Child Protection Team Program Handbook

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CHAPTER 1: PURPOSE AND ROLE

1.1 Purpose

This handbook establishes guidelines and practice for the Department of Health, Children’s Medical Services, Child Protection Team (CPT) program’s response to reports of child abuse and neglect, and the coordination with child protection staff of the Department of Children and Families (DCF) and designated local sheriff’s offices (SO) responsible for child abuse investigations, community-based care (CBC) providers, and law enforcement (LE). These program-specific definitions, and procedures for program operation, establish consistent standards and expectations for all Child Protection Teams and for contract providers who render services purchased by the Child Protection Teams.

1.2 Scope

The Child Protection Team Handbook is applicable to all Child Protection Teams in Florida. It should be utilized in conjunction with the contracts negotiated between the Department and individual providers. Specific areas addressed in this handbook include program objectives, roles and responsibilities, service delivery, practice, quality standards, information systems and program administration.

This handbook supersedes all previous policy memoranda and operating procedures distributed to the Teams by the Department of Health, Children’s Medical Services Program Office.

1.3 Authority

Section 39.303, Florida Statutes, provides for the establishment and maintenance of one or more Child Protection Teams in each of the DCF Regions. Chapter 64C-8, Florida Administrative Code, establishes specific definitions, standards, policies, and procedures for the operation of the Child Protection Team program.

1.4 Mission and Program Organization

The mission of the Department of Health (DOH) is to protect, promote & improve the health of all people in Florida through integrated state, county, and community efforts. The Bureau of Child Protection and Special Technology is responsible for the statutorily mandated Child Protection Team Program. The following mission statement focuses the activities of the Bureau on the delivery of healthcare services for abused, abandoned and neglected children.

“To promote the safety and well-being of Florida’s children by providing medically led multidisciplinary assessment services for children suspected of being abused or neglected.”

1.5 Department of Health Mission, Vision and Values

Mission:
To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.
Vision:
To be the Healthiest State in the Nation

Values:

Innovation: We search for creative solutions and manage resources wisely.

Collaboration: We use teamwork to achieve common goals and solve problems.

Accountability: We perform with integrity and respect.

Responsiveness: We achieve our mission by serving our customers and engaging our partners.

Excellence: We promote quality outcomes through learning and continuous performance improvement.

1.6 Child Protection Team Program Objectives

The Child Protection Team Program operates on the premise that child maltreatment is a multifaceted problem requiring a multidisciplinary response to child protective investigations. The purpose of the program is to supplement the child protective investigation activities of DCF or designated sheriff’s offices by providing multidisciplinary assessment services to children and families involved in child abuse and neglect investigations. Child Protection Teams may also provide assessments to Community Based Care providers to assist in case planning activities, when resources are available.

The Teams’ comprehensive multidisciplinary assessment activities are critical in identifying and evaluating child abuse, abandonment and neglect, in recommending effective interventions and treatments and in promoting successful long-term outcomes for children and families. Consistent with the legislative intent of the program and with the Department of Health’s mission, the objectives of the Child Protection Team Program include:

- Identification of child abuse and neglect is promoted through assessment activities that focus on child maltreatment as well as safety and risk factors; and
- Intervention in child abuse and neglect is promoted through multidisciplinary staffings, expert court testimony, direct service referrals and recommendations that support child safety; and
- Prevention of child abuse and neglect is promoted through consultation with other agencies, training of professionals and educating the public and community partners.

1.7 Background

In 1971, s. 827.07, F.S., mandated reporting of suspected child abuse and neglect. This resulted in a large increase in abuse reports to be investigated by the state. The statute required that child abuse investigators “include a determination of harm or threatened harm to each child, the nature and extent of present or prior injuries, abuse or neglect and evidence thereof.”

The Department of Health and Rehabilitative Services (HRS) recognized the need for a specialized medical resource and made a commitment to provide this under the auspices of the
Children's Medical Services Program. This plan culminated in a legislative appropriation in 1978 to fund a pilot project using a medically led multidisciplinary team approach.

The success of the first Child Protection Team established in Jacksonville in 1978 led to the establishment of four additional Teams in 1979, and between 1981 and 2010, additional Teams were added to cover all areas of the state. Pediatric medical direction was added in 1983 to coordinate the activities of the Child Protection Team Program. By the fall of 1995, a network of Teams throughout the state provided each HRS district with this resource. In addition to the evaluation of physical abuse and neglect, the Teams became the focal point for expertise in the medical examination of sexually abused children and the evaluation of sexual abuse allegations.

Legislation in 1997 required that the Department of Children and Families and Department of Health develop an interagency agreement specifying the roles of each department. Section 415.5055, Florida Statutes, (now s 39.303 F.S., first paragraph) was further amended in 1998 to provide that the continuing interagency agreement specify how coordination of services was to occur, joint oversight by the two departments, and how joint oversight was to be implemented.

In 1999, as a result of concerns regarding several serious child abuse deaths, the legislature established mandatory criteria for the referral of cases from child investigations to the Child Protection Teams and expanded the role of the Teams to include the review and assessment of all child abuse and neglect reports made to the Abuse Hotline to identify those reports meeting the mandatory criteria.

1.8 Eligibility and Target Group

Any report accepted by the Florida Abuse Hotline for investigation is eligible for Child Protection Team assessment services. Child on child sexual abuse reports to the hotline are also eligible for referral to Child Protection Teams even if accepted as a "special conditions" case. There are no financial criteria for determining eligibility for Team services.

1.9 Funding

The Child Protection Team Program is funded by the legislature through the Department of Health, Children’s Medical Services (CMS) office. The department, through the CMS program office, contracts with local providers for Team services. Providers currently under contract with the department include non-profit agencies, hospitals, universities, and county government.

A. Funding for Initial Medical Exams.

Section 39.304(5), Florida Statutes, provides that counties “in which the child is a resident shall bear the initial costs of the examination of the allegedly abused, abandoned, or neglected child; however, the parents or legal custodian of the child shall be required to reimburse the county for the costs of such examination, other than an initial forensic physical examination, and to reimburse the department for the cost of the photographs taken.”

B. Third Party and Other Funding Sources.

Child Protection Teams are encouraged to bill third party sources, including Crimes Compensation for the initial forensic sexual abuse/assault examination. Program revenue from all sources is to be utilized for the CPT program budget.
Teams may not bill for expert medical, psychological and related professional testimony in dependency cases, as this is a service identified in Section 39.303 (3)(e), Florida Statute.

1.10 Team Availability and Access

A. Availability of Services.

Child Protection Teams provide assessment services to supplement the child protective investigation activities of DCF and designated Sheriff’s Offices. They also can provide assessments for case planning and service activities to investigators and Community Based Care agencies.

Team services must be available twenty-four (24) hours a day, seven (7) days a week, for consultation by phone and immediate medical evaluation or other appropriate assessment services, when indicated.

A listing of the main Child Protection Team offices, the counties they serve, the names of the Team’s Medical Director and Team Coordinator, and a map that shows where the Teams are located, can be found on the CPT website: www.cms-kids.org

B. Access to Team Services.

Initial contact comes primarily from Child Protective Investigators (CPIs) employed by either DCF or the local sheriff’s office (SO). However, a Team may initially be contacted by another source such as law enforcement, a hospital, or a Community Based Care provider. Regardless, the Team must verify that a Hotline report has been made and then work in tandem with the designated CPI throughout the investigative phase.

1.11 Definitions

Definitions of terms used in this handbook can be found in the Glossary (Appendix C).

1.12 CPT Handbook Revisions

The CPT Program Handbook will be reviewed and any required revisions made as needed. The updated handbook will be posted on the CPT Website. Additionally, any programmatic revisions or updates will be distributed to the CPT providers and posted on the website. These revisions will be incorporated into the handbook during the next revision.
CHAPTER 2: PROGRAM ORGANIZATION

2.1 CMS Program Office

The Department of Health, Children’s Medical Services Program Office has oversight and contract management responsibility for the Child Protection Team Program. Specific responsibilities include:

- Ensuring that the Child Protection Team Program is implemented according to legislative intent and as provided in state law, rules and regulations
- Establishing program standards and performance objectives
- Managing contracts or OPS employment for the Statewide CPT Medical Director and individual Child Protection Team Medical Directors.
- Reviewing, monitoring, and ensuring compliance with statewide standards and performance measures
- Maintaining an automated information system to provide an electronic case file and management of data (CPTIS)
- Statewide supervision of the administration of the Child Protection Team program, including but not limited to:
  - Identifying statewide program needs and recommending solutions and priorities
  - Technical assistance for the Medical Directors, Team Coordinators, and staff of the Child Protection Teams
  - Monitoring individual Teams to ensure uniform program quality
  - Developing workload and productivity standards
  - Developing resource allocation methodologies
  - Compiling reports, analyses and assessments of individual and statewide Team data

2.2 Statewide Child Protection Team Medical Oversight

Department of Health/Children’s Medical Services employs a Statewide Medical Director who is a Florida licensed Physician and a board-certified pediatrician with a subspecialty certification in Child Abuse Pediatrics from the American Board of Pediatrics, to provide medical oversight for the Teams’ Medical Directors throughout the state. The Statewide CPT Medical Director provides these oversight functions in coordination with the Bureau of Child Protection and Special Technology under the direction of the Children’s Medical Services Deputy Secretary.

2.3 Team Composition

A. Composition

Each Child Protection Team functions under the oversight of a Medical Director who is a Children’s Medical Services (CMS) approved physician. Section 39.303(2)(b), F.S. requires that, as of July 1, 2015, each Medical Director must be a Florida licensed physician under Chapters 458 or 459, F.S., who is a board-certified pediatrician or family physician with a sub-specialty certification from the American Board of Pediatrics in Child Abuse Pediatrics, or meets the requirements established by a third-party credentialing entity recognizing demonstrated specialized competence in child abuse. The daily coordination of CPT activities is the responsibility of the Team Coordinator. Case Coordinators, varying in number depending on the size of the Team, arrange and provide the direct case assessment activities. Child Protection Team medical providers can be
physicians, Advanced Registered Nurse Practitioners (ARNPs) or Physician Assistants (PA's). All CPT medical providers must be approved by the local CPT Medical Director and the Statewide Medical Director. Additionally, they must be a CMS-approved physician or physician extender. All Teams have available (on a consultant basis or as paid staff) a Florida licensed Team Psychologist with experience in the evaluation and treatment of child abuse and neglect and a Team Attorney who is a member of the Florida Bar to provide legal services and consultation to the Team on a part-time basis. Subcontracts for all CPT services, that involve DOH funds, must be approved by the CMS Division Director or their designee.

B. Staffing Changes

The CPT Program Office must be immediately notified if the position of Team Coordinator is vacated. Changes to the Team Coordinator position must be coordinated with the Team’s Child Protection Team Medical Director. Staffing updates that include all staff changes must be provided to the contract manager in the quarterly performance measures report and conference calls. Resumes of Case Coordinators must be submitted to the Program Office contract manager prior to hire, if there are questions regarding qualifications.

Prior to filling the vacant Team Coordinator position, the provider is to send the applicant’s resume to the Program Office for review and concurrence that the individual meets the requirements of the position.

2.4 Personnel Qualifications and Responsibilities

Chapter 64C-8, Florida Administrative Code, addresses the staffing requirements and waiver process for Child Protection Teams. Beyond those professionals required by rule, the Teams determine the number and types of positions necessary to the performance of the annual contract. Staff in any additional position, such as Program Manager or Clinical Supervisor, that is delegated responsibilities of a required position, must meet the qualifications of that position or have an approved waiver.

The required qualifications, duties and responsibilities associated with each position employed or contracted for the Child Protection Team are listed in Appendix A. Depending on specialized needs in their area, additional duties or responsibilities may be identified by each team.

A. Background Screening

Providers will not be able to employ applicants for positions of special trust or responsibility, as defined in Section 110.1127(3)(a), F.S. until the applicant is cleared by Level 2 background screening, required by Section 435.04(1), F.S., the fingerprint based search of criminal records in Florida and nationally. Additionally, volunteers working with the program ten (10) hours or more a month will require Level 2 background screenings. Pursuant to Section 408.809 F.S., a background rescreening will be completed for individuals who fall under the Section 435 requirements.

Section 435.04(2), F.S. identifies charges and circumstances where an individual would be exempt from employment.
If an individual, who is being considered for hire has been employed with DOH and a background screening was completed in the last five (5) years, the individual will obtain a copy of the background screening results and provide to the hiring agency.

Individuals who work for DOH and are being hired/subcontracted to perform CPT services, must complete the DOH “Outside Employment” form and send to the DOH contract manager. The form will be forwarded to personnel for review and approval. This must occur prior to employment with the provider agency.
CHAPTER 3: CASE MANAGEMENT ACTIVITIES

3.1 Abuse Report Review Process

A. Medical Director and Team Coordinator Responsibilities

Section 39.303(3), F.S. requires that all abuse and neglect cases accepted for investigation by the Hotline must be reviewed by the Child Protection Team to determine if the case meets mandatory criteria for referral. The Medical Director and Team Coordinator are responsible to ensure the abuse report reviews occur promptly. **The Medical Director (or medical designee) and the Team Coordinator (or designee) must complete the review.**

B. Medical Review

The Child Protection Team Medical Director (or appropriate medical designee) must timely review all reports to determine whether a face-to-face medical evaluation by the Child Protection Team is needed. Cases can be reviewed by CPT physicians, ARNPs, PAs or RNs.

The Team Medical Director should periodically review the entire process with all medical providers to ensure that the same criteria are used in reaching such determinations.

C. Time Frame for Abuse Report Review

Reports of maltreatment accepted by the Hotline for investigation must be reviewed by the Team Coordinator (or their designee) and the Medical Director (or medical designee) within four (4) working days of obtaining the Hotline report. The review of the Hotline reports must be entered into CPTIS within four (4) working days on the Abuse screen.

Immediately upon completion of the review of abuse reports, CPT will notify DCF and/or sheriff’s offices of the cases which have been identified as mandatory referrals.

A list of mandated cases not referred is one of the reports available through CPTIS. If the DCF or Sheriff’s Office (SO) have direct access to CPTIS, an agreement to amend this requirement can be arranged. Any such agreement must be signed by both parties and a copy provided to the CPT contract manager.

D. Restricted Case

A restricted case is one in which a CPT or DCF Family Safety (FS) program employee, family member, household member, Sheriff’s Office staff responsible for child abuse investigations, or provider agency employee is the subject of a FSFN report of abuse, neglect, abandonment or exploitation and the referral is made to CPT, whether or not services are ultimately provided. If a subject of a Hotline report is a CPT employee or provider, the CPT will immediately notify the CPT Program Office and steps will be immediately taken to restrict access in CPTIS pending completion of the investigation.

To maintain confidentiality and ensure objectivity (or no conflict of interest occurs), the Team Coordinator will contact a neighboring CPT and request that the Team handle any
referral from the child protective investigator for assessment services. The FSFN report and any documented information will be immediately forwarded to the neighboring CPT.

Each Team Coordinator will be identified, as having the authorization to limit access to restricted cases. Team Coordinators will be responsible for ensuring that all security and confidentiality measures have been completed. Any violations of confidentiality and security will require notification to the Program Office and completion of a DOH Incident Report, which will be forwarded to the contract manager immediately.

E. Mandatory Referrals

Mandatory Criteria

Section 39.303(2), F.S. specifies the types of cases that must be referred to the Child Protection Teams for evaluation. Mandatory referral cases include those involving:

- Injuries to the head, bruises to the neck or head, burns or fractures in a child of any age
- Bruises anywhere on a child five (5) years of age or younger
- Any report alleging sexual abuse of a child
  
  (Sexual Abuse Threatened Harm is not mandatory. Victims of child on child sexual abuse may be accepted for Team services but are not mandatory referrals.)
- Any sexually transmitted disease in a prepubescent child
- Reported malnutrition of a child and failure of a child to thrive
- Reported medical neglect of a child
- Any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died, as a result of suspected abuse, abandonment, or neglect, when any sibling or other child remains in the home
- Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected

Human trafficking for sex cases are also eligible for CPT assessment services, though not mandatory unless the victim is being trafficked by a family member or caretaker.

