



Administrative Policies and Procedures: 20.22

Subject:	Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome
Authority:	TCA 37-5-106
Standards:	DCS 7-100 A, 7-101 A, 7-104 A, 7-111 B, 7-201 A, 8-306
Application:	All Department of Children's Services Employees

Policy Statement:

The Department of Children's Services (DCS) will protect the safety and health of children/youth by providing accurate information and appropriate resources for HIV-related health services, and respecting the right to privacy and confidentiality of children/youth in custody as well as their families. We will provide children/youth with a diagnosis of **Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)** quality medical care and a range of social services appropriate to their unique needs and the needs of their families.

Purpose:

The Department of Children's Services believes that good health is a basic human right. Children/youth with an HIV/AIDS diagnosis will be protected from any elements of alienation from the greater community through culturally competent care and respect.

Procedures:

A. Confidentiality

Maintaining confidentiality is particularly important when dealing with HIV-infected individuals. The confidentiality requirements for the disclosure of HIV/AIDS are more stringent than those for other medical records. Consent is required to disclose HIV related information unless the disclosure is otherwise authorized or required by law. HIV/AIDS confidential information is defined as information that a child/youth:

- a) Has submitted to an HIV test,
- b) Has had a positive or negative result from an HIV antibody test,
- c) Has sought and received counseling regarding HIV/AIDS,
- d) Has been determined to be a person at risk of being infected with HIV,
- e) Has been determined to be infected with HIV,
- f) Has been diagnosed as having AIDS, or
- g) Has been or is being treated for AIDS.

<p>B. Need to Know</p>	<p>The Department of Children's Services (DCS) staff and private provider staff will respect the right of the individual child/youth to confidentiality with regard to his/her HIV-antibody status or AIDS diagnosis. Information that is shared will be held in strict confidence and shared only with designated individuals on a right to know basis.</p> <ol style="list-style-type: none"> 1. Resource parents should be given known information on the child/youth's HIV status or high risk behaviors as part of the existing DCS requirement that resource parents be given information about a child/youth's medical and social history. Only non-identifying information should be shared before placement. 2. The Primary Care Provider (PCP) must be informed by the Family Service Worker (FSW) and/or resource parent. 3. Persons who may have a need to know are as follows: <ol style="list-style-type: none"> a) Central office program staff, b) Regional Health Unit Nurse, c) Regional Administrator, d) Team Coordinator, e) Team Leader, f) Family Service Worker (FSW), g) DCS legal staff, h) DCS Group Home Director, i) DCS Group Home Case Manager, j) YDC Superintendent, k) YDC Health Clinic staff, l) TDC Case Manager, m) Private Provider Agency Director, or n) Private Provider Agency Case Manager. 4. All other determinations of need to know will be on a case-by-case basis. 5. Sharing information with public schools is allowed. Determination of the school's need to know should be made in conjunction with medical personnel involved in the management of the child/youth's care and treatment and such disclosure should be to specific school personnel such as the principal and school nurse. 6. Any persons who are not employed by the Department of Children's Services and receive such information should be warned that disclosure of HIV status information relative to a child in custody to persons who do not have a necessity to know for treatment, counseling or case work purposes will be considered in violation of laws protecting the confidentiality of children receiving foster care services. Resource parents should be advised not to
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	<p>discuss the child's status with anyone who does not have a need to know.</p>
<p>C. Documentation</p>	<ol style="list-style-type: none"> 1. HIV/AIDS information is protected according to TCA 68-10-104 and needs to be kept in strict confidence except as outlined in Section B Need to Know. Any medical information regarding HIV status should be kept in hard copy form in a separate medical file. In the YDCs, HIV medical information can be kept in the medical file which is separate from the case file. 2. No documentation should be entered in the current child welfare information system or on the Permanency Plan about the HIV status of the child/youth or any family members of the child. A statement will be entered in the current child welfare information system medical section and on the Permanency Plan that the child/youth has a serious medical condition and that further information can be obtained from the Health Advocacy Nurse.
<p>D. HIV Testing and Special Populations</p>	<ol style="list-style-type: none"> 1. The Center for Disease Control (CDC) recommends that foster care and adoption agencies consider screening high-risk children. The child/youth's Primary Care Provider can evaluate his/her risk for HIV infection and, if indicated, can perform the test during a routine medical examination. The Health Dept. can test youth ages 13 years and up who want to voluntarily consent to a test. The child/youth's medical condition, family and social history/Functional Assessment, and risk assessment determinations must guide testing decisions. 2. Repeated testing should done if the child/youth continues to engage in risk behaviors, continues to be symptomatic and/or at the recommendation of the Primary Care Provider or the Department of Health. <p><u>Infants Born to HIV Infected Mothers</u></p> <ol style="list-style-type: none"> 3. Babies of HIV-positive women should be tested for the virus within 48 hours of birth. These early tests, which detect the virus itself, instead of antibodies, can detect about 40 percent of infected newborns. Testing is generally repeated, allowing identification of most infected babies by one month, and virtually all by six months. (The HIV screening test, which tests for antibodies to the virus, is not reliable for an infant born to an infected mother. This is because the mother's antibodies may be present in her baby's blood for up to 18 months, even if the baby has not been infected.) A negative HIV-specific IgG assay (ELISA) at 18 months of age definitively rules out HIV infection in exposed infants. <p><u>Pregnant Females</u></p> <ol style="list-style-type: none"> 4. The Center for Disease Control (CDC) recommends HIV screening for all pregnant women. HIV testing is important because antiviral therapy can improve the mother's health and greatly lowers the chance of an HIV-infected pregnant woman passing HIV to her infant before, during, or after birth. The treatment is most effective when started as early as possible during pregnancy.

