Foster Care (in revision);
• Guidance #2007/02 - Revised Casework Contacts for Families with Children in Foster Care, 10/23/07 (revised 3/30/10);
• Commissioner's Memorandum - Family Team Conferencing in Residential Care, 1/27/10
• FCLS Memorandum - Revised Notifications to Attorneys for Children of Placement Changes and Placement Change Family Team Conferences, issued 2/1/12 (revised 2/6/12);
• Policy & Procedure #2013/03 - Permanency Planning, 4/5/13</td><td>Supporting Regulations:
18 NYCRR §§ 430.11, 441.21, 443.4</td><td colspan="2">Key Words:
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<tr><td>Bulletins & Directives:
N/A</td><td colspan="2">Supersedes:
Policy #2010/02 Referral and Admission Policy for Children Needing Nursing Homes or Skilled Nursing Facilities, dated May 19, 2010</td></tr>
<tr><td colspan="4">Related Forms: DOH-694 Hospital and Community Patient Review Instrument Form; DOH-695 SCREEN Form</td></tr>
<tr><td colspan="4">SUMMARY: This policy summarizes the steps necessary for the assessment, referral, and monitoring of children entering or currently in foster care who may require placement in a nursing home or skilled nursing facility.</td></tr>
<tr><td colspan="4">SCOPE: This policy applies to Administration for Children's Services ("ACS") staff in the Divisions of Child Protection ("DCP"), Family Court Legal Services ("FCLS"), Family Permanency Services ("FPS"), and Family Support Services ("FSS"), as well as to foster care provider agency staff. This policy must be followed whenever a child entering or currently in foster care may need temporary or long-term care in a nursing home or skilled nursing facility as outlined herein.</td></tr>
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I. INTRODUCTION

A. No child entering or currently in foster care may be admitted into a nursing home[1] or skilled nursing facility[2] without the written authorization and consent of the deputy commissioner of the Division of Child Protection (DCP) or deputy commissioner of the Division of Family Permanency Services (FPS). This policy summarizes the steps necessary for the assessment, referral, and monitoring of children entering or currently in foster care who may require placement in a nursing home or skilled nursing facility, also known as a residential health care facility[3].

B. <u>This policy covers the following key elements</u>:

1. Medical criteria required for admission to a nursing home or skilled nursing facility;
2. Required documentation;
3. The use of Placement Preservation and Child Safety Conferences;
4. Roles of the ACS Office of Shared Response ("OSR"), Office of Child and Family Health ("OCFH"), child protective specialist ("CPS"), and the provider agency case planner; and
5. The approval process.

II. ADMISSION CRITERIA

A. <u>Admission to a nursing home or skilled nursing facility is limited to children entering foster care or children in foster care who</u>:

1. Have been determined by a physician, nurse practitioner, or physician assistant to have severe medical needs resulting in the inability to perform basic activities of daily living independently; and/or
2. Have been diagnosed with a life-threatening medical condition requiring 24-hour monitoring by a physician or nurse.[4]

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[1] A "nursing home" is defined as "a facility providing therein nursing care to sick, invalid, infirm, disabled or convalescent persons in addition to lodging and board or health-related service, or any combination of the foregoing, and in addition thereto, providing nursing care and health-related service, or either of them, persons who are not occupants of the facility" (Public Health Law § 2801).

[2] A "skilled nursing facility" is defined as an institution (or a distinct part of an institution) which "(1) is primarily engaged in providing to residents: (A) skilled nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases; (2) has in effect a transfer agreement…with one or more hospitals having agreements in effect;… and (3) meets the requirements for a skilled nursing facility…" (42 USC § 1395i-3).

[3] A "residential health care facility" is defined as "a nursing home or a facility providing health-related service"; and "health-related service means service in a facility or facilities which provide or offer lodging, board and physical care including, but not limited to, the recording of health information, dietary supervision and supervised hygienic services incident to such service" (Public Health Law § 2801).

[4] Examples include, but are not limited to, traumatic brain and/or spinal cord injury or trauma resulting in major organ damage where the child is in a persistent "vegetative" state.

B. Regardless of the diagnosis, a physician, nurse practitioner, or physician assistant must thoroughly evaluate each child for any additional physical or behavioral problems. Case planning staff shall explore and pursue all available less restrictive alternatives[5] (e.g., foster boarding homes for medically fragile children, "Bridges to Health" services) before making a decision to place a child in a nursing home or skilled nursing facility. When nursing home or skilled nursing facility placement is the most appropriate option, case planning staff shall consider age-appropriateness and give preference to facilities that are servicing other children.