F. Exceptions to the Mandatory Medical Evaluation Criteria

1. A Medical Director can authorize an exception for medical evaluations. A child meeting the mandatory criteria for Child Protection Team referral may be exempt from a face to face medical evaluation, as defined in Section 39.303(4), F.S. under the following circumstances:

   - The child was examined for the alleged abuse or neglect by a physician who is not a member of the Child Protection Team and a consultation between the Child Protection Team medical professional and the examining physician concluded that further medical evaluation was unnecessary.

Guidelines:
Emphasis should be placed on the requirement that the CPT medical professional has consulted with the examining physician and concluded that further medical evaluation was unnecessary. The CPT Case Coordinator should still determine if other CPT assessment activities are appropriate.

- The CPI, with supervisory approval, determined after conducting a child safety assessment that there were no indications of injuries meeting the criteria in Section 3.1, paragraph A.

Guidelines:
The DCF or the designated sheriff’s office can only request an exception to a medical evaluation when a child has no injury (physical abuse) meeting mandatory criteria, but this exception cannot be used when alleged abuse or neglect would not result in a visible injury. Notwithstanding the above, the CPT Medical Director can still require a child be referred if they think a medical evaluation is needed. Under no circumstances should any child with injuries meeting mandatory criteria be identified as a DCF or SO exemption from a face to face medical evaluation.

- The Child Protection Team board-certified pediatrician or family physician who is a Medical Director determined that a medical evaluation was not required.

Guidelines:
This should not be used to exempt a case from a medical evaluation solely because a child’s injuries are believed to be adequately explained by the CPI. It should be used judiciously, only in cases when the CPT Physician is certain that the child could not benefit from a medical evaluation. At a minimum, the CPT should consider prior reports, and determine if substance abuse, domestic violence or other high risk factors are indicated before granting this medical evaluation exception. The CPT Case Coordinator should still determine if other CPT assessment activities are appropriate before closing case after intake.

All cases involving mandatory criteria must be referred. An exception to the criteria for mandatory medical evaluation does not preclude the acceptance of a referral, if other assessment services offered by the Team are appropriate. If an exception to a face to face medical exam is granted, the Team must document the exception in CPTIS and notify the CPI.

In cases where the Hotline has coded the report as a maltreatment of medical neglect, Florida Statute requires the child be evaluated (medical evaluation or medical consultation). In these cases, an exception to CPT medical evaluation cannot be granted. A medical neglect allegation on a medically complex child requires that the CPT medical provider consults with a physician that has experience treating the child’s condition.

A CPT pediatrician or family physician may determine that a face-to-face medical evaluation would benefit a child with allegations not meeting the mandatory criteria. In these cases, the abuse review screen should indicate that a medical is needed; however, the case should not be coded as a mandatory referral. Teams should accept referrals on non-mandatory cases when the child would benefit from Team assessments.
G. Non-mandatory Referrals Not Accepted for Services

CPI referral information can be documented on the Abuse Screen page.

3.2 Child Protection Team Referral

A referral is defined as a discussion between the Child Protective Investigator (CPI) and CPT staff where the allegations, CPI allegation information and prior reports are discussed to determine if CPT assessment services are appropriate. CPT is responsible for the completion of the Intake/Referral Screen for all cases accepted for CPT services. The Intake/Referral Screen must also be completed for all mandatory reports referred, even if no CPT assessments are needed. Non-mandatory cases referred to the Team in which CPT services are not requested or provided can be documented on the abuse review screen. A CPT Medical Director must review and concur with the decision to not provide medical services in all mandatory reports and grant an appropriate exception to a face to face evaluation. CPT services should be scheduled promptly even if all information is not known.

3.3 Child Protection Team Case

A. Referral Source

CPIs are the primary referral source for Child Protection Team assessment services. Occasionally, the initial referral may come from other involved professionals (e.g., law enforcement, hospitals, and physicians) in situations where an abuse report has been made and an investigation is in progress. As soon as a referral is received from a source other than the CPI during an investigation, the Child Protection Team must contact the assigned CPI to coordinate appropriate Team assessment activities.

Additionally, Community Based Care case managers may refer cases to the Team that were either referred and closed to CPT, or were not referred during the investigation. The cases are not considered mandatory, even if the original allegations met the mandatory criteria, but can be accepted for assessment services to assist in case planning.

B. Referral Timeliness.

1. Timely Referrals. Timely referrals to the CPT are necessary to ensure an adequate assessment of the alleged injuries to the child.

2. Late Referrals. Unless there are extenuating circumstances which justify a CPI late referral to CPT, late referrals may be considered inappropriate for CPT assessment services at that time. According to statute, medical neglect cases must be accepted, even if they are late referrals.

C. Case Requirements

The CPT referral must include a discussion with the referral source and meet the following criteria for the referral to be considered for CPT services and entered as such in CPTIS:

• All cases referred to and accepted by the CPT must have an abuse report number and involve or have involved a protective investigation.
Referrals may be accepted for assessment services by Community Based Care (CBC) case managers (providers contracted by DCF) to assist in the identification of family strengths and needs for case planning purposes. These referrals MUST occur within 90 days of receipt of the abuse report to the Hotline and cannot be for the purposes of assessing new maltreatments. The child must be a subject in the abuse report, or the Case Coordinator or CPT medical provider must document that the referring CPI has stated that the child will be added to the abuse report.

CPT assessment activities and reports must be entered into CPTIS and the reports, upon completion, provided to the referral source within the contracted required time frames. The case progress notes in CPTIS must have documentation of when each report was sent. The Final Case Summary reports that include the information from individual assessments do not substitute for individual assessment reports. Combining assessments into one written report does not negate the individual report content or time frame requirements.

Once all of the assessments are completed and the case is closed in CPTIS, a copy of the data system generated Final Case Summary must be provided to the referral source. The case progress notes in CPTIS must have documentation of when the Final Case Summary report was provided.

The Department of Health and the Department of Children and Families have entered into an agreement that provides for designated child protective investigators and supervisors to have access to specific screens for the purpose of viewing and printing CPT reports (Client History, Intake/Referral, Finalized Assessment Reports and Final Case Summary) in CPTIS. For these areas, notification (via email or phone call) will be made that the report is ready to be printed. This notification will serve as the “date report sent”. Providers throughout the state will need to work with their local child protective investigations offices to ensure clear and timely communication occurs.

The system generated Final Case Summary (FCS) Addendum report must be completed and sent to the referral source for cases that were initially referred by the CPI and closed after CPT assessment were provided and subsequent contact with the CPI or a CBC case manager resulted in additional assessment activities being provided.

Child Protection Team review of the abuse report for the purposes of complying with Section 39.303(2), F.S., does not constitute a referral to the Child Protection Team.

3.4 Opening a Case

Opening a case involves completing the Intake and then Registration Screens in CPTIS. To open a case, assessment activities for the child must be identified as an alleged victim. Detailed instructions for the CPTIS data entry are included in the CPTIS User Guide.

A. Case Record Documentation

Each child referred to the Child Protection Team for Team assessment activities must have an electronic case record that includes documentation necessary to provide a comprehensive record of CPT involvement with the child. When more than one case record is generated as a result of an abuse report in which more than one related
child/victim is accepted for assessment services, Case Coordinators shall ensure that any recommendations made should be child/victim specific in each child’s file.

Clear and accurate documentation of assessment and case coordination activities is essential. Such documentation provides a comprehensive record of CPT involvement with the case and is necessary in order to accurately record:

- Referral information and requests for services
- Activities conducted on behalf of the child/victim (e.g., interviews, staffings, medical exams, psychological evaluations, and social assessments)
- Twenty-four (24)-hour notification of positive findings and risk
- When reports were provided to the CPI or CBC case manager

All case activities must be documented in the CPTIS electronic case record.

B. Case Information

The Intake/Referral Screen must be completed for all cases referred to the Team for service. This screen is required for all abuse reports (mandatory or non-mandatory) accepted for CPT assessment services in order to open a case in CPTIS. Information gathered during the Intake/Referral process shall be documented on the CPTIS Intake/Referral Screen. The discussion between the Case Coordinator and CPI shall be documented and provide appropriate justification for the decision to provide services or not. If a case is not a mandatory referral and the decision is made that no CPT services are needed, the documentation can be included on the Abuse Report Review Screen.

3.5 Case Progress Notes

The case progress record provides documentation of all pertinent case activities/events. This includes contacts and activities completed by the Case Coordinator, or other Team members involved in the case. The case progress notes should be entered into CPTIS as promptly as possible. Details regarding the case activities will be documented in the assessment reports and do not have to be documented in the case progress notes.

When Child Protection Team physicians, ARNPs, Physician Assistants and nurses do not have direct access to CPTIS, the assigned Case Coordinator should assure the critical medical case specific contacts and reports are documented and input into CPTIS.

Case progress notes should:

- Identify the person contacted followed by their role in the case or their relationship to the child/victim, if not previously identified.
- Document pertinent contacts (including attempts to contact) made on behalf of the child and any pertinent information shared.
- Include the dates of request for or receipt of pertinent documents as well as the transmittal of reports and other documents.
- Include documentation of supervisory review and consultation. The Case Coordinator’s follow-up to any recommendations resulting from the supervisor review or an explanation as to why Case Coordinator was unable to complete the supervisor
recommendations (e.g. “Supervisor review indicated need for staffing, however, PI had closed the case.”) should also be included. Explanations should be provided for planned activities that did not occur.

- When making twenty-four-hour (24) notification to DCF, there must be documentation that positive findings and the most important risk factors are communicated to DCF within twenty-four (24) hours.

3.6 Assessment Activity Reports

A. General Guidelines

- Child Protection Teams provide several types of assessments, including specialized and forensic interviews, family social assessments, case staffings, medical evaluations and psychological evaluations. Once the assessment activities are completed the Case Coordinator will generate the individual assessment reports in CPTIS. These reports should accurately record the purpose and nature of the assessment. These reports should accurately record the date(s) involved, the participants, the provided history, the child safety/risk, and the impressions/conclusions and recommendations. Adults mentioned in the report should be initially referenced by their full names and relationship to the child. Recommendations should be realistic and clear, and, when appropriate, responsible parties and specific time frames identified. Reports should be sent only to agencies legally entitled to receive them, and should only be sent on a case specific “need to know” basis.

Observations regarding adults should be placed in descriptive, not judgmental, language.

B. Time Frames – Required Reports

The case progress notes should provide documentation of the ongoing communication with the appropriate information provided. CPT contracts require that the following reports be submitted to the CPI or, when appropriate, the CBC case manager within the following time frames:

- Verbal notification of positive findings from any assessment activity within 24 hours.
- Written medical reports within 10 working days following completion of examination or assessment.
- Interview reports within 10 working days following completion of the interview.
- Staffing reports within 10 working days following completion of the staffing.
- Social Assessment reports within 20 working days following the completion of the assessment (last scheduled interview).
- Psychological reports within 20 working days following the completion of the evaluation (last interview completed).
- Final Case Summary (CPTIS generated) for all cases at the time of closure.

If assessment reports are combined (Specialized Interviews), they must meet the timeframe of the initial assessment activity report. The date each of the reports was provided to the CPI or CBC case manager must be documented on the case progress
notes. Compliance with CPT assessment reports is tracked in CPTIS, so staff must ensure that data is entered in a timely manner.

C. Timely Assessments – Reason for Delay

Team assessment activities should be completed within 20 calendar days following the initiation date, which is the Referral Date on the CPTIS registration screen, (the day after receipt of the referral counts as the first day). Performance on the timely provision of assessments will be tracked through CPTIS. Occasionally, there may be extenuating circumstances which make it impossible to meet the 20-day timeframe. These cases will be exempted from the management reports which document compliance with this performance measure. Reasons for delay that qualify for exemption in compliance measure monitoring are limited to those cases where assessments were delayed because:

- Additional CPT Referral or Information/Assessment – The Team has received a request for additional assessment services based on CPI staff or community based provider receiving new information or additional allegations. This does not require a new hotline report.
- Assessment No-Show – The assessment service was scheduled, however, the subject failed to show for the appointment and another appointment has been made.
- Medical No-Show – The medical exam was scheduled, however, the child failed to show for the appointment and another one has been scheduled.
- Waiting for Medical Records: The assessment service required that copies of the child’s medical records be received and reviewed.
- Post Termination: The Team had closed their case and additional assessment services were requested.
- Delay – Family Not Responsive – The family has failed to respond to CPI or CPT requests to schedule assessment activities within a timely manner.

Reasons for assessment delay must be documented in the case progress notes in CPTIS. If the delay does not meet one of the compliance exemptions, the selection “Late No Exception” should be selected. Since there was not an acceptable reason for delay, the assessment activity will show as not compliant with the required time frames in CPTIS.

When the Team accepts a referral from a CBC case manager and the CPI had already referred the case, and assessment services were completed and the case terminated in CPTIS, the Case Coordinator will complete the Addendum to the Intake/Referral Screen and document the referral discussion and decision to provide CPT services. Any additional services completed will be added as assessments to the terminated registration. The Case Coordinator will prepare the electronic assessment report and complete the Addendum to the Final Case Summary report and send to the CBC case manager. If the case was not previously referred by the CPI and is accepted for CPT services, it will be entered into CPTIS as a new case and handled with the same required timeframes for applicable assessment reports. Please note that certain CPTIS fields will be disabled when a registration is created from the referral source of CBC case manager. This is due to assessment activities being limited to providing services for case planning, not to supplement the CPI investigation.
D. Time Frames – Subcontracted Reports

Time frames for the provision of assessment activities and reports that are completed by subcontracted providers of the Teams must be included in the subcontract or written agreement with the provider. Except for unusual circumstances, subcontracted assessment activities should be received within the timeframe necessary to meet performance standards.

3.7 Supervisory Case Review

Supervisory case review is a formalized internal Team process for reviewing the content, status, and progress of completing Team assessment activities. This review should be done by the Team Coordinator or another designated individual on the Team (who meets the qualifications for Team Coordinator). While every case requires at least one supervisory review, the frequency of supervisory review should be driven by the complexity of the case and the experience level of the Case Coordinator. It is the Team Coordinator’s responsibility to determine the frequency of case reviews. All cases remaining open over 45 days shall be reviewed on a more frequent basis regardless of the experience level of the Case Coordinator.

Supervisory case reviews will be documented in CPTIS by the supervisor in the case progress notes and include:

- Date of review
- Name of the Team Coordinator or designated individual completing the review
- Concurrence with ongoing case activities, recommendations for additional case activities, or agreement that all case assessment activities have been completed and the case file is ready to close.

3.8 Case Closure

A. Guidelines

The case is ready for closure after all Team assessment activities have been completed, all reports of assessments have been provided to the investigator (or CBC case manager), all documentation in the electronic case file has been reviewed and approved by the Team Coordinator or designee, and all pertinent information has been entered into CPTIS. The date the final case summary report is provided to the CPI or CBC case manager is the date of closure (termination) and must be entered on the case progress notes in CPTIS.

In some Child Protection Team cases, closure may occur with no completed assessment activities. These situations may include cases in which the family refuses to cooperate and failed to show for scheduled appointments. CPIs should be notified immediately when a family fails to show so they can determine the level of intervention needed. In instances where no assessment activities were completed, the Team completes the Final Case Summary, which, documents the diligent efforts to provide services and contacts attempted regarding the case. There should be documentation in the CPTIS case progress notes that the supervisor reviewed the reasons for closure and concurred.

B. Time Frame for Closure
All case activities should be completed and cases closed in CPTIS within 60 days following the date of referral. Team Coordinators should use the CPTIS caseload report and complete a review of the electronic case records to monitor the number of cases open over 45 days in order to determine the reason and avoid closure backlogs. Cases open over 45 or 60 days should be reviewed and the reason still open documented.

3.9 Cross Team Cases

There are cases where the child’s primary residence is in a separate location from the county of the Hotline report is called from. For purposes of identification, the CPT Service area where a child lives is referred to as the “local CPT” and the place to which the child was transferred as the “secondary CPT”. Teams must communicate with each other to ensure continuity of service to the child and family. Upon discussion, the Teams will decide what services will be provided by their respective Teams.

A. The local CPT has responsibility:

1. For creating the Registration, ensuring all case progress notes, assessments and assessment reports are documented in CPTIS. Also responsible for preparing the Final Case Summary (FCS).
2. To provide on-going expertise to the Department of Children and Families (DCF), Community Based Care (CBC), law enforcement (LE), and the State’s Attorney Office (SAO) in general, and for questions about the case.
3. To interpret the medical and case findings from the secondary CPT to DCF, LE, and the SAO.
4. To testify on such cases in their local court, and to document court testimony in CPTIS.
5. Coordinating with the secondary Team to ensure all report time frames are met and provided to the child protective investigator, law enforcement or state attorney.

