


<b>1652 HIV-1/AIDS AND CHILDREN IN CARE</b>	
Chapter: <b>Out-of-Home Placements</b>	Section: <b>Well-Being</b>
	New Hampshire Division for Children, Youth and Families Policy Manual Policy Directive: <b>94-11</b> Approved: Effective Date: <b>April 11, 1994</b> Scheduled Review Date: _____ DCYF Director
	Related Statute(s): <a href="#">RSA 141-F</a> , <a href="#">RSA 169-B</a> , <a href="#">RSA 169-C</a> , <a href="#">RSA 169-D</a> , and <a href="#">RSA 170-E</a> Related Admin Rule(s): _____ Related Federal Regulation(s): <a href="#">PL 101-239</a>

**Purpose**

To establish the policy and procedures for sharing information about HIV/AIDS, testing for HIV-1, and placing children with HIV or AIDS.

**Definitions**

**"Acquired Immune Deficiency Syndrome"** (AIDS) means a severe infection of the immune system caused by the human immunodeficiency virus (HIV), which results in an acquired defect in immune function that reduces the infected person's resistance to opportunistic infections and cancer. (Meeting the Challenge of HIV Infection in Family Foster Care, CWLA 1991.)

**"Human Immunodeficiency Virus"** (HIV) or its variants, means the causative agents of acquired immune deficiency syndrome (AIDS), AIDS related conditions, and other clinical manifestations. (RSA 141-F:2, V.)

**"Serologic Positive"** means the presence in an individual, as detected by laboratory testing, of an antibody or antigen to the human immunodeficiency virus. (RSA 141-F:2 VI)

**"Universal Precautions"** means the practices individuals carry out in daily living to minimize the potential exposure to infectious agents between individuals. These practices are to be used "universally" to reduce the risk of transfer of communicable diseases.

**Policy**

- I. Sharing of Information
  - A. Information regarding HIV tests, tests results, and the child's medical status is strictly confidential. Physicians or persons authorized by a physician will follow their own guidelines/requirements concerning disclosure of test results to the child's parents or legal guardian. The parents or legal guardian is entitled to medical counseling.
  - B. If the parents or legal guardian of a child in foster care receive HIV test results, they must be encouraged to share this information, for their child's proper care and treatment, with the CPSW or JSO assigned to them.
  - C. If the parents or legal guardian refuses to share test results, the child must be considered at high risk of having the HIV infection and the foster parents must be advised to take universal precautions.

- D. When DCYF has legal responsibility for a child and the child is placed in foster care or an adoptive home, DCYF must inform the foster parents, adoptive parents, or the residential facility's director of the child's actual or suspected HIV status. Under the 1989 Amendments to the Adoption Assistance and Child Welfare Act (PL 101-239), case plans must include comprehensive health care information about the child and "a child's health and education record...." This law also requires the case plan be reviewed and updated, and supplied to the foster parent or residential care provider with whom the child is placed.
- E. RSA 170-E 13 requires "the release of information to persons receiving the (foster or adopted) child which pertains to the life and safety of the child either about to be placed or already in placement, and which may pertain to the life and safety of the persons who are receiving or who have received the child for placement."
- F. Information concerning HIV status, previous test results, treatment, or illness may be obtained with consent of the child if the child is 14 years or older or with the consent of the child's parents or guardian if the child is younger than age 14. If consent is given, this information is to be shared with foster parents or other residential care providers so they may provide care to the child.

## II. Risk Categories for HIV Infection

- A. Children are at varying risk of HIV infection depending on their parents as well as their own behaviors and/or circumstances. Described below are risk categories designed to assess the risk of contracting the HIV virus for children and the need for testing. These categories are to be used as a guide to decision making:
  - 1. Minimal Risk - "no testing recommended."
    - (a) No apparent risk factors are present.
    - (b) Sexual abuse is not suspected.
    - (c) Youth is not sexually active.
    - (d) Neither the parents nor the child received blood or blood products between 1978 and 1985.
  - 2. Moderate Risk - testing is recommended for these children.
    - (a) Child is born to an injection drug user or child is born with a positive urine toxicology for illicit drugs, e.g., crack/cocaine, and some other associated risk factor is present, or the sexual history of parent is unknown.
    - (b) Child has been sexually abused by an injection drug user or an individual whose drug history is unknown.
    - (c) Child has been sexually abused by an individual whose sexual history is unknown.
    - (d) Mother had a sexually transmitted disease during pregnancy and either the mother or the child had a positive VDRL (syphilis test) at the time of delivery.