<p>E. Factors to Determine Testing</p>	<ol style="list-style-type: none"> 1. Child/youth has symptoms. Some children/youth infected with HIV do not have any symptoms at all for many years; however some develop symptoms within a short period of time. HIV can have a variety of effects. The following may be warning signs of HIV infection when they persist for several months or recur over time: <ol style="list-style-type: none"> a) Persistent fever, b) Chronic or recurrent cough, c) Chronic or recurrent diarrhea, d) Persistent or recurrent swollen lymph glands, e) Chronic or recurrent ear infections, f) White spots or unusual blemishes on the tongue, in the mouth, or in the throat, g) Pneumonia, h) Red, brown, pink, or purplish blotches on or under the skin or inside the mouth, nose, or eyelids, or i) Failure to thrive or developmental delays. <p>Note: Each of these symptoms can be related to other illnesses, so this is not a definitive list.</p> 2. HIV test results are positive for either parent. 3. Either parent has a history of HIV infection or has died from HIV/AIDS infection 4. The child/youth has been sexually abused or sexual abuse is suspected, and there was intimate sexual contact. 5. The parent has been involved in risk behaviors and the child is under age 9. 6. The child/youth has been involved in risk behaviors associated with HIV.
<p>F. Informed Consent for HIV Testing</p>	<ol style="list-style-type: none"> 1. Consent for HIV testing of children/youth is not considered routine. The decision to test a child/youth is based on the consideration and protection of the rights and medical concerns of that particular individual. 2. HIV testing of a child/youth can <u>only</u> be performed after written consent is obtained from either the parent, guardian or in some cases, the mature minor. If the parent, guardian or youth refuses, DCS Regional legal staff should be consulted. If the child/youth is in full guardianship, the DCS Team Coordinator can give consent. Resource parents may not have a child/youth tested for HIV without consultation with the FSW and the Health Unit Nurse, and obtaining appropriate consent. 3. In accordance with Tennessee Code Annotated 68-10-104, minors in Tennessee can consent to the confidential diagnosis and treatment of STDs, including HIV through the local Health Dept. The test results are confidential and the Health Department only shares the results with the youth

	<ol style="list-style-type: none"> 4. HIV testing should not be done without consideration of the need to test for other sexually transmitted diseases. 5. Testing may be performed on a child/youth if there has been a significant exposure to health care personnel, emergency response workers, DCS staff, or other children/youth. Written permission must be obtained prior. If the child/youth or parent refuses, DCS Regional legal staff should be consulted. (
G. Pre and Post Test Counseling	<ol style="list-style-type: none"> 1. The health care provider is required to provide pre and post test counseling to the individual being tested for HIV, or, in the event that informed consent is given by the parent, guardian, or DCS staff, to the person giving consent. 2. If a HIV test is positive, the Department of Health policies require the Primary Care Provider or designee to: <ol style="list-style-type: none"> a) Notify the individual, from whom the blood sample was obtained, about the positive result in a face-to-face contact and b) Provide the individual with written information about HIV infection. c) If the test is negative, the individual may be advised to repeat the HIV test at a certain time in the future as it takes time for the body to develop HIV antibodies after infection. Almost all people develop HIV antibodies within 3 months, but it can take up to 6 months. d) Counsel the individual to inform all sexual and needle sharing partners of the positive HIV status, and gather information regarding these partners for contact tracing. In contact tracing, the individual's name will not be disclosed. The local Health Department is then required to refer the partners for care support and treatment. e) Advise the individual that the results must be reported to the Tennessee Department of Health.
H. Treatment	<ol style="list-style-type: none"> 1. There are three goals of HIV therapy; one is the maximal suppression of the HIV virus in those patients on antiretroviral therapy, another is the prevention of opportunistic infections and cancers, and a third is the management of other complications such as wasting disease. Education and support play a critical role in improving outcomes. Children/youth and families should be counseled regularly and provided a wide range of education materials and support services. 2. A Child/youth diagnosed with HIV or AIDS should be referred to a specialist or specialty clinic if at all possible. If a specialist is not geographically available, a consultation arrangement should be set up between the Primary Care Provider and a specialist via telephone or telemedicine. The Centers of Excellence are a good resource. 3. The CDC recommends that a baby born to an HIV-positive mother, even if the baby has not yet been diagnosed with HIV or AIDS, be treated beginning at four to six weeks of age, with drugs that help prevent pneumonia. The medication should be continued until HIV infection is ruled out.