The local Team may only provide a medical consult on the case if the results of the medical evaluation by the secondary CPT indicate that review of additional medical records are needed to augment the secondary CPT’s medical opinion regarding the allegations of abuse or neglect.

B. The secondary CPT assists as needed and is responsible for:

1) Providing on-site medical and/or other Team assessments as needed
2) Providing completed assessment reports in CPTIS to the local CPT within specified time frames that allows the local CPT to meet reporting requirements to the protective investigator.
3) Being available by phone to the local Team as needed or providing court testimony.
4) Documenting all contacts on the case progress notes, assessment activities and assessment reports in CPTIS.

C. Travel and Billing

If the physical presence of a secondary Team expert is needed by the local CPT, the travel expenses should be borne by the local CPT in dependency cases. Testimony may not be billed to the court or DCF on dependency cases.
D. Dispute Resolution

In the event there is a dispute between the two CPT providers that cannot be resolved between the respective Team Coordinators and Medical Directors, the matter should be referred to the CPT Program Office for mediation. Under no circumstances should a dispute interfere with the delivery of Child Protection Team services to a child or their family. The Deputy Secretary for Children’s Medical Services is the final authority for resolution of disputes that cannot be successfully mediated.

3.10 Documentation of Photographs and Audio, Video and DVD Recordings

When photographs are used to record physical injuries or when child interviews are recorded, the photographs and recordings must be clearly labeled and maintained.

A. Photographs

Pursuant to Section 39.304(1)(a) F.S., any CPT that examines a child who is the subject of a report must take, or cause to be taken, photographs of any areas of visible trauma on the child. The CPT will provide the photographs or duplicates of the photographs of physical abuse to the Child Protective Investigator (CPI) upon request.

Sexual abuse examination photographs are not covered under Section 39.304(1)(a) F.S. and cannot be released to the CPI, law enforcement or state attorney. Upon request by a CPI, law enforcement or state attorney, the CPT medical provider will be available to meet with the requesting party to review the original sexual abuse examination photographs, as well as provide interpretation of the exam photos. Copies of sexual abuse photographs should be provided only when a court order is issued.

B. Storage/Child Image Management

All photographs taken of a child are considered confidential and fall under the same policies regarding the medical records storage. When situations arise which cause for the documentation of injuries (physical or sexual), photographs will be stored in a secure fashion.

C. Recordings (Audio, Video, DVD)

Any Child Protection Team that utilizes audio, video, or DVD recording of an interview of a child who is the subject of a report must ensure that proper identification is provided on the audio, videotape, or DVD. Proper identification consists of date of recording, child/victim name and who completed the interview (name, title and agency).

D. Drawings

Drawings completed by child/victims will be scanned and then uploaded in to CPTIS. Drawings should also be referenced in the report.

3.11 Record Management and Report Confidentiality
Pursuant to s. 39.202 (6), F.S., all records and reports of the Child Protection Teams are confidential and exempt from the provisions of s. 119.07(1), F.S., the Florida Public Records Law, drawings should also be referenced and s. 456.057, F.S., regarding ownership and control of patient records. Team records shall not be disclosed, except, upon request, to the state attorney, law enforcement, DCF, and other necessary professionals, in furtherance of the treatment or additional evaluative needs of the child, by order of the court, or to health plan payers, limited to that information used for insurance reimbursement purposes.

Pursuant to s. 39.822, Florida Statutes, upon the presentation of a court order appointing an individual as a guardian ad litem (GAL), the GAL is entitled to records relating to the best interest of the child to whom they are acting as GAL. Said records include, but are not limited to, medical, mental health, substance abuse, child care, education, law enforcement, court, social services and financial records.

Child Protection Team records reside with the contracted provider and shall be maintained according to Florida Department of Health guidelines. Providers operate under the authority of the Florida Department of Health through a standard operating contract. The Florida Department of Health shall have access at all times to any information or records generated as a result of program operation. Records shall be made available in photocopy or electronic means upon request to authorized representatives of the Department for quality improvement activities or any other audit requirements. In any instance where a CPT contract provider ceases to hold an active CPT contract with the Department, the provider shall make arrangements with the representatives of the Department for the transfer of all physical records to the newly designated contract provider or the Department as deemed appropriate by the Department.

Computers with access to the DOH Network and CPTIS electronic case records should be maintained in a secure setting with only those individuals approved by the Program Office to have authorized access. All computers with DOH access have DOH email encryption. Remaining physical records are to be maintained in locked file cabinets or drawers, and behind locked doors. All Teams should give consideration to maintaining critical program and client records in fire/weather resistant filing cabinets in locked settings. Electronic and physical case records should be secured when a staff member leaves the office.

It is each employee’s responsibility to ensure that any confidential information remains confidential and all Department of Health (DOH) security requirements are maintained. Each CPT will develop a protocol for removing confidential information from the office and maintaining DOH security requirements.

3.12 Retention of Records

Administrative records pertinent to the contract must be retained per contract requirements pursuant to Section I, D., Audits, Records and Records Retention of the DOH Standard Contract. If an audit has been initiated and audit findings have not been resolved at the end of the specified retention period, the records shall be retained until resolution of the audit findings or any litigation that may be based on the terms of this contract.

All client records are considered medical records and must be retained for a minimum of seven years after the last entry was made, or until the child attains eighteen (18) years of age; whichever
comes first. If a Team decides to destroy the physical chart, they must ensure the assessment activities are uploaded into CPTIS and the photographs and recordings are maintained.

### 3.13 Team Logs

Certain logs and reports may be used by the Teams for tracking information other than what is gathered in CPTIS. All Team logs generated on CPT clients must adhere to the statutory and handbook confidentiality requirements for CPT records.
CHAPTER 4: CHILD PROTECTION TEAM SERVICES

4.1 Assessment Process

The multidisciplinary team assessment process is instrumental in assessing maltreatments and risk in reports of suspected child abuse and neglect. The assessment process is focused on determining whether or not a child has been abused or neglected, identifying the immediate safety and risk factors in a case, assessing the probability of future abuse or neglect and assisting in case planning. By completing the final risk assessment, appropriate and effective interventions are recommended to reduce the level of risk and provide safety for children.

A. Determining Assessment Activities

Upon acceptance of a referral, a Case Coordinator is assigned to coordinate the Team assessment activities and provide coordination with the CPI throughout the investigation. Unless extenuating circumstances exist, initial referrals for assessment services made late in the investigation may be determined inappropriate.

Referrals from the Community Based Care (CBC) case manager may be accepted for assessment services to assist in appropriate case planning for the child and family, and should not be considered “late referrals”. Acceptance of these referrals is not mandatory, however should be provided when beneficial.

B. Team Approach to Assessment.

The CPT Case Coordinator should make every effort to gather independent information from all appropriate family members and, if possible, the child. This includes parent/caregivers who may also be the alleged perpetrator. Child Protection Team assessments should clearly indicate what information is summarized from that made available by the referral source or existing reports, and what has been obtained from interviews with the victim, involved family members and other collaterals.

C. Types of Assessment Activities Available

Team assessment activities include, but are not limited to those listed in s. 39.303, F.S. These activities include medical examination and diagnosis, medical consultation, specialized interviews of children and family members, forensic interviews of children, social assessments, psychological evaluation and consultation and CPT staffing.

D. Findings

If, as a result of completing assessment activities, there are findings that support the allegations of abuse or neglect, the CPI or supervisor must be verbally notified within 24 hours from the date of the findings. Findings included in written reports must be submitted to the CPI or CBC case manager within the contractual time frames. However, upon request for court hearings or when otherwise needed to ensure the safety of a child, the Team should provide a preliminary report or be available for court testimony.
E. Conflict Resolution

If consensus regarding the need for a CPT assessment cannot be reached, or disagreement with the finding of a CPT assessment, the Team Coordinator should contact the CPI’s supervisor to discuss the issue. Each Child Protection Team must work with their local child protection agency to develop a local protocol for achieving consensus, including representation from appropriate legal staff, and follow this procedure in disputed cases. If the issue cannot be resolved, a CPT staffing should be held. If the Case Coordinator learns that the CPI is closing the case prior to receipt of CPT reports and there are child safety concerns the CPT Team Coordinator should be consulted to determine if the CPI Supervisor should be contacted.

F. Intake/Referral Assessment

The Intake report is to be completed, at a minimum, on all abuse reports referred to the Child Protection Team, either for assessment services or for an exemption to the mandatory medical evaluation. If it is determined that CPT assessment services are not appropriate on a mandatory report, the CPT Medical Director or another CPT Board Certified Pediatrician must review and concur with the decision. The Intake report may be made available, either in a printed or electronic version to the CPI.

G. Final Case Summary

When the Team assessment activities for a child are complete, the Final Case Summary must be provided to the assigned CPI or CBC case manager. The Final Case Summary is a computer generated formal written document that provides pertinent information regarding specific assessment activities provided in each case referred to the Child Protection Team. Additional information is the list of the assessments provided and the date each individual assessment report was sent to the CPI.

Each final case summary must include an assessment of risk. Issues such as domestic violence, substance and alcohol abuse, prior criminal or child abuse history, or the presence of a paramour in the home can present significant risk of serious child abuse injuries as well as child deaths. This is the Team’s opportunity to offer an overview of the family functioning based on information available and to assist the CPI in ascertaining both the validity of the current alleged maltreatment and the likelihood of re-maltreatment, or to assist the CBC case manager in case planning.

The final case summary should be completed and provided to the CPI or CBC Case Manager following the completion of all assessment activities.

4.2 Assessment Activities

At the discretion of the medical providers and Team Coordinators, advocates or any persons whose primary role is to support the family and/or provide referrals to community organizations may observe interviews after it has been determined that the child is a victim of abuse/neglect and is in need of advocacy.
Each assessment should be tailored to the specific child and family. Assessment activities in cases may range from a one-time consultation (medical/legal/psychological only) to the provision of a variety and number of multidisciplinary team assessment activities. Assessment activities include:

A. **Intake/Referral Review**

The Intake/Referral Screen will be completed on all abuse reports referred to the team. If, through discussion, it is determined that CPT assessment services are not necessary, the Intake/Referral report is the final report. Please note that the Intake/Referral Screen must be completed on all referrals accepted for CPT services in order for a registration to be created in CPTIS.

In order to reach the referral decision, it is important that the following be discussed with the CPI and documented:

- The demographic information of the victim child. On the Intake Report, the Family Information section needs to include all family members.
- Reason for Referral: Includes the allegations and a summary of the information the CPI obtained during his/her initial assessment/contact with subjects.
- The alleged maltreatments.
- Prior DCF reports and CPT referrals should be reviewed.
- Assessment Services to be provided.

B. **Medical Evaluation**

Medical examination and diagnosis examination includes obtaining a medical history and conducting a physical examination performed by a CPT medical provider to assess allegations of abuse or neglect. This can also include obtaining imaging studies, laboratory or other diagnostic procedures.

1. **Determining acuity and setting the medical evaluation.**

While the mandatory nature of referrals and follow-up after screening have resulted in an increase in the number of children requiring medical evaluations, determining the setting for the evaluation and the acuity of the evaluation is based on medical judgment. In every instance, accurate triage depends on accurate information; making close communication among the Case Coordinator, the CPI, and the medical provider critical. Each case must be evaluated individually, however suggested guidelines include:

Hospitalized patients, acute sexual assault, and patients being seen in a medical facility for injuries thought to be secondary to abuse take first priority. Injuries that are life threatening or allegations of acute sexual abuse must be evaluated on an immediate basis unless the CPT examiner is convinced, after contact with the treating physician, that the evaluation needs of the patient have been met. The definition of immediate takes into consideration such factors as the safety of the child, the threat to life, evidence collection requirements, and other special considerations such as imminent arrest or the possibility of the family absconding. Special attention to the evaluation of children residing in the same environment must be given.
Urgent evaluations may be indicated in children with some head and/or torso injuries, children whose age makes injuries suspect, children whose injuries make returning to their environment of origin potentially dangerous, alleged sexual abuse in which there are evidence collection issues, and similar cases.

Scheduled evaluations for those children determined already to be in a safe environment are indicated in the following circumstances: sexual abuse alleged to have occurred in the past, sexual abuse in which there is no allegation of penetration, and/or bruises in locations more typical for accidental injuries. Teams might consider the development of clinics where patients with minor injuries and screening of non-urgent referrals can be evaluated in a very short time with documentation and referral if needed.

A child protection team that is evaluating a report of medical neglect and assessing the health care needs of a medically complex child shall consult with a physician who has experience in treating children with the same condition. If the medical team substantiates medical neglect, DCF must be notified of the need to conduct a staffing. Substantiation of medical neglect, the date DCF notified, and medically complex status must be captured in CPTIS. Appendix G provides definition of medically complex, medical neglect, and the responsibility CPT staff has with these children.

The medical provider shall provide, or facilitate provision of, adequate follow-up and prevention services consistent with good medical practice.

Telemedicine: Real-time CPT telemedicine service programs for the evaluation of children suspected to be abused or neglected have been implemented in remote or rural areas. This allows for the performance of child assessments (specifically medical evaluations) via electronic communication and information technologies between Main (hub) and Satellite (remote) sites. Only CPT medical providers approved as CMS medical providers and are specifically trained to do telemedicine exams can perform these exams at the hub site. Only registered nurses (RNs) specifically trained to assist with telemedicine exams can participate in the CPT medical exam at the remote site. All persons at the remote site will act under the direct supervision of the telemedicine Physician or Physician extender.

2. Documenting Medical findings

In all cases where a medical evaluation has been completed, a clear statement of findings and conclusions must be documented in the medical report. The medical report must be available in CPTIS, either as a stored document or, once developed, on the medical report template and provided to the CPI as soon as completed, but no later than within 10 working days following the date of the evaluation.

In cases where the initial medical evaluation results in findings of no indication of abuse or neglect, the initial written medical report, which may be provided in a legally sufficient checklist format, may serve as the final medical report submitted to the CPI. This information can also be provided, as appropriate, to law enforcement personnel, or state attorney’s office.

Medical assessments often require the provision and interpretation of lab work, x-rays, and other related services and photographs to document a child’s injuries or condition. These reports/photographs become part of the child’s record along with the CPT medical
providers written medical report. If additional information about the same allegation or injury is received after the written medical report has been provided, an addendum report should be provided to the referral source. This does not result in an additional medical evaluation or medical consult in CPTIS. Additional medical evaluations or consults related to new allegations can be provided and counted in CPTIS provided all the Handbook requirements are met.

3. STD Prophylactic Medication

The provision of prophylactic medications to be used in the prevention of STD for sexual assault in adolescents and pre-pubertal children referred to the Child Protection Team for medical evaluation is part of the assessment and overall treatment provided by the CPT. Medical providers who wish to participate in this program must comply with Appendix F of this handbook. Teams and medical providers who participate in this program are required to enter STD data in CPTIS.

C. Medical Consultation

Medical consultation is an evaluation by review of the medical history, not including a physical examination, provided to render a medical opinion regarding abuse/neglect on a child(ren) that already has been evaluated by a non-CPT medical provider. The Medical Consultation may be completed by a CPT medical provider. Medical consultation involves situations where the CPI (or court) requests CPT to assist with a medical opinion. Consultation should not be a substitute for a CPT medical examination when appropriate, nor does it exclude the need for other CPT assessments. A medical consultation must result in a prepared report that references all the pertinent history, examination findings and laboratory/imaging studies used to reach the medical conclusions. The CPT medical record must include copies of the relevant records and reports used to arrive at the medical opinion. Consultations must be formally documented in the established team format and a report provided to the CPI upon completion, but no later than ten (10) working days following the consultation (receipt of all pertinent medical records). According to s. 39.304(3)F.S., the Team may obtain records from facilities licensed under Florida Chapter 395 (hospitals); however requested records are limited to those records that involve investigation or assessment of cases of abuse, neglect or exploitation of children only. The CPI is responsible for obtaining other medical records needed for review. Receipt of the medical records must be documented.