- (e) Older child has a parent or sibling who is HIV infected.
3. High Risk - testing is strongly recommended.
- (a) Child displays symptoms consistent with HIV infection/AIDS.
  - (b) Child is under 5 years of age and a parent or sibling has been diagnosed as HIV infected or died of AIDS-associated illnesses. This age limit may increase as older asymptomatic children are identified.
  - (c) Child's family history includes an unexplained, premature death of a parent or sibling which may be due to HIV infection, e.g., PCP pneumonia, AIDS related opportunistic infections, and some other associated risk factors exists.
  - (d) Child or child's family refuses to share HIV test results with DCYF.
  - (e) Child is born to an injection drug user or child is born with positive urine toxicology.
  - (f) Child is born to a parent who is presenting symptoms consistent with HIV infection and who has had a drug history.
  - (g) Child is injection drug user or sexually active and may not take precautions to prevent infection.
  - (h) Child has been sexually abused with oral, anal, or vaginal penetration and the perpetrator is HIV positive, at risk for HIV, or not known.

### III. Testing

- A. Regular or routine testing is not required or desirable for children in foster care.
- B. Testing of children under age 2 whose birth mother is known to be HIV positive is inconclusive because the test may be positive for HIV antibodies, but the child may not be infected.
- C. Any decision to request or encourage testing must be considered very carefully because of the need to provide treatment and prevent further infection to the child and the caregivers.
- D. The risk categories in POLICY part II must be used to determine if a test is to be requested from a physician.
- E. Under RSA 141-F:5 the "person being tested must be informed about the medical interpretations of positive and negative test findings and the applicable provisions of RSA 141-F:7 and RSA 141-F:8" and then the person must consent to the test of an antibody or antigen to an HIV virus. For children under 14 years of age consents for HIV testing must be obtained from the child's parents or legal guardian.
- F. Adolescents 14 years and older (RSA 141-C:18 II Sexually Transmitted Disease) who have symptoms consistent with HIV infection cannot be required to be tested but are to be encouraged to seek counseling and testing.

- G. Children under 14 years of age who have symptoms consistent with the HIV infection can request testing but must have the informed consent of their parents or legal guardian to be tested.
- H. If DCYF has guardianship of a child under the age of 14, the Probate Court must issue approval for testing.
- I. Children who are in out-of-state placements must follow the laws of the state in which they are living.

#### IV. Placement of Children

- A. Children who are under DCYF care because of family situations or abuse, neglect, CHINS, or delinquency and are suspected of being HIV infected must be placed in the least restrictive family-like setting which meets the needs of the child.
- B. These factors must be considered:
  - 1. Foster parents and other residential providers must be trained and prepared to care for an infected child. Caregivers must follow universal precautions - those measures used to keep a barrier between a person and blood or other body fluids.
  - 2. Children are to be placed where resources are available to meet the child's social, medical, emotional, and educational needs.
  - 3. Children who are HIV infected may be placed with other children who are not infected. Factors which need to be considered are:
    - (a) The number of children in the foster home,
    - (b) The protection of the infected child from exposure to other infections from children in the home, and
    - (c) The control of behaviors likely to transmit HIV infection, particularly in sexually active adolescents.
    - (d) The child's caregiver must allow parents or other relatives to visit and provide support to the child.
    - (e) The child's caregiver must be willing to participate as a team member in the care of an infected child and must be willing to participate in training on an on-going basis.
    - (f) Mature children must be included in the selection of their placement.