III. DOCUMENTATION

A. The assessment and approval process begins with the CPS' or provider agency case planner's submission of all supporting documentation to the ACS Office of Shared Response. This documentation shall include, but not be limited to:

1. The Hospital/Community Patient Review Instrument (H/C PRI) (Form DOH-694 - 12/2005, available at http://www.health.ny.gov/forms/doh-694.pdf) and SCREEN Form (Form DOH-695 - 2/2009, available at http://www.health.ny.gov/forms/doh-695.pdf);

2. Parental consent, as applicable;[6]

3. All applicable medical documentation regarding the request for admission to the nursing home or skilled nursing facility including, but not limited to:

   a. The most recent diagnosis and basis for the diagnosis
   b. Assistance needs for activities of daily living
   c. Nursing care needs
   d. Equipment needs
   e. A psychosocial evaluation
   f. Occupational, physical, speech, and language therapy reports, and
   g. Any other forms the prospective facility may require

4. A copy of the child's most recent educational records including (if applicable):

   a. Individualized Education Program (IEP)
   b. Individualized Family Service Plan (IFSP)
   c. Early Intervention (EI) evaluations

[5] See 18 NYCRR § 430.11 regarding the appropriateness of placements.
[6] See Procedure 102/Bulletin 99-1 (Amended) *Guidelines for Providing Medical Consents for Children in Foster Care* (in revision).

d. A letter from the child's treating physician that documents the child's ability to participate in his or her usual school program or the child's need for time-limited home/hospital instruction and the medical basis for the home/hospital instruction request

IV. CASES IN THE DIVISION OF CHILD PROTECTION (DCP)

A. If a CPS identifies a child who may need the services of a nursing home or a skilled nursing facility based on the criteria outlined in section II above, a Child Safety Conference ("CSC") must be held to discuss the child's service needs and develop a recommendation. The medical services consultant assigned to the appropriate borough office shall participate in the CSC to assist the CPS in identifying and accessing a facility that is best suited to meet the child's medical needs. If the CPS and the medical services consultant determine that the child's needs can only be met in a nursing home or a skilled nursing facility, the CPS shall forward the supporting documentation, conference summary sheet, and a nursing home placement request to the Office of Shared Response via email to Steven Bieber, executive director, at steven.bieber@acs.nyc.gov as part of a complete referral package.

B. If a CPS identifies a child who may need the services of a nursing home or skilled nursing facility based on the criteria outlined in section II above, and there is no plan to file an Article 10 petition against the parent, the CPS shall work with the parent to obtain placement in a nursing home or skilled nursing facility through the parent's health care coverage.

V. CASES IN THE DIVISION OF FAMILY PERMANENCY SERVICES (FPS)

A. If a provider agency case planner identifies a child who may need the services of a nursing home or a skilled nursing facility based on the criteria outlined in section II above, a Family Team Conference ("FTC") shall be held to discuss the child's service needs and develop a recommendation. The case planner should consider inviting the senior director for clinical programs and services in the Office of Child and Family Health to discuss the child's medical needs.

B. If the FTC consensus is that the child's needs can only be met in a nursing home or a skilled nursing facility, the case planner shall submit the supporting documentation (as outlined in section III above) and the FTC summary sheet to the Office of Shared Response by email to Steven Bieber, executive director, at steven.bieber@acs.nyc.gov.

C. Staff in the Office of Shared Response shall review all submitted documentation together with the nursing home placement request and forward this information to the Office of Child and Family Health's senior director for clinical programs and services who will review the documents for medical sufficiency. The assistant

commissioner of the Office of Child and Family Health or his or her designee shall make the final recommendation regarding medical necessity to the appropriate deputy commissioner.

VI. FINAL APPROVALS

A. If placement in a nursing home or skilled nursing facility is recommended by all reviewing parties, Office of Shared Response staff shall forward supporting documentation to the deputy commissioner of DCP or the deputy commissioner of FPS for final approval.

B. No child entering or currently in foster care may be admitted into a nursing home or skilled nursing facility without the written authorization and consent of the deputy commissioner of DCP or the deputy commissioner of FPS.

C. For DCP cases, the **CPS** shall make arrangements for the child's admission to the facility with the facility representative after receiving approval. For FPS cases, the **provider agency** shall make arrangements for the child's admission to the facility with the facility representative after receiving approval. Before applying to a nursing home or skilled nursing facility for admission of a youth in foster care or otherwise in the custody of the commissioner of ACS, the Hospital/Community Patient Review Instrument (H/C PRI) must be completed by a qualified assessor who has a New York State Department of Health (DOH)-issued identification number.