D. Medical Second Opinions

It is the intent of CPT to be accurate and informative when issuing opinions about impressions and recommendations. However, as with any medical opinion there will be occasions when a non-CPT party may request another opinion. This may arise in various circumstances including: when there is a disagreement with the CPT response, or sometimes when a non-CPT physician has stated a different opinion and a community partner desires clarification/resolution. Therefore, the following procedures will apply:

1. Requests by community partners authorized to receive CPT reports and who are involved in the investigation or prosecution of the case (i.e. DCF, Law Enforcement, Children’s Legal Services, and State Attorney’s Office):
Request should be made to the team Medical Director in writing asking for:

a. The Medical Director’s 2nd opinion in reference to a medical provider opinion.

b. An opinion by the Statewide Medical Director if that does not resolve the concern.

c. An opinion by the Statewide Medical Director if the original concern is in reference to the opinion of the Medical Director.

The purpose is to solicit the Medical Director’s opinion first, and then the Statewide Medical Director’s opinion only if this is not sufficient.

All pertinent records should be forwarded to the Medical Director for review.

If the review is by the Statewide Medical Director, all pertinent records should be forwarded through the Medical Director’s CPT.

2. Request by non-authorized party

If a request for another medical opinion is asked of the Medical Director, this will be considered on an individual basis.

While a response should be made, a formal opinion is not necessary and may be a violation of confidentiality, depending upon circumstances.

If the request comes to the Statewide Medical Director it will be referred to the Medical Director, or discussed with the Medical Director if the Medical Director gave the opinion that is questioned.

3. Response

A verbal response will be made within seventy-two (72) hours of receiving the records, and a formal written response will be sent within ten (10) working days.

a. If the opinion is requested of the Medical Director, this report will be sent to the authorized party.

b. If the opinion is requested of the Statewide Medical Director, this report will be sent to the authorized party and a copy to the Medical Director.

Note: Normal release of CPT records policy must be enforced.

E. Social Assessment

A social assessment is an evaluation of the history of the child and the child’s family system, conducted by a Case Coordinator or other trained professional. This involves a systematic process of gathering information from more than one subject which professional impressions and recommendations regarding issues of child maltreatment are formulated.
The social assessment includes separate interviews of all the key members of the immediate family unless specific reasons are documented for why these could not occur, and may include interviews of extended family members or others who directly impact family dynamics. Emphasis is placed on gathering individual family histories of parent/caregivers, and the child as a context for the presenting abuse or neglect allegations. Family dynamics, protective capacity of the caretakers, identifying risk factors and child safety all assist in assessing the allegations and evaluating all information to reach conclusions regarding risk and make recommendations that address the needs of the child and family.

The results of the assessment must be documented in the CPTIS report template and provided to the CPI or CBC case manager upon completion, but no later than within 20 working days following the assessment (completion of the last interview). This report may be used to assist in case planning and legal decision making. The social assessment report consists of narrative sections which provide the following:

- **History of Presenting Problems** – This section provides a summary account of the maltreatments in the abuse report, information the CPI has obtained during the course of the investigation, as well as any information the Case Coordinator may have obtained from other sources. The Reason for referral on the Intake/Referral Screen will auto populate with the ability to edit. This section also will document the need for the social assessment.

- **Family History** – This section consists of descriptions of past personal history for each parent/caregiver or other family members, prior agency interventions, medical history of family members and any developmental/disability issues.

- **Family Functioning** – This section will include family dynamics, factors that may contribute to risk, areas of dysfunction (financial, marital, substance misuse, and lack of family support, to name a few). Identification of family strengths, stability and willingness to accept assistance should also be documented here.

- **Safety, Risk and Protective Capacity** – This section will provide information on the parent/caretaker’s protective capacities and strengths as well as any factors that affect child safety and risk.

- **Impressions** – This section documents impressions reached based on gathered information. Impressions should relate to identified safety or risk issues for child, and the parent/caretaker’s ability to take steps to remedy the situation, address any pertinent issues and protection of the children.

- **Recommendations** – These are specific actions identified to assist the family in working towards problem resolution as well as ensuring child safety in the process. Recommendations can be individual or agency specific and must be supported by documentation in the report.

F. **Specialized Interviews**

A specialized interview is an interview with a child or a member of the child’s family, is information gathering in nature, and includes sufficient information to assist with the...
assessment of alleged child maltreatment; however, is not a maltreatment focused interview. The specialized interview presents an overview of the family history, family functioning and dynamics, the development of child safety, risk and parent/caregiver’s protective capacity and impressions and recommendations. The specialized interview can be a stand-alone interview or be included as part of a family social assessment. The specialized interview’s primary focus is not for legal purposes; however, they may be used in dependency or criminal cases as determined by Child Legal Services or State Attorney’s offices.

Specialized interviews of children and others often serve as the key component in the assessment process. Without evidence of physical injuries or other witnesses to the abuse, the interview may be the only way to establish reliable, detailed information.

Following the provision of a specialized interview the Case Coordinator must document the interview in CPTIS and provide the interview report to the CPI or CBC case manager upon completion, but no later than 10 working days following the interview. The specialized interview report consists of narrative sections which provide the following:

- **Summary of interview** – This section should include the exploration of the Hotline allegations as well as gathering information on the family history, family dynamics and functioning. Please note that maltreatment focused interviews do not meet the requirements of a specialized interview.

- **Safety, Risk and Protective Capacity** – this section includes an exploration of child safety and risk based on all information gathered. This includes protective capacities and strengths of the parent/caregiver as well as overall family functioning. Consideration of prior reports/agency involvement should also be explored.

- **Impressions and Recommendations** – This section will document impressions reached based on all information gathered so far. They should relate to identified child safety or risk and the parent/caretakers ability to take steps to remedy the situation. Recommendations are actions identified to assist the family in working towards problem resolution as well as child safety. Recommendations can be agency or individual specific but must be supported by documentation in the interview report.

G. **Forensic Interviews**

A forensic interview is a structured interview to elicit a complete and accurate narrative of facts from the alleged child/victim in a manner that is legally sound, neutral, and fact finding in nature, to determine whether the child has been abused (or is at imminent risk of abuse) and, if so, by whom.

Forensic interviews are conducted by a qualified CPT interviewer. A forensic interview is conducted with the alleged child/victim, while a specialized interview may extend to family members or other parties in a child abuse investigation. Case identifier fields will auto populate to the created report. The forensic interview report consists of narrative sections which provide the following:
• **Summary of Interview** – This section should include a clear statement of events, as told by the child/victim. This section also documents the names and roles of individuals observing the interview.

• **Safety and Risk Factors** – This section should document any child safety or risk factors identified as a result of gathering any information known thus far, including any caregiver protective capacity. It is important to note any immediate child safety issues here, or any discussion of child safety planning, if applicable.

• **Interview Findings** – This section will document the findings related to the information obtained from the child’s interview regarding the maltreatments explored.

While there are no established guidelines that set specific ages for determination of the appropriateness for interviewing children forensically, there are research studies that suggest that children under the age of four (4) are at higher susceptibility for suggestibility and memory issues than older children. Decisions to interview children under the age of four (4) should be based on a sound and thorough developmental assessment; however, at no point should a child under three and one-half (3 ½) years old be interviewed forensically.

Teams may interview children under 4 years old and include it as a specialized interview or as part of a psychosocial assessment, provided there is documentation of the child’s cognitive, language and attention capabilities.

DOH strongly encourages that all forensic interviews be electronically recorded and include, both video and audio recording. If video recording is not possible, audio recording should be done. Written notes of the interview should only be used if electronic documentation is not possible, and written notes should be as close to verbatim as possible. All forensic interviews will be documented in CPTIS and provided to the CPI upon completion, but no later than within 10 working days following the interview. Forensic interview information may be included in a social assessment; however, the forensic interview report is not exempt from the timeline requirements.

All CPT staff that conduct interviews or supervise staff who conducts interviews are required to complete DOH approved forensic interview training.

**H. Psychological Evaluations**

The Child Protection Team may recommend a psychological evaluation of a child or family member in order to provide a comprehensive assessment of an individual’s emotional, behavioral, psychological, or intellectual functioning. The psychological evaluation must be performed by, or supervised by, a licensed Psychologist. These evaluations are particularly helpful in identifying the short and long-term psychological effects of abuse, identifying factors that predispose families to the abuse or neglect of children, and in identifying and determining the appropriate mental health needs and interventions.

The report must be stored in CPTIS and provided to the CPI or CBC case manager upon completion, but no later than 20 working days following the evaluation (last interview date).
I. Psychological Consultation

A psychological consultation is the rendering of a psychological opinion by a CPT Psychologist. Psychological consultation may include a review of existing records and must result in a report that is stored in CPTIS and provided to the referral source upon completion, but no later than 20 working days following the consultation. At a minimum the report should include reason for the consultation, records reviewed and the resulting opinion provided by the Psychologist to the team.

J. Developmental Screening

The CPT Program Policy is that all children seen by the CPT, who are under the age of three (36 months), will be screened for developmental delays. Exceptions to the screening are: when the only assessment activity provided is a medical consultation, staffing attended, CPT staffing or the child referred has a date of death or the child is an active client with the local Early Steps program (ES). The developmental screening will be completed by the CPT medical provider or Case Coordinator and stored in CPTIS. If the screening indicates developmental delays, the child will be referred to the local Early Step office utilizing the referral process defined in the agreement between the local CPT and local ES. When the referral is made, a copy of the ES referral checklist and form will be provided to the local ES program. Additionally, this will be documented on the registration screen and the case progress notes in CPTIS.

If the developmental screening indicated the child has not obtained his/her milestones, then a referral to the local ES should be completed. Section 3 contains other concerns that could justify a referral to the local ES program.
4.3 Staffings

Teams may assist CPIs and CBC case managers by facilitating or attending multi-disciplinary staffings. Information presented and shared during reviews and staffings is confidential and participants must be informed of the required CPT confidentiality. CPT Staffings are considered a core CPT service. CPT staff convene and lead CPT staffings. Types of staffings include:

A. Child Protection Team (CPT) Staffing

A Child Protection Team staffing is a meeting scheduled and led by the Child Protection Team, which may include, but is not limited to, representatives from medical, psychological or mental health (i.e., psychologist, licensed mental health counselor, LCSW, LMFT), legal (CPT attorney, GAL attorney, CWLS, SA), social worker or case manager, a representative from DCF or sheriff’s office (preferably the CPI), and/or the designated community-based care provider who has primary responsibility for the case, and other professionals who have interacted with the child and family (i.e. local CMS Office, Early Steps Program and school personnel). Participants in the staffing will be determined by the needs of the child/case.

A Child Protection Team staffing may be convened by the team for the purposes of gathering information; or may be requested by the CPI or any other professional working with a specific family who has been referred to the child protection team for assessment services and should be scheduled and arranged as timely as possible by the CPT Case Coordinator. The Team Coordinator or their designee will facilitate the staffing.

The purpose of a Child Protection Team staffing is sharing or obtaining information (recent allegations and any history), assessing risk, planning additional assessment activities and/or reaching consensus regarding recommendations.

Suggested cases that would benefit from a CPT staffing are as follows:

- children who have three or more prior reports, regardless of findings, and the report meets the mandatory criteria for referral to the Child Protection Team.
- cases in which there is concern about placement and safety,
- cases in which there are legal issues needing clarification prior to dependency or criminal court,
- cases in which professionals involved do not agree,
- any complex or high risk cases in which a multidisciplinary approach is needed for comprehensive case collaboration and intervention planning, and
- medically complex children

Case Coordinators must document the date of the staffing in the CPTIS case progress notes and create the CPTIS electronic report. The report will be provided to the CPI or CBC case manager upon completion but not more than 10 working days following the staffing. The report consists of the following narrative sections:

- **Purpose of Staffing** - This section clearly identifies and explores the Hotline allegations and related referral information. The information in the Reason for Referral section on the intake screen shall auto populate to this section with the ability to edit. Documentation in this section should indicate the need for the staffing.
• **Summary of Discussion** – This section includes a summary of actions that have already occurred on the current case and any history of prior involvement with DCF/CPT or other community partners, as shared by all involved in the staffing.

• **Safety, Risk and Protective Capacity** - Documentation in this section should clearly indicate all identified child safety and risk factors with supporting documentation. This includes parent/caretaker protective capacity as well as identification of any barriers to the services and supports needed.

• **Summary of Services and Supports Needed** - Services and supports needed to address issues which impact on child safety and risk, as identified by the group.

**B. Documentation of Staffings Attended**

Child Protection Teams may receive requests to attend a variety of meetings convened and led by other providers or agency representatives. These staffings are formal meetings of two or more separate service providers or agency representatives for the purpose of sharing information, to determine present risk to a child, making plans to complete additional assessment activities, or obtaining more information, if needed. An example would be an Early Service Intervention (ESI) Staffing. Staffings initiated by other than the CPT are included in this category if the purpose of the staffing includes assessment or risk issues and meets the above criteria.

Teams should document this assessment activity in CPTIS only when the team has accepted the referral and provided other CPT assessment services. Staffings attended by a member of the Child Protection Team must be documented in the electronic case progress notes indicating the date and time of the staffing, who attended on behalf of the team and summary of the staffing. The team is not responsible for completing the staffing report.

**C. Medical Neglect Staffings**

In CPT cases where there has been a positive finding for medical neglect, CPT must notify DCF and/or sheriff’s office of positive findings within twenty-four (24) hours. It is the responsibility of DCF to arrange for a medical neglect staffing. All CPT personnel involved in the case must attend. Documentation of attendance at this staffing should be in CPTIS. This staffing does not require a written report by CPT personnel.

**4.4 Court Activity – Testimony or Deposition**

Section 39.303(1)(e), Florida Statutes, requires Child Protection Teams to provide expert medical, psychological, and related professional testimony in court cases. Court activity only includes sworn or affirmed testimony in or out of court by a member of the Child Protection Team, and that activity includes the time spent in reviewing records and in team consultation for court preparation.

Since CPT records are confidential, information is usually only provided to those as specified in Chapter 3, Section 3.12 of this Handbook. Depositions in criminal and family court require court orders for members of the Child Protection Team to release records and information.

**4.5 Other Child Protection Team Activities**
In addition to case-specific assessment activities, CPT staff is responsible for other activities that are not related to a case that has been opened in CPTIS. These activities include:

A. Training

Section 39.303(1)(h), Florida Statutes, requires that Child Protection Teams provide training to physicians and other medical personnel and to other professionals, including, but not limited to DCF staff, law enforcement, school personnel and GALs, on the identification or determination of abuse or neglect. Training includes public and media presentations on child abuse as well as specific training designed to develop and maintain the professional skills and abilities of those handling child abuse, abandonment and neglect cases.

Additionally, staff is required to complete training that includes a minimum of eight hours per year in child abuse, abandonment, and neglect for appropriate Child Protection Team staff and subcontractors.

Data on physician, team and staff trainings must be entered into CPTIS. To avoid duplication of training events, the training event itself is counted as one activity if it covers the same training topic. For training events that provide multiple sessions, different topics and presenters, each session may be counted as a single event. If there are multiple presenters for one topic only one presenter may be identified in CPTIS and the training will be entered one time only. Also note that training a medical student (medical resident completing a rotation at the CPT) over a period of time is counted as one event.
CHAPTER 5: PROGRAM STANDARDS AND QUALITY ASSURANCE

5.1 Standards Authority

The Child Protection Team program operates in accordance with the standards and program rules established in s. 39.303, F.S., and Chapter 64C-8, Florida Administrative Code. Operational procedures and standards are further clarified in this handbook and in the annual CPT contract. Program rules and standards address issues of eligibility for services, provider qualifications, services, and record/data requirements. A formal assessment of team services and compliance with program standards and requirements is conducted through the quality assurance/improvement reviews as identified in the CPT Program Quality Assurance/Improvement Handbook.

5.2 Performance Standards

A. Standards

By executing the contracts, CPT providers agree to comply with the conditions, standards, and indicators of performance set forth in the contracts. These requirements include but are not limited to:

Assessment Activities. For all children appropriately referred to and accepted by the Team, assessment activities will be completed within 20 calendar days following the date of referral, unless an appropriate exception is documented, 90% of the time. Achievement will be determined through a review of CPTIS statistical reports.

Abuse Report Review. All reports of abuse, neglect and abandonment received by the Team shall be reviewed by the Medical Director and the Team Coordinator (or their respective designees) to determine if the report meets the mandatory criteria for referral to CPT, 98% of the time. Achievement will be determined through a review of CPTIS statistical reports.