#### V. HIV/AIDS Cases

- A. Routine problems of children who are HIV positive or have AIDS are to be resolved by the District Office Supervisor and CPSW/JSO.

- B. If there is an unusual case when problems cannot be resolved in the D.O., it is to be referred to the Area Administrators. If the problem still cannot be resolved, the Area Administrators, with the assistance of State Office staff will seek additional information from the Division of Public Health Services and other professionals.

### **Procedures**

- I. CPSW and JSO staff requesting HIV-1 tests performed on children in care who have a legal relationship with DCYF must:
  - A. Review the Risk Categories for HIV-1 infection,
  - B. Confirm that the child is at moderate or high risk based on the information about the child's behaviors, sexual abuse history, if any, and caregivers' behaviors,
  - C. Obtain the parents' signature on the "Consent for HIV-1 Antibodies Testing" (Form 2279) for all children under 14 years old,
  - D. Obtain the child's signature if 14 or older on the "Consent for HIV-1 Antibodies Testing" (Form 2279) and the physician's signature or person authorized by the physician to sign the form,
  - E. Make an appointment with the child's physician who must bill the Medicaid program for the HIV-1 test,
  - F. Share the test results with the child's parents (if they are the guardians), the foster parents, residential care providers, or adoptive parents,
  - G. Arrange for any medical care of the child with a physician,
  - H. Obtain District Court approval for testing if the child and parents refuse consent to testing and the child is at high risk of contracting the HIV virus, and
  - I. Obtain Probate Court approval for testing of children when the DCYF Director is the guardian and the child does not voluntarily seek testing.

<b>DCYF Policy on AIDS</b>
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- I. This policy is intended to serve as a guideline for the most common issues encountered in dealing with individuals who have received a medical diagnosis which falls within one of the policy definitions. The guidelines reflect distinctions with respect to the age of the child, testing, treatment, placement, and liability.
  - A. **The following definitions help establish a uniform standard for these terms:**
    - 1. AIDS (Acquired Immune Deficiency Syndrome) is a disease complex characterized by a collapse of the body's natural immunity against disease. Because of this failure of the immune system, individuals with AIDS are vulnerable to one or more unusual infections or cancers that usually do not pose a threat to anyone whose immune system is working normally.
    - 2. Acquired Immunodeficiency Syndrome (AIDS), a complex of illnesses caused by the virus - Human Immunodeficiency Virus (HIV), in which the body's immune system is

severely impaired. Some person infected with HIV are susceptible to serious opportunistic infections such as Pneumocystis Carinii Pneumonia, and to certain malignancies like Kaposi Sarcoma which otherwise would not cause disease in a healthy individual.

3. AIDS Related Complex (ARC). Persons with ARC do not have fully developed AIDS but exhibit abnormal laboratory findings and certain clinical features which are not attributable to a known cause.
4. A.R.C. is no longer used as a classification term by medical professionals or the centers for disease control. Instead: the manifestations of infection with HIV, the causative agent of AIDS, cover a broad spectrum. Some infected individuals may look perfectly healthy, have no symptoms, and feel well. In some, the infection leads to detectable but mild abnormalities of the immune system that do not result in the development of opportunistic infections or malignancies. All persons infected with HIV, regardless of their health status, may be capable of transmitting the infection to others in specific types of situations (i.e. sexual intercourse, sharing intravenous needles).
5. HIV Positive means the presence in an individual, as detected by laboratory testing, of an antibody or antigen to the human immunodeficiency virus.
6. A positive HIV antibody test means the person was exposed AND infected by the HIV virus, as evidenced by the presence of HIV antibodies in their blood, which are solely produced by the body in response to HIV infection. A positive HIV antibody test only determines the presence of infection and does not mean a person has AIDS or will get it.