1. A qualified assessor may be an employee of a hospital or a community provider, which includes both community-based medical practitioners as well as foster care provider medical personnel. Following the completion of this instrument, a SCREEN[7], which is based on federal regulations, must be administered for the following reasons:

    a. To determine the individual's capacity to be properly cared for in a place other than a residential health care facility.

    b. To assess individuals who are being recommended for a nursing home or skilled nursing facility for potential mental illness (MI) and/or mental retardation or developmental disability (MR/DD) with a Level I Review.

2. The SCREEN must be completed by a health care professional who has completed the DOH SCREEN certification course and has been given a 10-digit SCREENER identification code. Trained SCREENERS in residential health care

[7] The New York State Department of Health (DOH) SCREEN Form (DOH-695) is an assessment tool that a qualified assessor must complete in order to place an individual in a nursing home or skilled nursing facility.

facilities, hospitals, certified home health agencies, long-term home health care programs, and community-based and independent health care agencies are permitted to complete the SCREEN form. For updates or more information on this process go to www.nyhealth.gov or call 1-866-333-4702.

3. The case planner or CPS is responsible for verifying that the required forms, H/C PRI, and SCREEN have been completed by the health care professional and are included as part of the supporting documentation that must be submitted to the appropriate ACS staff, and that copies of these documents have been placed in the child's case file. In the case that the Level I Review exhibits an individual who is suspected of having a serious mental illness and/or mental retardation/developmental disability, the next step is to conduct a Level II Pre-Admission Screen Resident Review ("PASRR"). The Pre-Admission Screen ("PAS") of the PASRR refers to individuals pursuing nursing home or skilled nursing facility placement, and the Residential Review ("RR") of the PASRR requires a Level II Referral for individuals presently living in a nursing home or skilled nursing facility. The Level II Evaluation will provide information about the need for specialized services and placement recommendations.

VII. CASE PLANNING/MONITORING RESPONSIBILITIES AFTER ADMISSION

A. Coordination of Inpatient Care and Discharge Planning

1. Children in foster care who have been diagnosed with having specific complex physical or cognitive conditions require nursing home or skilled nursing services, as ordered by a licensed physician (i.e., MD or DO). It is important that child welfare staff, the selected nursing home or skilled nursing facility treatment team, and the discharge resource coordinate the inpatient care and discharge planning for children with complex medical needs.

2. It is equally critical that any other child-serving systems that are working with the child and caregivers are engaged, and that parents and foster parents are involved in the child's treatment and discharge planning whenever appropriate. The following section of this document clarifies the responsibilities of DCP, foster care provider agencies, and case planners when it has been determined that a child in foster care requires the services of a nursing home or skilled nursing facility.

B. Immediate Case Planning Responsibilities - Contact with the Facility:

When a child is placed in a nursing home or skilled nursing facility through a planned nursing home or skilled nursing facility placement (non-emergency basis), contact with the nursing home or skilled nursing facility must be initiated within 24 hours of the child's admission and must be maintained with at least one member of the

treatment team (e.g., physician, nurse, social worker, and any individual involved in the case) through the following contacts:

1. Daily phone contact for the first three (3) days of the child's admission;
2. Weekly phone contacts after the first three (3) days for the duration of the child's stay in the facility; and
3. Additional contacts as needed, determined by the treatment team and based on the child's progress and condition.

C. Immediate Case Planning Responsibilities - Notification to the Division of Family Court Legal Services

The foster care provider agency case planner must immediately alert the Division of Family Court Legal Services ("FCLS") through the notifications mailbox after receiving information of the child's nursing home or skilled nursing facility admission or any other change of placement as soon as it is being considered. The mailbox is administered and managed by FCLS. All notifications must be sent to the mailbox at one of the following email addresses: notify@dfa.state.ny.us OR acs.sm.notify. FCLS staff will then contact and inform the designated FCLS attorney and the assigned attorney for the child. In cases where parental consent has not been received, FCLS will make efforts to inform the parent or parent's counsel.

D. Ongoing Case Planning Responsibilities

Current foster care casework contact requirements apply when children are placed in nursing homes or skilled nursing facilities. These requirements are set forth in New York State regulations[8] and in ACS Guidance #2007/02, *Revised Casework Contacts for Families with Children in Foster Care*, dated October 23, 2007 and revised on March 30, 2010[9]. Refer to these documents for guidance regarding the required casework contacts for children placed in nursing homes or skilled nursing facilities.