	<ol style="list-style-type: none"> 4. Babies with HIV infection should receive all routine childhood immunizations, plus some additional ones. The chickenpox vaccine, however, is not recommended. Babies with HIV/AIDS should be vaccinated yearly against influenza, starting at seven months of age, and should receive the conjugated pneumococcal vaccine in the first year. 5. HIV positive children/youth should be referred to the DCS Health Unit Nurse for consultation. A referral should also be made for case management services through TennCare Select, if appropriate. 6. It is vital that HIV/AIDS patients continue their treatment with as little interruption as possible, provisions must be made for them to continue therapy if their placement is changed. This includes obtaining a supply of medications, making appointments for follow-up, forwarding medical records, and, in some cases, arranging for medical insurance coverage when the child/youth is discharged to home or discharged from a YDC.
<p>I. Rights</p>	<p>Individuals with HIV infection or AIDS are considered to be handicapped under 504 of the Rehabilitation Act of 1973 and under the Americans with Disabilities Act and therefore have the same rights as anyone else to employment, health care, welfare and social services.</p>
<p>J. Placement</p>	<ol style="list-style-type: none"> 1. Optimally, testing for children/youth that are at risk for HIV infection should be done as part of the pre-placement physical. However, since this will not always be feasible, the placement should be informed that consultation will be arranged when a child is considered to be at risk for HIV infection. When placing a child/youth in a foster home, a child/youth at risk for HIV infection should be placed with foster parents who have indicated that they are willing to care for a child who might possibly be infected with HIV. 2. Efforts are to be made to place each child/youth in the most home-like setting where the child's emotional needs can be met and the risk for further infection from other viruses and bacteria will be minimized. Youth known to have HIV/AIDS may be referred for placement to a group home or treatment facility after an assessment of his/her behavior and medical condition. Juvenile justice youth diagnosed with HIV/AIDS and housed in a Youth Development Center will be maintained in the facility's general population. 3. Children/youth with HIV/AIDS may be medically fragile depending on their clinical care needs as defined in the Medically Fragile Scope of Services. 4. Successful placement of an HIV infected child/youth requires careful preparation. Before a HIV positive child/youth is placed, the FSW and Placement Services Division (PSD) or Resource staff must make the following determinations: <ol style="list-style-type: none"> a) Make sure the caregiver has consented to care for a child with HIV infection. b) The caregiver understands the child/youth's symptoms and required

	<p>care.</p> <p>c) The caregiver has assistance in setting up specific supports including, but not limited to, medical care and consultation, treatment services, transportation, and support groups.</p>
<p>K. Adoption</p>	<p>Children/youth preparing to enter adoptive placements shall be referred to their regular Primary Care Provider for a review of history and other indicators to determine if HIV testing is warranted under the following circumstances:</p> <ol style="list-style-type: none"> 1. Any of the circumstances in HIV risk factors apply or 2. The adoptive parents request HIV testing and specific health history information is unavailable, i.e., child abandoned and parents cannot be located.
<p>L. Occupational Exposure of Staff</p>	<p>Transmission of the HIV virus through casual contact has not been documented and is highly unlikely. Every employee shall use universal precautions when interacting with children/youth. (see DCS Policy 20.19 Communicable Diseases, section L Universal Precautions) In those rare instances when staff is exposed or exposure is suspected, the guidelines in the department's Exposure Control Manual for Bloodborne Pathogens must be followed.</p>

<p>Forms:</p>	<p>CS-0683, HIV Antibody Test Informed Consent</p>
<p>Collateral documents:</p>	<p>Exposure Control Manual for Bloodborne Pathogens Attachment to Policy 20.22</p>