## II. **Factors which influence decision-making:**

### A. Age of the child:

1. Birth to 15 months: HIV anti-body testing in infants may not be conclusive evidence of infection. Infants born to antibody positive mothers will be antibody positive due to transplacental antibodies: only approximately 50% will be actually infected. Placentally transferred maternal antibodies generally wane by the age of 6-8 months, and conclusively are gone by 15 months. Therefore, antibody testing of infants less than 15 months and certainly less than 6-8 months does not conclude actual infection. Elisa antibody test usually not reliable in this age group.
2. 15 months to 13 years:
3. 13 years to 18 years: Youths aged 14 and older can give informed consent for medical test in some circumstances without parental consent.

### B. Legal relationship with child: see section D 2 & 3 for DCYF Guardians.

1. custodian no legal authority for this type of testing probably
2. guardian if testing is indicated - as determined by Medical personnel and guardian refuses to give consent, a neglect petition could be filed and the issue could go to probate court for a Judicial Mandate. Testing could probably be done on those under

18, with the guardian's consent but not with the youths, if medically indicated. Client should have primary physician assigned ASAP.

C. Placement of the child:

1. with parents, family members: most desirable from a psycho-social stand point - medical condition for HIV youths usually allows this. A large proportion of HIV infected youths are hemophiliacs and so parents are already well-versed with providing medical care at home.
2. with foster parents: guardianship for consent (medical) must be clear. Training special parents to be HIV client specialized.
3. with group home/institution (including Y.D.C. and Philbrook Center): Hospitalization for acutely ill youths, psych. hospital for those youths displaying HIV organic symptoms.
4. with adoptive parents:

All of the above would need basic education regarding HIV infection.

III. **Testing:**

A. Testing will be done only to ensure adequate health care for that particular child. Testing must be based on a medical determination. A physicians order - especially for DCYF kids, and not simply an administrative decision.

1. Authority of the agency:

(a) Testing in the first place: (subject to RSA) Testing for AIDS is permitted only when a treating physician believes testing is medically indicated by symptoms or by known exposure to HIV or when the individual child requests it. When testing is requested by a child below the age of thirteen, the consent of DCYF is required and the testing must be obtained through a physician. In cases where the rights of the biological parents have not be terminated, parents should be consulted and involved in the decision to conduct the testing, even though DCYF clearly has the legal authority to obtain the test without the parent's permission. See below.

(b) High Risk identification: (and its connection with mandatory testing, if any)  
High risk behavior:

- (1) homosexual activity
- (2) IV drug user
- (3) known HIV positive sexual partner
- (4) sharing of needles with known HIV positive IV drug user
- (5) children born to HIV positive parents

- (6) high number of sexual partners

The determination of high risk is not necessarily "Black and White" especially around the issue of the number of sexual contacts that determines "High Risk". Symptoms would be an important consideration. As would competence on the client's part, to give or refuse consent (informed consent). Each cause needs to be individually considered before testing without consent (mandatory) is performed.

2. Re-testing: Initial test seronegative: Public Health recommends retesting at 3 month intervals for a year after the last exposure to the virus. Initial test seropositive: because NH Public Health performs 2 Elisa tests on each specimen, with a follow-up western blot if one +, one -. Further testing is not indicated. Initial test indeterminate: Public Health recommends immediate retesting.
3. Counseling: All testing must be accompanied by both Pre & Post test counseling. Performed by an individual certified by the centers for disease control, through NH Public Health, Bureau of Disease Control.
  - (a) Pre-test Counseling
  - (b) Post-test Counseling
    - (1) Persons who give their informed consent to an HIV test must be offered post-test counseling. The counseling must include:
      - (i) the test results and the significance of the test results
      - (ii) the social and emotional consequences of the information;
      - (iii) information and good preventive practices and risk reduction plans; and
      - (iv) referrals for medical care and other support services as needed.
4. Storage/retrieval of results of testing: see below. Results only given in person and only with Post-test Counseling.
  - (a) storage of results: case file, separate file, where maintained?: Results and consent forms should be maintained in the client's medical file. Result, consent form and any other documents alluding to the fact that the test was performed should be stamped with the following statement "CONFIDENTIAL THIS DOCUMENT REQUIRES SPECIFIC CONSENT BEFORE IT MAY BE RELEASED OR COPIED."
  - (b) access to results, establish need to know; restrictions on further release, etc.:
    - (1) Disclosure of HIV test results to employees of DCYF
    - (2) Specific informed consent must be obtained in writing before the above (results etc.) can be released, except as mandated in RSA 141-F:7:
      - (i) the physician ordering the test or the person authorized by the physician