E. Monitoring the Appropriateness of the Placement

1. The case planner, with the assistance of the treatment team, shall monitor and document the progress of a child who has been placed in a nursing home or skilled nursing facility. This includes monitoring the child's physical and mental health, monitoring compliance with the child's service plan, and arranging all required conferences.

[8] See 18 NYCRR §§ 441.21; 443.4.
[9] See the ACS Policy Library at http://www.nyc.gov/html/acs/html/home/policy_library.shtml.

2. The case planner is responsible for continually monitoring the appropriateness of nursing home or skilled nursing facility care. If it is indicated that the child's physical and mental health needs can be met at a less restrictive level of care, the case planner is responsible for actively seeking to identify a less restrictive placement for the child and, upon finding such an appropriate placement, placing the child in this less restrictive setting.

3. The Division of Family Support Services ("FSS") Clinical Programs and Services Unit ("CPSU") shall monitor the appropriateness of the child's stay in the nursing home or skilled nursing facility and the extent to which his or her medical service needs are being met. The CPSU will work with the CPS or case planner to obtain and maintain a list of foster children in its database currently residing in nursing homes or skilled nursing facilities. The information will be extracted from the case planner's report after each required casework contact and quarterly phone calls made to the medical director of the selected nursing home or skilled nursing facility.

4. The CPSU shall provide technical assistance and make direct quarterly phone calls to the nursing home or skilled nursing facility to verify that case planning-related activities are ongoing and to confirm any changes in the child's current medical condition or status.

F. Education Services

The case planner is responsible for regular case planning activities throughout the child's stay at the nursing home or skilled nursing facility. These case planning activities include addressing the child's educational needs, in consultation with the ACS Office of Education Support and Policy Planning[10], as needed.

G. Notification of Placement Change

If it is determined that a child's current nursing home or skilled nursing facility is not meeting his or her needs, the foster care case planner must convene a Placement Preservation Conference to discuss the issues that may warrant a placement change. FCLS must provide notice of the conference to the attorney for the child. Placement stability may also be addressed in a Permanency Planning FTC. If the child's placement does change, as with any placement change, the case planner is required to follow current ACS procedures with regard to documentation, notifications, and approvals of the placement change.[11]

[10] For guidance and consultation on education services for children in foster care, contact Kathleen Hoskins, Director of the Children's Services Office of Education Support and Policy Planning, at kathleen.hoskins@dfa.state.ny.us

[11] See FCLS Memorandum, *Revised Notifications to Attorneys for Children of Placement Changes and Placement Change Family Team Conferences (Originally issued February 1, 2012)*, February 6, 2012.

VIII. DISCHARGE PLANNING/PERMANENCY PLANNING

A. Planning for Discharge

1. In order to facilitate and expedite a seamless discharge of a child from a nursing home or skilled nursing facility, the case planner is expected to begin planning for discharge upon the child's admission to the facility. In some cases, discharge planning involves transitioning from the child welfare system to adult placement with the Office of People with Developmental Disabilities (OPWDD).[12]

2. During each casework contact with the child, parent, foster parent, caretaker, and treatment team, the case planner shall discuss ongoing progress toward the child's discharge, including any training the parent or foster parent may need to meet the child's special medical needs. This will include training on the operation of any medical device/equipment that the child may need to use. In addition, any potential changes and contingencies in the discharge plan need to be discussed. The case planner is required to conduct the appropriate FTC prior to discharge.[13] Upon the outcome of the FTC, the case planner is required to follow current ACS procedures with regard to proceeding with or relinquishing the plan to discharge.[14]

B. Follow-Up Care

Discharge planning shall include all the appropriate follow-up care after the child leaves the nursing home or skilled nursing facility. The case planner must request a written service plan from the facility, which shall include:

1. Information on the child's current physical/mental status;
2. Information on the child's medication and/or medical equipment needs;
3. The child's diagnos(es) upon discharge and treatment recommendations; and,
4. Information regarding referrals for outpatient treatment and other community-based health services, including contact information, appointment dates and times, and the status of referral packages. The facility treatment team should make these referrals in coordination with the planning agency.

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[12] The case planning agency must contact the ACS Developmental Disabilities Unit at (212) 341-3384 or ddunit.fss.acs.nyc.gov prior to the youth's 18th birthday to start the eligibility determination and referral process for OPWDD adult housing/services. The process must begin early in order to secure proper clinical documentation for OPWDD to determine the youth's eligibility for long-term OPWDD services.

[13] See Commissioner's Memorandum, *Family Team Conferencing in Residential Care*, 1/27/10.

[14] See Policy and Procedure #2013/03 *Permanency Planning*, 4/5/13.