Guidelines for Foster Care Public Health Nurses:
Consultation and Care Coordination for
Out-of County Placements

The purpose of this guideline is to assure statewide uniformity for peer to peer Foster Care Public Health Nurse (FC-PHN) consultation and health care coordination for children/youth placed outside of their county of jurisdiction or transferred into a new county of jurisdiction.

On behalf of the child, FC-PHNs work collaboratively with a variety of persons and systems to assist the caseworker to assure:

- Timely communication with the foster care team members;
- Relevant consultation on health care needs;
- Effective collaboration with the principle parties involved in case supervision and provision of services; and
- Accurate and timely documentation in the case record.

GOAL:

Each child in out-of-county placement shall receive timely and appropriate health care services consistent with the case plan.

GUIDELINE:

To accomplish this goal, FC-PHNs will collaborate with their FC-PHN counterparts and foster care team members in the relevant counties to ensure that the health care needs are addressed and documented in the Child Welfare System/Case Management System (CWS/CMS), Health and Education Passport (HEP) or its equivalent. Specifically,

1. The caseworker and the FC-PHN in the county of jurisdiction are responsible for care coordination to ensure health care services are obtained and documented for the child/youth in the county of placement. The Foster Care PHNs in the counties of jurisdiction and placement will notify and consult with each other on the needed care coordination activities once they become aware of the out-of-county placement status of the child.

2. The FC-PHN in the county of placement will provide a list of health care providers and information on community support service contacts to the county of jurisdiction foster care team as needed. Further involvement in care coordination, i.e. facilitating referrals, follow-up on health services needs, and consultation with the substitute care provider will depend upon the complexity of the health services needs and the availability of the FC-PHN in the county of placement for these activities.

PROCEDURE:

Situation 1. **When the jurisdictional responsibility for the child/youth is transferred from one county to another county, full financial responsibility for case supervision and services become the responsibility of the new county of jurisdiction.**

1. The FC-PHN and caseworker in the county of jurisdiction work together to address health care needs and keep the HEP up-to-date.

2. When notified of the transfer-in, the FC-PHN in the new county of jurisdiction may contact the FC-PHN in the previous county to confer on the health care services needs of the child/youth.

Situation 2. **When the child/youth is placed outside of the county of jurisdiction, the original county Juvenile Court maintains responsibility even though the placement is in another county. The case stays with the caseworker in the original county of jurisdiction. Health services are usually provided in the county of placement.**

1. The FC-PHN and caseworker in the county of jurisdiction assure health care needs are addressed and documented in theCWS/CMS, HEP or its equivalent.

2. The FC-PHN in the county of placement will provide a list of current medical, dental, developmental and mental health providers.

3. The FC-PHN in the county of placement may be requested to:
   a. consult on the availability of health services in the county of placement
   b. provide updates as often as needed,
   c. participate in case conferences as necessary, and
   d. assist with the documentation of services.

Situation 3. **When the child/youth is placed outside of the county of jurisdiction, the original county Juvenile court maintains responsibility and then contracts with the county of placement for selected supervision and services. Case supervision and services are outlined in the written agreement (contract) between the contracting counties. Health services are usually provided in the county of placement.**

1. The FC-PHN in the county of jurisdiction will work with the caseworker to assure health care needs are addressed and documented in CWS/CMS, HEP or its equivalent.

2. The FC-PHN and caseworker in the county of jurisdiction assure that all health information including the HEP is sent to the county of placement in a timely manner.

Note: Key to the success of FC-PHN consultation and care coordination is prompt notification from the case worker of the location of the child/youth and the terms of the written agreement regarding the health care services.

KEY ELEMENTS TO SUPPORT THE PROCEDURES

FC-PHNs must have:

- **Access to past, current and future health care needs and services information for the child/youth;**

- **Contact with the sending/ receiving caseworker and sending/receiving FC-PHN** responsible for the case planning, supervision and services. Prompt communication through the use of the telephone, FAX and/or CWS/CMS;

- **Information on the jurisdiction and current placement** from the caseworker who is requesting health services consultation for a child/youth. Timely and accurate notification of changes in placement is essential (Child Welfare System/Case Management System or contact with the child welfare services supervisor);

- **Access to caseworker** for consultation on health issues i.e. Medi-Cal eligibility determination, Medi-Cal aid code transfer, Medi-Cal Managed Care Plan dis-enrollment and secondary residence assignment, removal of Other Health Coverage code from the Medical Eligibility Data System (MEDS);

- **Active knowledge of the provider resources and community support services** available to provide services to children/youth in foster care within the county of placement; and

- **Access to local CHDP program personnel** for information on the provider network and the coordination of resources for the child/youth as needed.