- (ii) the director of the division of public health
- (iii) the person tested.
- (iv) Additionally: (RSA 141) "if the person with a serologic positive test result is less than 18 years of age or is mentally incapable of understanding the ramifications of a positive test result, the physician or the person authorized by the physician may disclose the test results to a parent or legal guardian. In such cases, the parent or legal guardian shall be entitled to appropriate counseling" Additionally: (RSA 141) "If the person with a serologic positive test is confined to a facility pursuant to an order of a court, or committed to a mental health facility, the results of the test shall be disclosed by the physician or the person authorized by the physician to the medical director or chief officer of such facility".

(3) The results of an HIV test of a child in the legal custody of DCYF may be disclosed to a DCYF employee who has any one or a combination of the following responsibilities for the child who was the subject of the test, provided that the HIV test results are relevant and necessary to the employee's decisions and actions relative to the care or treatment of that child. These responsibilities include:

- (i) assessment of the child's needs, short and long term planning regarding the child, decision-making regarding the care, treatment, supervision, placement, and/or safety of the child, or any other activities necessary to discharge DCYF' parental rights and responsibilities for the child, or
- (ii) formulation and/or presentation of an appropriate plan for the child and the basis of this plan to a court, or
- (iii) monitoring or review of the appropriateness of DCYF' plans and actions relative to the child, or
- (iv) submission of applications for third party benefits for the child.

(4) A DCYF employee who receives HIV status information may not disclose the results further except as permitted in Item 605, Safeguarding Information.

#### B. Disclosure of HIV Test Result to Other Persons

1. The results of an HIV test of a child in the legal custody of DCYF may be disclosed to any of the following designated persons provided that information is relevant and necessary in order for the child to receive appropriate care or treatment:

- (a) a person responsible for regular day-to-day residential care and supervision of the child. This includes, but is not limited to, licensed family foster home providers.
- (b) a parent of the child who was the subject of the test provided his parental rights to the child have not been terminated by a court.

- (c) a person responsible for developing a plan for the child based on the child's needs and/or presenting such a plan of a court proceeding. These include but are not limited to guardians ad litem, citizen members of administrative case review panels, and persons with responsibilities under the Interstate Compact on the Placement of Children.
  - (d) a person temporarily providing care and supervision to the child as a supplement to care provided by (a) above.
  - (e) a person who is willing and able to provide regular 24-hour, residential care to a child with special medical considerations, but needs to know specific health status information in order to decide whether to accept the child for care, provided the identity of the child is not given until the child is placed with that person/family or the facility agrees to accept the child for placement.
  - (f) a person who is assigned to , contracted to, or responsible to deliver a specific service or services to or for the child, provided the knowledge of HIV status is relevant to the service to be delivered, or
- 2. No person designated in B. 1. above may disclose the results of any HIV test except in a medical emergency in which lack of this information by medical providers and/or delay to have a DCYF employee disclose the HIV status may place the child at risk, in a medical emergency in which the person is consenting to treatment.
  - 3. Upon receipt of any HIV status information, any person designated in B. 1. shall confirm in writing that he has been informed of the results of an HIV test and of the confidentiality of this HIV status information.
- C. Disclosure by or Without Approval of the Subject of the Test
- 1. The child who is the subject of an HIV test may disclose the results to whomever he chooses. However, to the degree possible the potential consequences or impact of disclosure is to be identified with the child.
  - 2. DCYF' custodial rights and responsibilities in loco parentis have precedence over the desire for confidentiality by a child who was the subject of an HIV test and who is in the legal custody of DCYF. Therefore, the desire by the child for HIV test results not to be disclosed to any one or more of the persons designated in sections I. and II. of this policy does not prevent disclosure as set forth in this policy.