Final Case Summary. A formal written document will be sent to the CPI or CBC case manager to provide pertinent case information at the time of case closure. Achievement will be determined through a review of CPTIS statistical reports.

Positive Findings – Verbal Notification. CPT will verbally communicate any positive indication of abuse or neglect to the CPI, or his/her superior, within 24 hours of determination, 95% of the time. Achievement will be determined through a review of CPTIS statistical reports.

Assessment Report Timeliness. Written assessment reports will be provided to the CPI or CBC case manager within the time frames, 90% of the time, and must contain all elements as specified in the CPT Handbook. Achievement will be determined through a review of CPTIS statistical reports.

Medical Training. The provision of a minimum number of training sessions for emergency room and other non-CPT medical personnel in the detection of child
abuse and neglect during the contract period. Achievement will be determined through a review of CPTIS statistical reports.

**Child Protection Team Training.** The provision of a minimum number of training sessions for DCF, local sheriff’s offices and other local agencies, involved in child protective investigations or services, in mutually agreed upon subject areas of child abuse and neglect during the contract period. Achievement will be determined through a review of CPTIS statistical reports.

**Child Protection Staff Training.** The provision of a minimum number of hours of training in child abuse, abandonment and neglect for appropriate Child Protection Team staff and subcontractors. Achievement will be determined through a review of CPTIS statistical reports.

The core contract for the Teams identifies services that must be provided by each Child Protection Team and the required percentages for compliance with the above standards. Compliance with contract standards will be determined through CPTIS reports and Team quarterly performance measure reports and, if applicable, quarterly conference calls with the contract manager. For this reason, the Team Coordinator and Medical Director must ensure that all services and activities are documented in CPTIS. On-site or desk reviews validate data in CPTIS.

If a Team meets one or more of the following criteria, a weekly phone call will take place between the Team Coordinator or designee and the contract manager or designee until all issues necessitating the weekly call are cleared:

1. The Team has 50% or more of their cases open over 60 days.
2. The Team’s quarterly performance measures have been out of compliance for two (2) consecutive quarters.
3. The Team has received a penalty on their monthly invoice due to noncompliance.

**B. Monitoring**

Child Protection Teams must meet the core performance standards set forth in the executed contracts. By execution of the contracts, providers acknowledge an understanding that the achievement of these standards will be reviewed, achievement reported, and corrective action made when performance standards have not been met. If the department affords the provider an opportunity to achieve compliance, and the provider fails to achieve compliance within the specified time frame, the department can terminate the contract in the absence of any extenuating or mitigating circumstances. The determination of the extenuating or mitigating circumstances is the exclusive determination of the department.

1. **Scope of Review**

At a minimum, all quality assurance reviews must include an assessment of compliance with the standards and requirements outlined in the contract.
2. **Methodology**

The provider’s program will be reviewed annually, unless otherwise determined by the program office, utilizing standard statewide monitoring instruments.

3. **Reports**

The report resulting from the review will address the Team’s performance in relation to minimum standards and CPT Handbook requirements. The report may include recommendations for addressing performance measures not met.

Additionally, the quarterly CPTIS Performance Measure report (emailed to providers and contract managers the 10th day of the month following the quarter) is used by the Team Coordinators to complete the Quarterly Report which is provided to the contract manager no later than 10 working days after the 10th day. Data from this report is used to address ongoing compliance with contractual performance standards. Appropriate follow up via a conference call, if needed, will be determined by the contract manager and Team Coordinator.

C. **Waivers**

In the event that compliance with a standard established in Chapter 64C-8, Florida Administrative Code, is not attained, a team may request a waiver of that standard. The CMS program office will make final approval or disapproval of all requests for waivers. The CMS Program Office shall notify the team in writing that the request for waiver of a specific standard has been granted or denied. All requests for waiver involving personnel qualification must be submitted by the team and approved by the program office prior to hire. All requests for waivers to be submitted must follow the protocol established by the Program Office.
CHAPTER 6: CHILD PROTECTION TEAM INFORMATION SYSTEM

6.1 Child Protection Team Information System (CPTIS)

The Child Protection Team Information System has been created to meet the data needs of the local Child Protection Teams and Children's Medical Services. This includes tracking client registration, service provision, assessment reports and case progress notes as well as the ability to track program compliance with contractual requirements, and measuring program performance on key indicators. This system provides all authorized CPTIS users with the ability to follow the case from the date the case was accepted for services until the date the case was closed. Key elements of the system include on-line display or printable case-specific information, and printed management reports (individual coordinator, team and statewide) for use by both CPT and CMS staff.

CPTIS is a .NET web-based program supported by the CPT program office and the DOH Office of Information Technology (OIT). Major elements of the system are: demographic information, referral information, registration information, assessment activities and reports, family information, abuse report review, other CPT activity, and provider information. Each of these sections contain screens necessary for data input. Each screen has “mandatory” fields, i.e., fields that are required to successfully create a new record. Each screen also has built-in edit checks to ensure data integrity.

6.2 System Security

The system requires the user to enter a unique USER ID and PASSWORD. The USER ID/PASSWORD combination contains the security codes necessary for the various security profiles. The four security levels are: Administrator, Manager, User and View Only. The Administrator profile is limited to key program office staff. The Manager profile has unrestricted rights and may view, update and delete information in the system, with the exception of a demographic screen. The User profile has restricted rights and may add and update, but cannot delete specified information. The View Only profile may only view records and print reports. Users and managers must not share USER IDs or PASSWORDS with anyone, including other persons who have access to the data system.

All new staff/providers/volunteers will be required to complete the DOH Information Security and Privacy Awareness test in the TRAIN system prior to being given approval for access to the DOH Network and any database systems accessed through the DOH Network. Once the Team Coordinator has submitted the appropriate forms to the program office and access has been approved, the usernames and passwords will be sent to the individual. At no time will passwords and usernames be shared or access provided by use of a staff person’s username and password. Please review the CPTIS Guide for the policy and procedures related to new user access.

The CPTIS User Guide provides instructions for navigating through the data system. Please refer to the Guide for more specific explanations and instructions.

6.3 System Screens

CPTIS screens capture case specific information to create the electronic case file. Each Team is responsible for ensuring that data in CPTIS is accurate and up to date. Team Coordinators and
Case Coordinators are expected to review CPTIS case specific screens, reports and client histories for accuracy.

CPTIS data screens include:

- **Abuse Report Review** – Documents all abuse reports received from the Department of Children and Families or designated sheriffs’ offices and reviewed by the team. It also documents all abuse reports identified as meeting mandatory referral criteria.

- **Intake / Referral Screen** - Captures information pertaining to child abuse investigations, client and family demographic data, alleged maltreatments identified, assessment services agreed upon and the intake/referral decision.

- **Demographic Screen** – Provides specific information on each client in the data system (name, address, age, race, etc.). This screen is also used to enter family/household member information.

- **Registration Screen** – Documents initiation and termination dates, alleged and assessed maltreatments, the overall case finding, and the dates that the Interim, if completed and Final Case Summary reports sent.

- **Assessment Activity Screen** – Tracks all assessment activities provided by the team.

- **Assessment Report Screens** – Provides specific information based on the type of assessment activity completed.

- **Case Progress Notes Screen** – Provides individual case activities completed.

- **Case Progress Notes Report** – Provides complete history of case notes completed.

- **Report Summary Screen (Interim, Final and Addendum)** – Captures information on the reason for referral, assessments provided, assessment of risk, and conclusions/recommendations in a case.

- **Other CPT Training** – Tracks contractually mandated training provided or attended by team members and appropriate subcontracts.

- **Provider Information** – Contains information regarding individuals (such as Psychologists, attorneys, medical providers, Case Coordinators, or Team Coordinators) who provide team services.

### 6.4 CPTIS Management Reports

**Management Reports** – Compiles data specific information in the team or statewide format. CPTIS reports assist the teams in case management, review and performance measures. These include but are not limited to:

- Abuse Report Review
- Performance Measure Report
- Mandatory Abuse Reports Not Referred
- Caseload Report
- Summary of CPT Assessment Activities
Active Cases
CPT Training Report
Management Data Review
Early Steps Report
Telemedicine Report

Additional CPTIS Menu options are:

- **Help Center** – Allows users to type in data requests, questions and concerns related to CPTIS.
- **Training Videos**
- **SATIS** – Sexual Abuse Treatment Information System – This is available through the CPTIS but only to those authorized to access.
- **System Guide** – This user guide will be maintained on the Children’s Medical Services website and in CPTIS. It will be updated regularly to reflect modifications to the system or changes in policy that might impact code tables or definitions.
- **Help Maintenance** – Allow the administrator of the system to update the definition of a specific field. This item will not show for any user other than administrator.

**User Options** – Allow the user to enable/disable the pop-up calendar used in the system and add signature credentials to accompany their signatures on assessment reports.

**System Enhancements and Changes**

During the course of the year, system enhancements or changes may be implemented to improve data collection or to increase system outputs. Team staff will receive email notifications of system enhancement and changes prior to the changes being moved into production. Team staff will be responsible for maintaining an updated CPTIS Guide (which will include email notifications throughout the year) to ensure accurate data input and collection.
APPENDIX A:
PERSONNEL QUALIFICATIONS AND RESPONSIBILITIES

A. Statewide Medical Director

Qualifications:

- As of July 1, 2015, must be a Florida licensed physician under Chapters 458 or 459, F.S., who is a board-certified pediatrician with a subspecialty certification in child abuse from the American Board of Pediatrics. Approved CMS physician provider.
- Have demonstrated interest in and received training in child abuse and neglect diagnosis, maintain direct medical skills in medical evaluations of child abuse and be willing, as directed by CMS, to continue child abuse and neglect in-service training.

Responsibilities and Duties:

- Provide statewide overall medical over site of the child protection teams and team Medical Directors.
- Provide statewide leadership in establishing an effective and coordinated response to Child Abuse Hotline reports with the Department of Children and Families representatives.
- Provide, upon request, second opinion medical evaluations of children within time frames as specified in the CPT Handbook.
- Recruit, and make recommendations to the Division Director of Children’s Medical Services for appointment and dismissal of team Medical Directors.
- Complete and provide to the CMS Division Director or designee, annual evaluations of all team Medical Directors within 30 days of the departments fiscal year end date.
- Coordinate with the team Medical Directors to ensure that all team medical providers have obtained CMS approved physician or physician Extender Status, prior to employment or execution of service contract.
- Direct and monitor child abuse education for CPT medical providers and team staff by utilizing video conferencing and webinar technology. Provide abuse and neglect training sessions for scheduled meetings.
- Participate on the DCF Critical Incident Rapid Response Team (CIRRT) Advisory Committee, which meets quarterly.
- Provide statewide guidance and annual review of Medical Directors’ (or designee) screening of child abuse reports made to the Florida Abuse Hotline.
- Be available 24 hours a day, seven days a week for consultation to team members and team physicians, including telemedicine consultation, when available and appropriate, for medical assessment needs. Arrange coverage by another CMS approved CPT Medical Director when unavailable.
- Participate in monitoring of the medical assessments completed by the child protection teams as a member of the statewide designated monitoring team.
• Attend statewide child protection team meetings and other meetings and training sessions as required to maintain the knowledge and skills required for this position. Maintain direct medical skills in medical evaluations of child abuse.
• Provide depositions and expert court testimony when appropriate. Reimbursement for expert testimony is not provided by CMS and must be sought by the physician through the usual court procedures.
• Successful completion of a minimum of eight hours of medical training per year in child abuse, abandonment, and neglect.
• Utilize the Child Protection Team Information System (CPTIS) to document CPT assessment activities.
• Serve on the Statewide Child Abuse Death Review (CADR) Committee.

B. Team Medical Director

Qualifications:
In accordance with CS/HR 1269:
Must be a Florida licensed physician under Chapters 458 or 459, F.S. who is:
(1) A board-certified Pediatrician and who, within four (4) years following the date of employment, either (a) obtains a sub-specialty certification from the American Board of Pediatrics in Child Abuse Pediatrics or (b) meets the requirements established by a third-party credentialing entity recognizing demonstrated specialized competence in child abuse or
(2) A board-certified Family Physician who, within 2 (two) years following the date of employment, meets the requirements established by a third-party credentialing entity recognizing demonstrated specialized competence in child abuse.

Each Child Protection Team Medical Director already employed as of July 1, 2015, must, by July 1, 2019, either obtain a subspecialty certification in Child Abuse from the American Board of Pediatrics or meet the minimum requirements established by a third-party credentialing entity recognizing a demonstrated specialized competence in Child Abuse Pediatrics.

Responsibilities and Duties:
• Provide overall direction and supervision of the team(s) for program service delivery and administration.
• Provide leadership in establishing an effective and coordinated response to Child Abuse Hotline reports with the designated area Department of Children and Families representatives. Participate and represent the team(s) in the designated community service area as appropriate.
• Provide medical evaluations of children and supervise and review the work of the provider agency's team medical practitioners, including contracted and fee for service medical personnel for the provision of team medical evaluations of children suspected to be abused or neglected.
• Recruit, and make recommendations to the Deputy Secretary for Children’s Medical Services for appointment and dismissal of team physicians and other medical professionals, including fee for service or independent contract personnel for team medical services. Assist physicians and advanced registered nurse practitioners recruited in obtaining CMS approved physician or physician Extender Status.

• Work in collaboration with contracted agency representatives in the recruitment, appointment and dismissal of Team Coordinator or Case Coordinator positions.

• Review and sign off on the annual team budget and final revenue and expenditure report.

• Arrange for and provide in-service training and other professional development for team staff and medical personnel. Assist the statewide CPT Medical Director in the planning and provision of training for regional and statewide training sessions.

• Participate as a committee member (or appoint a medical designee) in the local Child Abuse Death Review (CADR) Committee.

• Annually, plan and conduct a minimum of two training sessions in the detection of child abuse and neglect for area physicians and other medical staff, particularly those working in the hospital emergency rooms.

• Provide guidance and oversee the team’s screening of child abuse reports made to the Florida Abuse Hotline and provide selected direct screening as required by law, or when otherwise determined appropriate.

• Be available 24 hours a day, seven days a week for consultation to team members and team physicians, including telemedicine consultation, when available and appropriate, for medical assessment needs. Arrange coverage by another CMS approved CPT Medical Director when unavailable.

• Assure medical representation for team staffings.

• Participate in peer reviews with other team physicians and other medical providers. If designated and approved, participate in monitoring of child protection teams as a member of the statewide designated monitoring team.

• Attend statewide child protection team meetings and other meetings and training sessions as required to maintain the knowledge and skills required for this position. Maintain direct medical skills in medical evaluations of child abuse.

• Provide medical consultation in an area of expertise to other teams when requested.

• Provide depositions and expert court testimony when appropriate. Reimbursement for expert testimony is not provided by CMS and must be sought by the Physician through the usual court procedures.

• Successful completion of a minimum of eight hours of medical training per year in child abuse, abandonment, and neglect.

• Track the completion of training requirements for all medical providers.

• Ensure all medical providers have been approved as a CMS Physician provider prior to employment.

• Serve on the DCF Critical Incident Rapid Response Team (CIRRT) if appointed.
C. Medical Provider

I. Advanced Registered Nurse Practitioner (ARNP)

Qualifications:
- Licensure in the state of Florida to practice professional nursing and certification in advanced or specialized pediatrics or family medicine nursing practice.
- Experience in the evaluation and treatment of child abuse and neglect or agree to receive training deemed necessary by the department for evaluating alleged abuse and neglect.
- CMS approved physician extender.

Responsibilities and Duties:
- Provide diagnostic evaluations and medical consultations regarding abused and neglected children.
- Attend team staffings, as necessary.
- Prepare medical reports of evaluations and medical consultations in CPTIS.
- Provide depositions and court testimony.
- Participate in after hours on call, as scheduled.
- Successful completion of a minimum of eight hours of training per year in child abuse, abandonment, and neglect.

II. Physicians

Qualifications:
- Graduation from an accredited school of medicine with board certification/eligibility in pediatrics and licensed to practice in Florida.
- An approved CMS medical provider.
- Experience in the evaluation and treatment of child abuse and neglect or agreement to receive training deemed necessary by the department for evaluating alleged abuse and neglect.