#### IV. **Treatment:**

- A. For seropositives the following must be done - Labs RPR or VDRC with FTA confirmation if indicated. Tuberculosis testing - specific guidelines. Immunizations - in most circumstances childhood immunizations are indicated. Physical exam and nutritional assessment. Flu and pneumococcal vaccines are usually indicated.
  - 1. Every-day: (by persons coming in contact with the child) the Centers for Disease Control state "Universal Precautions" are sufficient to prevent the transmission of HIV. "Universal Precautions" states that gloves are only required for contact with blood or other body fluids with visible blood in them. Isolation, masks, disposable

dishes, special laundering of linen, individual bathrooms are not indicated, unless specific opportunistic infections are present. Individual bedroom assignment is indicated with youths with a Hx of sexual perpetration. Tooth brushes, razors and other items should not be shared (blood c.)

2. Clinical trials: (decisions about submitting child to experimental treatments)  
Institutions requesting the enrollment of foster children in clinical trials must have their protocols and procedures approved by the directors of DCYF and DPH. Following approval, individual infants and children to be enrolled in a clinical trial must be approved by the AIDS Review Committee prior to enrollment.
  - (a) There is a list of experimental treatments put out by the National Institutes of Health titled "AIDS Clinical Trials Group (A.C.T.G.)" which include inclusion criteria to help health care professionals determine the appropriateness of a specific treatment to the client in question. Most clinical trials are only open to those above age 12. A.Z.T. is now recognized as an effective therapy and there are several protocols for it's use. Generally the decision to enroll in a clinical trial must be made with the parents, primary physician, the client if appropriate and the legal guardian. If DCYF is the guardian then an ethics committee, comprised of clergy, patient's advocate, community MD's etc. must be involved. The decision to, or not to engage in a clinical trial should not be made solely by a committee of DCYF employees or administrators. Additionally a MD specialist in infectious diseases should be consulted. Clinical trials are available locally, some can be done at MHMC, institutions or in Boston (Mass Medical Center, Mass General, Beth Israel, Deaconess, etc.)
3. Other: AIDS Review Committee. The purpose of the AIDS Review Committee is as follows:
  - (a) to provide guidance on issues such as testing, placement, and confidentiality
  - (b) to share and make recommendations regarding the utilization of specific resources and
  - (c) to offer support to staff.

## V. **Liability:**

- A. All clinical trials require the signing of a waiver of liability by the guardian and the client (if 14 or older). Because most therapies are experimental, if DCYF declined to enroll a client, liability would be very unlikely. See section on universal precautions. Documentation is extensive in medical and epidemiological research that states people coming in contact, through casual contact, with someone infected with HIV are not at risk. Infection, through exposure from a bite is unlikely, as is contact with vomitus, saliva or through fomites (i.e. toilet seats, chairs, phones etc.)
  1. To child, and to those coming in contact with child as foster parents, other foster children, adoptive parents, etc.
  2. Notification/obligation to "warn": Information regarding HIV status is confidential and should be shared with DCYF staff or released to providers on a "need to know" basis

in order to provide the highest quality care to the child. Will research 2+ court cases pending.

3. Confidentiality issues: Regarding DCYF employees "Right to Know" as to which clients are HIV positive, it is important to bear in mind that they should be practicing universal precautions with all clients and that, if it was discovered that a client was HIV Positive, the Precautions would stay the same, in other words, from an infectious control standpoint, they should not be doing anything different. HIV infection status information becomes important around the issue of bedroom assignments and more importantly for the client's own health.
4. Other: So that health care professionals can administer prophylactic (preventative) treatment, and so the child can be kept from school classroom when there are outbreaks of chickenpox and other infections - for the HIV infected child's own protection.

**NOTE:** Regarding pregnant health care workers - CDC recommends pregnant health care workers limit their contact with HIV clients, as such clients often harbor the opportunistic infection CMV, which can be spread and can cause birth defects in unborn children.