Responsibilities and Duties:
- Provide diagnostic evaluations and medical consultations regarding abused and neglected children.
- Attend team staffings, as necessary.
- Prepare written reports of evaluations and medical consultations.
- Provide depositions and court testimony.
- Participate in after hours on call, as scheduled.
- Successful completion of a minimum of eight hours of training per year in child abuse, abandonment, and neglect.

III. Physician Assistant (PA)

Qualifications:
- Licensure in the state of Florida to practice.
• Experience in the evaluation and treatment of child abuse and neglect or agree to receive training deemed necessary by the Department for evaluating alleged abuse and neglect.
• CMS approved physician extender.

Responsibilities and Duties:
• Provide diagnostic evaluations and medical consultations regarding abused and neglected children.
• Attend team staffings, as necessary.
• Prepare written reports of evaluations and medical consultations.
• Provide depositions and court testimony.
• Participate in after hours on call, as scheduled.
• Successful completion of a minimum of eight hours of training per year in child abuse, abandonment, and neglect.
• Maintain national certification as a physician assistant (recertifying board exams every six years).

D. Team Coordinator

Qualifications:
• Bachelor or Master’s Degree in a Human Services field, Psychology, Social Work, or Nursing.
• At least three years of post-bachelor experience in the field of child abuse and neglect, one of which must have been in program management.
• In addition to the requirements as specified in Florida Administrative rule, 64C-8.002(2)-(b), Team Coordinator qualifications will include at least one year of experience in Child Protection Services (Child Protective Investigations, Community Based Care Case Management, Child Protection Teams).

Responsibilities and Duties:
• Coordinate the daily activities and services of the CPT, including arranging for non-medical staff availability 24 hours a day, 7 days a week.
• Train, coordinate, and supervise team staff.
• In conjunction with the Medical Director, ensure that child abuse reports made to the Florida Abuse Hotline are received and that reports are reviewed by the Medical Director.
• Coordinate services with the child protection staff from DCF and other agencies, other health programs, and local community resources.
• Serve as a liaison with the CMS Program Office to ensure compliance with standards, policies, and performance criteria.
• Participate in the development of the team budget.
• Assist the team Medical Director in the overall operation of the team.
• Provide or arrange for training in the community for professional staff and others.
• Successful completion of a minimum of eight hours of training per year in child abuse, abandonment, and neglect.
• Ensure that required training hours for staff and subcontractors is documented in the Child Protection Team Information System.
E. **Case Coordinator**

**Qualifications:**
- A Bachelors or Master's degree in a Human Services field, Psychology, Social Work or Nursing.
- At least two years of post-bachelor experience working with children or families, one year of which must be working with abused and neglected children.

**Responsibilities and Duties:**
- Interview children, family members, and significant others as needed to obtain medical and psychosocial information.
- Complete assessments and send reports to the CPI upon completion, but no later than within the time frames consistent with program requirements and best practice.
- Coordinate client services and referrals to community agencies.
- Arrange for and conduct team staffings and participate in the development of the recommendations.
- Provide depositions and court testimony.
- Maintain client records.
- Conduct training in the community for professional staff and others, as designated by the Team Coordinator.
- Participate in scheduled after hours on call.
- Successful completion of a minimum of eight hours of training per year in child abuse, abandonment, and neglect.

F. **Team Psychologist:**

**Qualifications.**
The Psychologist for the Child Protection Team shall be required to meet the following standards and qualifications:
- Licensure under Section 490, Florida Statute, and will adhere to the standards of competent, ethical practices in accordance with the American Psychological Association and the Florida Department of Business and Professional Regulation (DBPR).
- Formal, specialized graduate training and successful completion of ongoing continuing educational training in the areas of child development, child and adult psychopathology, all aspects of childhood abuse and victimization, post-traumatic stress disorder (PTSD), and psychotherapy with children and adults.
- A minimum of one year of supervised experience and two years minimum of independent professional experience in the evaluation of children and adults. Included in the three years of professional experience shall be at least 100 hours of experience in dealing with child abuse cases including neglect, physical abuse, sexual abuse, psychological abuse, failure to thrive, and other forms of childhood victimization.
• Should have sufficient professional experience and expertise that would allow them to be qualified as a mental health and family violence expert in criminal, civil and dependency courts in Florida.
• A CMS approved provider.
• Available to work with the team on a part-time or full time basis under the administrative supervision of the team Medical Director and/or Team Coordinator as appropriate.

Responsibilities and Duties.
The Psychologist for the CPT must play a number of essential roles for the team that involve both clinical and forensic aspects of child abuse or neglect and family violence. The Psychologist will be required to provide a broad array of clinical services that will include but not necessarily be limited to:
• Psychological evaluation of children and adults in cases of alleged child abuse and neglect.
• Clinical interviews with children.
• Consultation with Case Coordinators in their assessments
• Referral of children and adults to psychotherapy for abuse and neglect issues.
• Timely submission of written reports of evaluations to the team as required by contract or dictated by best practice.
• Participate in team staffings and the development of recommendations.
• Provide depositions and expert court testimony when appropriate.
Reimbursement for expert testimony is not provided by CMS and must be sought by the Physician through the usual court procedures.

G. Team Attorney

Qualifications:
• Member of the Florida Bar.
• Availability to work with the team on a part-time basis under the administrative supervision of the team Medical Director or designee.

Responsibilities and Duties:
• Provide legal services, consultation, and training to the team.
• Attend staffings as necessary and, when appropriate, participate in the development of recommendations.
• Represent the team or individual members who are acting in their official capacity as team members in court.

H. Professional Consultants (which includes physicians, ARNPs, attorneys, Psychologists (or psychiatrists))

Qualifications:
• Availability, as needed or appropriate, for consultation, diagnosis and evaluation in cases of child abuse or neglect
• Experience in the evaluation and treatment of child abuse and neglect or agreement to participate in training, as required.
• Must meet the qualifications as listed above.
• For appropriate positions, be a CMS approved provider.
• For consulting pediatricians: graduation from an accredited school of medicine with board certification/eligibility in pediatrics, licensed to practice in Florida and be an approved CMS physician.

Responsibilities and Duties:
• Provide diagnostic evaluations and medical consultations regarding abused and neglected children.
• Attend team staffings, as requested, on children for whom services were provided to assist in the development of recommendations.
• Provide written reports to the team within established time frames as specified in the contract.
APPENDIX B:

ADMINISTRATION

Certain statewide guidelines and protocols have been developed to assist providers in complying with requirements for the delivery of program services under the Child Protection Team program (CPT contract). The Child Protection Team contract is a statewide program-specific model contract. The information in this section is specific and supplemental to the contract language. Contract language may be repeated for clarification.

A. Fiscal

1. Method of Payment.

The Child Protection Team contract method of payment is based on a negotiated fixed rate (fixed fee) total annual contract amount disbursed monthly at a fixed rate, paid after the delivery of a month’s services. When there is a renegotiation of the total annual contract amount during the contract year, the remaining monthly fixed rates are adjusted accordingly.

2. Program Budget

Once contract amounts are determined, providers must submit a proposed program budget and supporting narrative to the program office. The proposed budget is the justification for funding service delivery and must have documentation that the budget was reviewed by the CPT Medical Director. The budget will provide a breakdown of all CPT program revenue and expenditures. All program income available (including any received but not expended to date) and expected to be received during the contract period must be projected, and each type identified by line item with narrative explanation. The proposed program budget must project revenue and expenditures for the program services and eligible clients defined in the CPT contract. Provider will separate program funds by funding sources. Specifically, DOH funds and expenditures will be separate from third party funds and expenditures.

Proposed expenditures must be reasonable and necessary in order to provide the program services defined in the contract. An accompanying DOH budget narrative must indicate the type of expenditure by line item and clearly explain how the proposed expenditure supports the program.

The contract manager reviews the proposed and/or amended program budget, resolves any questions/issues with the provider and approves prior to contract execution or approves with written contingencies and due dates that are binding on the provider.

a. Deficit Budgeting

Deficit budgeting is not allowed. However, if revenue projections exceed planned expenditures, initially and temporarily, a “contingency” expense line item may be budgeted to allow time for planning for the use of the unexpected revenue available prior to the end of the contract year.
b. **Format**  
Providers must complete their CPT budgets utilizing the DOH Provider Budget format.

c. **Cost Sharing**  
When costs are shared with other programs of the provider agency, the provider must determine the Child Protection Team share of cost based on an acceptable methodology (i.e. head count, square footage). The proposed budget narrative must specify the totals (e.g. head count) and the total cost and show the calculations to arrive at the CPT share of the cost.

Positions that show shared funding must have time study reports completed to provide justification for the time spent and cost charged to the CPT program budget.

d. **Percentages of Cost**  
Any percentage of direct personnel salary and benefit costs for general agency management paid for by CPT funds must include clear documentation of each individual’s functional activities supporting the provision of CPT services and related administrative duties. **NOTE:** The Team Coordinators and/or designees must spend a minimum total of 75% of their time providing programmatic and administrative oversight of the CPT contract program.

Indirect Cost Rate Percentage must be negotiated (except for maximum statutory rates for state agencies).

e. **Travel Expense Budgeting.**  
The provider must budget and pay for any work-related costs for travel and required training of the CPT Medical Director, and may pay for travel and training costs specified as needed by the CMS Program Office for other professional contractual personnel, unless such costs are included in the rate of pay agreed upon with the sub-contractor. **Language in the subcontract for other professional contractual personnel must clearly state the provider's intent to pay for required travel and training, as it relates to services provided to the CPT.**

The provider must budget sufficient travel expense to ensure that Child Protection Team staff attend all required meetings and trainings. If a CPT employee’s financial resources are not sufficient to support required travel, the provider must consider prepayment or advance funds to accommodate the employee’s participation.

All travel reimbursement must be supported by the use of travel voucher forms which identify meal allowance, per diem rates, mileage rates and date/time of departure and return. Further, the purpose of travel and benefit to the program should be clearly documented.

f. **Prohibited Expenditures**  
Certain types of expenditures are prohibited when utilizing DOH funds. These are:

1) Depreciation of non-expendable property, which is defined as those items costing $1000 or more per item (or packaged item). Expenditures to acquire such property are allowed provided they are reasonable and necessary.
2) Depreciation of assets other than non-expendable property, including fixtures and buildings. Necessary and reasonable acquisition costs for assets and buildings may be budgeted based on the CPT share of cost. Actual current building expenses presented as rent must be evaluated as to reasonableness based on local market rates.

3) Food

4) Purchases that confer or provide ownership by clients (food, clothing, furniture, etc.) Travel costs may be paid for a client in order for them to participate in CPT services when not available otherwise.

5) Fund-raising and lobbying costs.

6) Miscellaneous line-item costs (or petty cash funds) exceeding $150.00

7) Any other cost that is determined not to be reasonable and necessary to the provisions of services under the contract as specified in the Department of Financial Services, Reference Guide of State Expenditures.

g. Incentive Compensation/Bonuses:
Inventive pay (with DOH funds) is not permitted pursuant to Section, 215.425, Florida Statutes.

h. Special Projects Budgeting
Special projects are those services not considered a part of the basic CPT statewide assessment services. These projects must be separately identified and budgeted as a special sub-category with specific line items, including narrative explanation and justification. Any income specifically designated for the project must also be identified as a line item in the income section of the budget, including a narrative to explain all sources of income.

These projects must have separately identified program deliverables. Final expenditures and income must be reported in the same separately identified format as in the approved budget.

1) Telemedicine Component. If a provider’s CPT contract has a telemedicine support component and funds are received to support the telemedicine costs and activities, the income and budget must be separately identified in the budget process and final reporting.

2) Medical Oversight. For those teams that contract for medical oversight, this component is not considered a “special project”, however, the deliverables must be separately identified in the contract program budget, and final expenditure and revenue report.

i. Use of Child Protection Team Funds for Matching Purposes
Child Protection Team funding is primarily state general revenue and federal Social Services Block Grant Funds. Most CPT contracts include both sources of funding. The federal Social Services Block Grant Funds used by the DOH CPT program do not have
any matching requirements; therefore, the CPT state general revenue is not being used to match any federal funding source.

While state funds can be used to match federal funds, because CPT state general revenue can only be used for carrying out the CPT contract program these funds can only be used to match federal funds if the use expands the CPT program to provide additional services or contract eligible clients. Additional federal funds received would become CPT program income and must be budgeted as such.

Note: The administering agency for federal funds makes the determination as to what funds are acceptable as matching funds for their particular federal program. If consideration is being given to use of the CPT program state general revenue as match, the provider must share the department's position as to their use stated in the above paragraph.

j. Program Budget Management.
Each provider must have a contract budget management team that, at a minimum, includes the CPT Medical Director, the CPT Team Coordinator and provider agency administrative and fiscal personnel. The budget management team must routinely review the approved budget, program expenditures and generated revenue and plan for any necessary revisions as needed. This management team will also prepare the Child Protection Team proposed budget, any amended budgets and review the six-month expenditure report and final expenditure report.

k. Documentation. The Provider is required to maintain separate accounting of revenues and expenditures of funds under this contract and each CSFA or CFDA number identified on Exhibit 1 of the contract, in accordance with generally accepted accounting practices and procedures. Expenditures which support Provider activities not solely authorized under this contract must be allocated in accordance with applicable laws, rules and regulations, and the allocation methodology must be documented and supported by competent evidence.

Provider must maintain sufficient documentation of all expenditures incurred (e.g. invoices, canceled checks, payroll detail, bank statements, etc.) under this contract which evidences that expenditures are:

a. allowable under the contract and applicable laws, rules and regulations;
b. reasonable; and
c. necessary in order for Provider to fulfill its obligations under this contract.

The aforementioned documentation is subject to review by the Department and/or the State Chief Financial Officer, and Provider will timely comply with any requests for documentation.

l. Financial Report. The provider must submit financial reports, as stated in the DOH contract within the required contractual time frames. The financial reports will state, by line item all expenditures made as a direct result of services provided through the DOH funding of this contract. Each report must be accompanied by a statement signed by an individual with legal authority to bind provider certifying that these expenditures are true, accurate and directly related to this contract.
B. **Network System and Information Security**

All Child Protection Team main sites and certain designated satellite offices require DOH network services to access DOH email and approved data systems, and may also access the Department of Children and Families (DCF) network. This access is provided for CPT mandated abuse report functions. These network services are maintained and supported by the DOH Office of Information Technology, the CMS Special Technologies Unit, and CMS Distributed Computer System Analysts (DCSAs). A local CMS DCSA is assigned to each Child Protection Team to provide technical support for these services. The provider must report any technical problems with the use of the services or for connected equipment to their designated CMS DCSA.

1. **Changes and New Connections**

When the provider is moving its office site, the CMS Program Office and the DCSA must be informed of the planned move date and the new site information at least 90 days prior to the effective date of the move. Lead time is needed in order for the timely installation of the network service at the new site. New site network services requests will be reviewed as to their cost benefit by the CMS Program Office.

2. **DOH Authorized Users**

Child Protection Team provider staff and subcontractors must be approved by the CMS Program Office as authorized users. They must have completed the DOH Security Information training in the TRAIN Florida System, and signed the DOH “Confidentiality and Security Statement of Understanding” prior to being given access to the DOH network. Thereafter all appropriate CPT staff and subcontractors are required to retake the test annually.

The “Request to Add/Delete Authorized Users” form must be completed and signed by the requestor and the Team Coordinator and sent to the CMS Program Office before a new user access can be created. The Certificate of Completion (DOH Security Test) must be attached. The CMS Program Office must also be advised and a user change document provided when a user’s authorization needs to be terminated or changed.

Team Coordinators, or their designee, are responsible for timely submission of the form to remove an individual’s access to the Network and data system no later than the last day of employment.

3. **Child Protection Team Information System (CPTIS)**

The department maintains a CPT web-based data management system for the CPT program for which the CMS Program Office provides technical and management support. The provider is required to participate in entering all client data in CPTIS, and has the responsibility of ensuring the quality of the data.
4. **Protection and Security of Equipment**

The provider is responsible for the protection of electronic confidential information. Any security breach or lost or stolen equipment must be reported immediately to the contract manager and the local CMS DCSA. See sections D (Information Security) and E (Asset [Tangible Property] Management) for additional information related to equipment security requirements.

C. **Information Security**

1. **Child Protection Team Program Specific Confidentiality**

Section 39.202(6), Florida Statutes (2012) primarily governs the release of records and reports of child protection teams (CPTs):

- CPT records may be deemed to include all electronic and physical records made by CPTs within the scope of CPT duties and responsibilities under section 39.303, Florida Statutes. (This does not include administrative and business records.)
- CPT records are confidential
- CPT records are exempt from section 119.07(1), Florida Statutes (public records disclosure)
- CPT records are exempt from section 456.057, Florida Statutes (medical records disclosure)
- CPT records may be released upon request to:
  - State attorney
  - Law enforcement
  - Department of Children and Family Services
  - Necessary professionals in furtherance of treatment or additional evaluative needs
  - Health plan payers—limited to information used for insurance reimbursement, and
  - By order of court

CPT records, client demographic data or any CPT client specific information may not be shared within an agency (this includes agency data systems) unless covered by one of the above criteria.

**CAVEAT:** Release upon request to authorized agencies is tempered by proper identification and the requestor’s need to know. Release upon request to authorized agencies is not an open invitation for any employee of those agencies to request and receive CPT records without a legitimate need to have access to those records in order to perform their official duties.

**ADDITIONAL STATUTORY AUTHORITY** for Release of CPT Records

- Child Abuse Death Review Committees: Under section 383.402(8), Florida Statutes, the chairperson of the Statewide Child Abuse Death Review Committee and the chairpersons of duly designated local child abuse death review committees may have access to CPT records.
RELEASE PROHIBITED: CPT records may not be released by means of:

➢ Subpoena duces tecum (identifies documents subject to the subpoena), except from state attorney or chairperson of the Statewide Child Abuse Death Review Committee, or other subpoena (not duces tecum) for deposition or to testify
➢ Consent for release by a child or the child’s parent, legal guardian, legal custodian, guardian ad litem, attorney ad litem, or legal representative

CONTINUING CONFIDENTIALITY: Generally, the confidential and exempt status of CPT records attaches to the documents; that is, it retains its confidential and exempt status when it is properly released to an authorized agency or person, who in turn generally has a legal obligation to maintain the confidential and exempt nature of the documents.

All CPT reports must have the following statement of confidentiality included in all written reports:

“Pursuant to section 39.202(6): All records and reports of the child protection team of the Department of Health are confidential and exempt from the provisions of ss. 119.07(1) and 456.057, and shall not be disclosed, except, upon request, to the state attorney, law enforcement, the department, and necessary professionals, in furtherance of the treatment or additional evaluative needs of the child, by order of the court, or to health plan payors, limited to that information used for insurance reimbursement purposes.

Pursuant to 39.205 (3) A person who knowingly and willfully makes public or discloses any confidential information contained in the central abuse hotline or in the records of any child abuse, abandonment, or neglect case, except as provided in this chapter, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

DISCOVERY EXCEPTION:

➢ CPT records in possession of the state attorney, law enforcement, and the Department of Children and Family Services are discoverable in dependency cases, under Rule of Juvenile Procedure 8.245, and in criminal cases, under Rule of Criminal Procedure 3.220. B.B. v. Dept. of Children and Family Services, 731 So. 2d 30 (Fla. 4th DCA 1999).
➢ Those authorized agencies may release CPT records in their possession pursuant to the applicable rules of discovery, without a court order or review by CPT.
➢ CPTs are not a “party” in dependency and criminal proceedings; however, CPT personnel and experts are often material witnesses, and they are subject to properly served subpoenas to appear and testify at depositions, hearings, and trials for dependency and criminal proceedings. (Remember, for depositions, CPT personnel may testify about CPT records already obtained through discovery; however, a subpoena duces tecum from defense counsel is not adequate to release CPT records, whether already received by counsel in discovery or not. At a hearing or trial, a judge is available to rule on the release of any records.)

CAVEAT: CPTs should involve their team attorney whenever the team receives a subpoena, discovery request, or court order that in anyway appears out of the ordinary or raises any
questions about how to respond. Similarly, CPTs should ask their team attorney to review any request for CPT records from any person or organization not discussed herein.

2. **Annual Security Checklist**

Each provider must complete an annual Security Checklist utilizing the CMS Central Office form. This is an annual self-assessment review and must be completed and sent to the contract manager.

D. **Asset (Tangible Property) Management**

1. **Maintenance of Contract Equipment**

The provider is responsible for maintaining this equipment in working order and arranging and paying for any maintenance costs or upgrades of the equipment while the contract is in effect. These expenses are to be budgeted in the CPT contract program budget. Informational technical assistance should be sought from the local CMS DCSA to ensure that the equipment continues to meet the department’s standards. Under no circumstances should equipment or upgrades be purchased without CMS Program Office IRR approval.

2. **Use of Provider Equipment**

The equipment purchased with CPT contract program revenue must be used for activities necessary to perform services specified in the contract. Provider personnel who spend a significant portion of their work time supporting the CPT program may use this equipment. This equipment may also be assigned to the CPT Medical Director or to other CPT professional providers with the concurrence of the CPT Medical Director. CPT equipment (i.e. servers, printers) not connected to the DOH network, may be shared by other provider staff for promoting the agency’s overall service delivery. Only authorized DOH users may use equipment that is connected to the DOH network.

3. **Disposal of Contract Inventory – Certification of Non-Expendable Property as Surplus**

Disposal of non-expendable property, either owned by the provider or department requires the permission of the department per DOHP-250-11-12, “Management of State-Owned Property.” While some property is considered owned by the provider (agency), provider use of department funds in part or whole to purchase equipment, the department reserves the right to take title should the contract be terminated for any reason. The protocol for disposal requires the department’s written certification of the property as “surplus”. The department’s “Certification of State Surplus Property” DH1100 form must be completed and submitted to the contract manager to initiate the process for disposal of the property. The provider must maintain physical custody of the equipment until such time as they receive approval from the program office to dispose.

4. **Protocol for Disposal – Surplus Certification**

It is imperative that all disposal action be documented and supporting documentation be kept in the inventory section of the provider contract file for the fiscal year in which the disposal was completed. The following are the steps to be taken:
a. Identify the equipment that is to be certified as surplus for disposal on the DOH 1100 form “Certificate of State Surplus Property.” Make sure that all appropriate equipment has been sanitized and the CMS DCSA has signed and noted the method of sanitization.

b. Develop a plan for disposal and put in written memo form to the contract manager

c. Submit the completed “Certificate of State Surplus Property”, along with the provider memo describing how the provider will surplus the equipment once final approval is received from the CMS Program Office, to the contract manager. The form will not be reviewed or approved unless completely filled out with all appropriate provider and IT signatures.

d. The contract manager will work with the DOH Support Services Section and the CMS System Analyst to arrange for the posting of the equipment on the department’s Asset Management System, surplus property report. These items will remain on the report for 14 days during which another state agency may request the equipment. If this occurs, it would take precedent over the plan for donation to a non-profit organization.

e. The contract manager will notify provider of authorization to dispose of the property after the posting is completed and no requests for the property have been made.

f. The provider must ensure that all property tags are removed from the equipment prior to disposal.

g. Property may be disposed of in the following acceptable ways:

1. Donation to Private Non-Profit Organization – In order for the non-profit organization to receive the asset, it must produce a current 501C3 letter from the federal government or Florida Certificate of Exemption denoting the organization has met the federal 501C3 certifying them as a non-profit. If the organization cannot produce this document, the assets cannot be donated to it.

2. Sales to department employees or provider staff, excluding those sales open to the general public are not permitted. All proceeds from these sales will be collected and deposited.

3. Cannibalizing or Scrapping – Non expendable property may be disposed of in landfills or other appropriate sites, such as recycling, or through cannibalizing for usable parts. This disposal procedure should include the following steps:

   a. Removal of asset decals/property tags
   b. Disassembling of asset (when possible)
   c. If any part of the asset can be recycled, it should be recycled prior to cannibalizing or scrapping the asset
   d. All costs incurred in the disposing of assets must be the responsibility of the disposition entity (provider). Maintain receipts to validate method of disposition
e. If any of the equipment is an information technology asset, it will need to meet DOH standards for sanitization of information technology assets. The local DCSA should be contacted to either sanitize the equipment or ensure methods to be used meet the DOH standards prior to disposition.

Once it is decided that this equipment is no longer useful in the CPT contract program, it becomes “surplus,” is “disposed of,” and removed from the CPT contract inventory. Example: If an agency finds the equipment is no longer needed or useful in the CPT contract program, it may surplus the equipment and donates it to another program within the same agency.

Special dispositions:

- Provider purchased and owned Telemedicine equipment being given to another CPT: indicate the CPT Team I.D. in the last column. The receiving team will need to add the equipment to its inventory upon receipt.
- Telemedicine equipment being donated to DOH –CMS’s Special Technologies Unit or Telemedicine equipment being donated to other than DOH: No plan for disposing of contract purchased telemedicine equipment should be made without discussing it with the DOH-CMS Telehealth Technology Unit.
- If, after exploring all the options above for equipment that is in workable condition, no party has been identified to receive the equipment and the only option left appears to be “scrap”, then it may be possible to donate the equipment to other than a non-profit agency. Contact the CMS contract manager if this status is reached. Under no circumstances can equipment be donated to employees of the provider agency. However, employees and the general public may buy equipment at a public auction.

h. Provide the following documentation to the CMS contract manager upon disposal of property:

1) A signed and dated receipt on the letterhead of the party receiving the equipment with each item detailed on the receipt.

2) If scraping, email the contract manager with the name of the vendor who will dispose of the equipment according to the local county environmental standards. Keep a receipt of the scraping agency in the team’s contract file or a copy of the paid invoice from the vendor.

5. Contract Termination and Expendable Property (less than $1,000) Purchased by Provider

See the contract’s Attachment I, Section D, and “Termination Process.” While expendable tangible property purchased by the provider is not required to be inventoried annually, title to all property bought with state funds, regardless of dollar amount, is vested in the department upon completion or termination of the contract. Therefore, the provider must maintain an inventory of all equipment. At the time of completion or termination of a CPT contract, the provider must follow the department’s instructions as to the disposition of all tangible non-expendable and expendable property.
E. Department (DOH) Owned Equipment Deployed to Provider

Department equipment, including all non-expendable and expendable of a general office, medical, or data processing type, must be used for contracted CPT service provision only, in accordance with any additional department instructions, including any security program-specific supplemental protocols referenced in the CPT Resource Book.

1. Specific Use of DOH owned equipment.

The equipment purchased with DOH revenue must be used for activities necessary to perform services specified in the contract. Provider personnel who spend a significant portion of their work time supporting the CPT program may use this equipment. Except for DOH owned laptops which require written approval from the contract manager, DOH owned equipment may also be used by the CPT Medical Director or other CPT professional providers with the concurrence of the CPT Medical Director. Child Protection Team equipment (i.e. servers, printers) not connected to the DOH network, may be shared by other provider staff for promoting the agency’s overall service delivery. DOH shared equipment may be used on the provider’s LAN when the majority of the users on the provider’s LAN are CPT provider personnel. Only authorized DOH users may use equipment that is connected to the DOH network.

2. Maintenance of DOH owned equipment.

The department will arrange for and pay for all maintenance, upgrades and repairs of DOH owned equipment. Non-functioning equipment should be brought to the attention of the local CMS DCSA and the contract manager. The CMS DCSA will work with the CMS Program Office to arrange and pay for the repair or upgrading of DOH equipment. At no time must the provider alter or have altered any DOH equipment (hardware or software) without the department’s written approval.

3. Provider’s Responsibilities for DOH equipment.

The provider must:

- Obtain the department’s written approval prior to moving any equipment to a physical site other than the site indicated at the last annual inventory, so as to ensure that DOH’s fire insurance carrier has accurate information regarding the site location. The provider will also be asked to provide pertinent information about any new physical site.

- Immediately notify local law enforcement and the CMS Program Office of any lost or stolen equipment.

- Cooperate fully in the DOH annual inventory of its equipment within the established deadlines.

- Immediately notify the department of any casualty loss.

- Immediately notify CMS Program Office when new DOH equipment is received. Provide the information needed for DOH payment and immediately place the DOH
decals on new equipment when received. At any time it is discovered that a decal has been removed or destroyed, advise the CMS Program Office of the need for DOH replacement decals.

4. **Procedure for Disposal of State-owned (deployed at provider site) Non-expendable Property**

DOH property is any property (regardless of acquisition cost) that has been designated as an item to be inventoried and has been given property tag #. An example of such equipment is the Optra T series Lexmark printers that are deployed to CPT providers.

DOH property also includes the following:

a. Former Department of Health and Rehabilitative Services property
b. Property transferred to the Department of Health by the Department of Children and Families at the time the CPT program was transferred to DOH
   1. Any equipment purchased by DOH and deployed to the CPTs

The procedure for requesting disposal of DOH equipment that is deployed to the provider is the same as that of the provider owned property; however the DOH equipment should be separately identified on the Certification of State Surplus Property, DOH1100 form. If the provider anticipates a cost for disposing of DOH equipment, DOH can pay for this type of expenditure. The contract manager should be contacted if this is the case; however no cost will be covered by DOH unless a formal DOH authorization (Purchase Order) was issued prior to incurring the cost.

F. **Child Protection Team Medical Oversight**

This section provides the standards, requirements, benefits, and related protocols for the medical oversight of the CPT program. It covers all CMS physicians designated as CPT Medical Director and addresses specific medical supervision protocol for physicians and other medical personnel.

1. **CMS and CPT Physician Standards, Role and Functions, Malpractice Coverage and Dispute Resolution Standards.**

Any Physician designated as a statewide or team Medical Director or team Physician must meet the standards specified in the CMS Physician’s Handbook and be an approved CMS physician. This Handbook is posted on the DOH Internet under CMS. Additional CPT specific personnel qualifications and responsibilities are listed in Appendix A of this Handbook. Waiver of any of these standards can only be granted by the Deputy Secretary for CMS.

2. **Roles.**

The CMS Physician’s Handbook (CPT Provisions) specifies standards and outlines medical oversight roles and relationships between CPT physicians, DOH, contracted providers, and other physicians. Specific personnel qualifications and responsibilities are addressed in Appendix A of this CPT Handbook.
3. **Malpractice Coverage.**

The CPT section of the CMS Physician’s Manual addresses the area of malpractice coverage and sovereign immunity for provision of services to the extent provided by law.

According to DOH Risk Management, CPT medical providers appear to act under the color of law and are agents of the state when they examine children allegedly abused or neglected under Section 39, F.S. Risk management further acknowledged that they would be able to provide coverage for Medical Directors and medical providers in the event of liability lawsuits that arise from Section 39, F.S.

**G. Employment Status Requirements and Compensation**

1. **Employment Status and Requirements.**

The Statewide Medical Director and the team Medical Directors must meet the CMS and CPT specific standards outlined elsewhere in this section. The Surgeon General of the Department of Health, with the concurrence of the Secretary of DCF, appoints individuals to these positions.

CPT Medical Directors who become DOH OPS employees must meet all the applicable OPS requirements of the DOH Employee Handbook (available on the DOH Intranet). Any CPT Physician who is employed by a DOH contract provider must also meet the requirements of the contract under the auspices of the provider agency.

**2. Negotiation of Compensation for Child Protection Team Medical Directors.**

Regardless of the method of compensation, the rate of pay is negotiated between the department and the individual or the individual’s contract provider based on the willing individual physician’s expertise and experience and a reasonable and necessary rate for a specified time period, usually on an annual basis. A minimum (adjusted when across the board increases have been given in the past) standard rate of pay for 8 hours a week is the guide for beginning negotiations.

**3. Sub-contracts - Compensation for Child Protection Team Medical Directors.**

Medical evaluation services and CPT related travel must be compensated for by the CPT contract provider. Sub-contracts must not include any of the medical oversight functions.

**4. Information Security Training.**

All CPT physicians noted in the first paragraph of this sub-section, regardless of their employment status, must complete the DOH Security Information training when appointed and annually thereafter.

**H. Performance Specifications**

The following performance specifications apply to all CPT Medical Directors, regardless of method of compensation:
1. **Service Definition**

All medical oversight functions must be performed in compliance with the designated team’s CPT contract requirements and any corrective action indicated as a result of a quality assurance review of the team.

2. **Unit of Service**

A unit of service consists of carrying out the CPT Medical Director functions for a period of one month.

3. **Specific Standard**

The successful completion of CPT Medical Director functions, on-going throughout a state fiscal year.

4. **Methodology for Measurement**

The completion of functions will be considered successful when the annual monitoring report of the CPT Medical Director’s designated team(s) indicates the standards are met or corrective action taken in accordance with the standards and terms of the CPT provider’s contract.

5. **Monitoring and Evaluation Methodology**

The performance of the CPT Medical Director must be reviewed by the Statewide Medical Director, at a minimum, at the end of each annual state fiscal year.

6. **Provider Subcontracts – Approval Process**

Providers whose contracts were procured through the exemption process, listed in section 287.057 (5) (f), Florida Statute, must request approval from DOH to subcontract their services. The following must be provided to the DOH contract manager prior to the provider executing the subcontracts:

1. A copy of the proposed subcontract
2. The completed subcontractor form which identifies the name of the subcontractor and the type of business organization (sole proprietor, partnership, corporation), whether they are an entity or provide a service or commodity, which is exempt from competitive procurement.
3. The percentage of the provider contract to be paid to the subcontractor
4. Whether the subcontractor has any other contracts with DOH and what the contract numbers are.
5. Documentation of Debarment Search on the provider.
6. Determination of sub recipient or vendor.
APPENDIX C:

GLOSSARY

Abandonment – A situation in which the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver responsible for the child’s welfare, while being able, makes no provision for the child’s support and makes no effort to communicate with the child, which situation is sufficient to evince a willful rejection of parental obligations.

Abuse - Any willful act or threatened act that results in any physical, mental, or sexual injury or harm that causes or is likely to cause the child’s physical, mental, or emotional health to be significantly impaired. Abuse of a child includes acts or omissions. Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child.

Allegation Matrix - The Department of Children and Families document that defines each specific type of abuse, abandonment, or neglect; guides department staff or designated representative in determining whether abuse, abandonment or neglect has occurred; and helps to ensure that all factors are considered when assessing specific types of maltreatment.

ARNP - Advanced Registered Nurse Practitioner.

At Risk - The likelihood that a child will be abused or neglected in the near future without intervention.

Assessment Activities - Services provided by child protection teams. Assessment activities include: medical evaluations, medical consultations, psychological evaluations, psychological record reviews, specialized and forensic interviews, social assessments, nursing assessments, and CPT staffings.

Background Screening – The fingerprint based search of criminal records. All positions of special trust or responsibility as defined in F.S. 110.1127(3)a, are required to have a level 2 background screening which is a fingerprint based search of criminal records in Florida and nationally.

Case - An individual child referred to and accepted by a child protection team for assessment services as a result of a report of alleged abuse or neglect made to the Hotline.

Case Progress Notes Record – Case documentation in CPTIS which provides details on all case activities completed. This includes dates, times, individual contacted, assessment activity completed, and summary of the activity.

Case Coordination - Those activities that are provided on behalf of clients to complete a team assessment (e.g., contacts to arrange specific assessments, case activities and collateral contacts with law enforcement, state’s attorney, DCF, GAL, schools).

Case Coordinator - A member of the child protection team professional staff who provides or directs the assessment activities on behalf of clients.

Case Documentation – Consists of all material and photographs in the case file.
Case Review - A formalized internal process for supervisory review of the content, status and progress of completing the team assessment services. Case reviews must be documented in the case progress notes in CPTIS.

Child - Any unmarried person under the age of 18 years who has not been emancipated by order of the court. [s. 39.01 (12), F.S.]

Child Protection Staff - Refers to Department of Children and Families or Sheriff’s Office Child Protective Investigators (CPIs), and community based care (CBC) case managers who provide protective services supervision, foster care, and/or adoption services.

Child Protection Team (CPT) - A medically led multidisciplinary team available to supplement the child protection activities of DCF or designated community-based providers and sheriff’s offices.

Child Protection Team Medical Director – The CMS approved pediatrician responsible for overall direction and supervision of a child protection team.

Child Protection Team Information System (CPTIS) - The web-based application developed for the collection and reporting of CPT client and service information.

Child Protection Team Information System Report – System generated management, performance reports based on individual, team and statewide data.

Child Protection Team Resource Book – A notebook that contains all the current law, rules, operation procedures, contract, and information pertaining to the functioning of the CPT program. Each team is responsible for keeping this notebook up to date and in a common area assessable to all CPT staff.

Child Protective Investigator (CPI) – The individual employed by the Department of Children and Families or by the local Sheriff’s Office, who is responsible for investigating allegations of abuse, neglect, and/or abandonment of children by a caretaker.

Children’s Medical Services (CMS) - The Children’s Medical Services Program within the Department of Health.

CMS Consultant Physician - A Physician who is an approved CMS medical provider licensed to practice in the state of Florida. All CPT Medical Directors and contracted physicians must be CMS approved physicians.

Community Based Care (CBC) Provider - A provider contracted with DCF to perform specific child protection functions (e.g., protective services, foster care or adoptions).

COOP – Continuity of Operations Plan – A mandated initiative to ensure that will provide for the prompt and effective continuation of critical program functions in the event of a disaster, natural or manmade.

Court Activity (Testimony/Deposition) - The sworn or affirmed testimony in or out of court by a member of the CPT.
Department of Children and Families (DCF) – As it pertains to Child Protection Teams, the state agency responsible, either directly or through contracted providers, for receiving child abuse reports, case management of dependency court ordered and voluntary protective services, foster care, licensing and adoption services. DCF CPIs are responsible for child abuse, neglect, and/or abandonment investigations by a parent or caretaker responsible for the child’s welfare.

Department of Health (DOH) - The public health agency responsible for the health and safety of all citizens in the state.

Developmental Screenings – A checklist is used to determine if an infant or toddler, birth to 36 months of age, has a condition or concern that may make the child eligible for early intervention.

Electronic Case File – documentation in CPTIS necessary to provide a comprehensive record of CPT involvement with the child.

Florida Safe Families Network – The DCF web-based information system that contains Child Safety Assessments (CSAs) generated by the Hotline for investigation; protective services supervision, foster care, or adoption case information; and all available information concerning children and families who have been referred for investigation of abuse, abandonment, or neglect. This system replaced the DCF HomeSafeNet system which replaced the Florida Abuse Hotline Information System (FAHIS).

Final Case Summary – The document completed upon case closure.

Hotline - The receiving point in DCF for all calls regarding reported cases of suspected abuse, neglect, or exploitation of children, disabled adults and the elderly.

Intake Referral – The documentation of the discussion between the Case Coordinator and referral source regarding appropriateness of providing CPT assessment services, or whether services are not warranted.

Interim Case Summary – A status report sent to the CPI if the CPT case remains open 20 days following the date of referral (the day after referral receipt counted as day one).

Neglect - When a child is deprived of, or is allowed to be deprived of necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child’s physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired. Neglect is an omission which is a serious disregard of parental responsibilities for the child’s welfare including:

- Prolonged or repeated lack of supervision or failure to exercise a minimum degree of care that resulted in injury or harm.
- Failure to make reasonable efforts to stop the actions of another person, which resulted in injury or harm.

Refer to Section 39.01(45) FS for clarification of neglect based on financial inability or religious beliefs.

PA – Physician’s Assistant

Physician Training - Training provided to physicians and other medical personnel on the detection of child abuse and neglect.
**Other Training** - Training provided to other professionals such as DCF staff or other members of the community involved in the identification or determination of abuse or neglect and may include public and media presentations on child abuse.

**Referral** - The discussion between the CPI and CPT Case Coordinator where the current abuse report allegations, CPI interview information and prior reports are discussed at length to determine if CPT assessment services are appropriate or not warranted.

**Referral Source** – The source of the initial referral. In a majority of the cases, the referral source will be the CPI; however the initial referral may come from other involved professionals (e.g., law enforcement, hospitals, physicians, and CBC case managers).

**RN** – Registered Nurse

**Risk Factors** – Conditions and/or behaviors that create a threat to the child’s safety or risk of maltreatment. (Environmental, developmental, behavioral, medical as well as the composition of the family unit are factors that would be assessed when determining the abuse/neglect dynamics that impact on the overall level of risk to a child.)

**Session** - Use of the telemedicine network for the medical examination/diagnosis of a child alleged to be abused or neglected.

**STD** – Sexually Transmitted Disease

**STD Prophylactic Medication** – medication used in the prevention of STD for sexual assault in adolescents and pre-pubertal children referred to the CPT for medical evaluation.

**Team Coordinator** - The person in charge of managing the day to day operation of a CPT.

**Telemedicine** - Telemedicine is defined as the use of telecommunication and information technology to provide clinical care to individuals at a distance and to transmit the information needed to provide that care.

**Threatened Harm** – Behavior that is not accidental and which is likely to result in harm to the child.

**Waiver** - A written request for the waiver submitted by a contract provider to the Children’s Medical Services Program Office. The request for waiver of a personnel standard as defined in Chapter 64C-8, Florida Administrative Code, must include documentation of the need for the waiver and follow protocol established by the Program Office.
APPENDIX D
DEVELOPMENTAL SCREENING
EARLY STEPS (ES) CHECKLIST

This checklist is used to determine if an infant or toddler, birth to 36 months of age, has a condition or concern that may make the child eligible for early intervention. The checklist can be used by a professional (physician, nurse, social worker, child welfare worker, and so on) or any other practitioner to make a referral for early intervention. If you are concerned that a child has one or more of the conditions listed, you should consider referring the child to Early Steps. A copy of the ES Checklist and Referral Form must be included in the CPT case file. (PROVIDE A COPY OF THIS CHECKLIST TO LOCAL ES PROGRAM WITH REFERRAL FORM).

Child’s Name _________________________ Date of Birth ____________ Age ________
Parent/Caregiver Name ________________________ Telephone __________________
Address ________________________________________________________________
City ___________________________ State ______ Zip Code ______________

This checklist includes many but not all of the conditions or concerns that may make a child eligible for early intervention. If a child has any condition or concern that has a high probability of being associated with a developmental delay or poor behavioral outcome the child should be referred for early intervention services.

<table>
<thead>
<tr>
<th>CERTIFIED CONDITION</th>
<th>SECTION 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Impairment</td>
<td>□</td>
</tr>
<tr>
<td>Visual Impairment/blind</td>
<td>□</td>
</tr>
<tr>
<td>Chromosome anomaly (such as Down’s Syndrome)</td>
<td>□</td>
</tr>
<tr>
<td>Neurological condition (such as Cerebral Palsy)</td>
<td>□</td>
</tr>
<tr>
<td>Seizure Disorder (such as epilepsy)</td>
<td>□</td>
</tr>
<tr>
<td>Physical abnormality/abnormal movement</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEVELOPMENTAL DELAYS</th>
<th>SECTION 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months and child does not watch moving objects or respond to sounds</td>
<td>□</td>
</tr>
<tr>
<td>6 months and unable to roll over</td>
<td>□</td>
</tr>
<tr>
<td>9 months and unable to sit alone</td>
<td>□</td>
</tr>
<tr>
<td>12 months and unable to crawl (or crawls with great difficulty)</td>
<td>□</td>
</tr>
<tr>
<td>15 months unable to stand alone</td>
<td>□</td>
</tr>
<tr>
<td>15 months and unable to hold a cup</td>
<td>□</td>
</tr>
<tr>
<td>18 months and has no speech or only babbles</td>
<td>□</td>
</tr>
<tr>
<td>18 months and unable to walk</td>
<td>□</td>
</tr>
<tr>
<td>24 months and unable to use objects like crayons or spoons</td>
<td>□</td>
</tr>
<tr>
<td>24 months and does not engage in play or social interaction</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER CONCERNS</th>
<th>SECTION 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding/Eating difficulty</td>
<td>□</td>
</tr>
<tr>
<td>Shaken Baby/Head Injury</td>
<td>□</td>
</tr>
<tr>
<td>Chronic illness</td>
<td>□</td>
</tr>
<tr>
<td>Child in hospital or recent hospitalization</td>
<td>□</td>
</tr>
<tr>
<td>Child extremely underweight or appears malnourished</td>
<td>□</td>
</tr>
<tr>
<td>Lack of eye contact or lack or interest in interaction with parent/caregiver</td>
<td>□</td>
</tr>
<tr>
<td>☐☐</td>
<td></td>
</tr>
<tr>
<td>__________</td>
<td>__________________________</td>
</tr>
<tr>
<td><strong>If you checked any of the Boxes above,</strong> a referral to the local Early Steps provider is appropriate.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT STAFF/PHONE NUMBER</th>
<th>DATE Checklist Completed</th>
</tr>
</thead>
</table>
**EARLY STEP REFERRAL FORM**

WHEN MAKING A REFERRAL TO LOCAL ES PROGRAM PROVIDE A COPY OF THE ES CHECKLIST AND THE REFERRAL FORM

| Referring Agency: ________________________________ |
| Reason for referral: |
| Date of referral: ________________________________ |
| CPT Staff/Phone Number: __________________________ |
APPENDIX E:

INTERAGENCY AGREEMENT
Interagency Agreement Between the
Department of Children and Families and the Department of Health
Child Protection Teams and Sexual Abuse Treatment Programs

In order to ensure optimal coordination between the Department of Children and Families and the Department of Health's Child Protection Teams and Sexual Abuse Treatment Programs, both of which provide services to abused and neglected children and their families, the two parties, in accordance with Section 39.303, Florida Statutes, agree to maintain this interagency agreement as the foundation for collaboration and the establishment of protocols for joint oversight and operation of the Child Protection Teams and Sexual Abuse Treatment Programs.

Further, the Department of Children and Families and the Department of Health agree to the following:

1. **JOINT OVERSIGHT:** Joint oversight of the activities of the Teams and Programs will be accomplished through the activities outlined below:

   a. **Program Planning and Development.** Both parties will consult with each other regarding future plans, substantive legislation, rules, legal opinions, policy, standards, contract specifications, and resource allocation and utilization having significant impact on these teams and programs, and the roles and responsibilities of both departments and their respective contract providers. Both parties will keep each other apprised, in a timely manner, of training, procedural, and other changes that impact, or might impact, the other. Both departments will adhere to rules, policy, standards, and protocols jointly agreed upon and modified accordingly by both parties.

   b. **Community Development and Interagency Coordination.** Recognizing the need for comprehensive and community coordinated efforts to effectively protect children, both departments will work in concert with each other and with other agencies involved in the protection of children, both local and state, in developing resources and enhancing coordination of existing resources. When not specified in statute, each respective party to this agreement will consider the appropriateness of participation of the other party when initiating task forces or similar activities, or recommend to other entities initiating such activities, the appropriateness of participation of both parties.

   c. **Appointment of Child Protection Team Medical Directors.** The appointment and other personnel actions for the Statewide Child Protection Team Medical Director and the individual Child Protection Team Medical Directors will be approved by the Secretary of Health, and the Deputy Secretary for Children's Medical Services, with the concurrence of the Secretary of the Department of Children and Families.

   d. **Liaison Activities**
      1. The Office of Child Welfare and the Division of Children's Medical Services will each appoint a designated state liaison to oversee the implementation of this agreement.
      2. Each Department of Children and Families Regional Managing Director will appoint a local staff person to act as liaison with the corresponding Child Protection Team(s) and Sexual Abuse Treatment Programs providers.
a. the issuance of standard operating procedures, developed, modified as needed, and approved jointly by both parties. In order to address local needs, local representatives must further delineate working protocols to support effective service delivery, consistent with standard operating procedure.

b. ensuring provider contract specifications related to working relationships are consistent with standard operating procedures.

c. sharing of pertinent information and correspondence directed to either the Teams/Programs or to Office of Child Welfare staff originating at the program office or local level.

3. MAINTENANCE OF AGREEMENT. Both departments agree to meet periodically to discuss issues and areas of mutual concern. This agreement, effective April 30, 2015, or on the date signed by all parties, whichever occurs last, may be updated by written agreement of the parties at any time.

IN WITNESS THEREOF, the parties hereto have caused this agreement to be executed by their undersigned officials as duly authorized.

STATE OF FLORIDA, DEPARTMENT OF HEALTH

SIGNED BY: John H. Armstrong, MD, FACS
Surgeon General & Secretary
Department of Health
DATE: 5-14-15

SIGNED BY: Celeste Philip, MD, MPH
Deputy Secretary for Health
Deputy State Health Officer for Children's Medical Services
DATE: 5/13/15

STATE OF FLORIDA, DEPARTMENT OF CHILDREN AND FAMILIES

SIGNED BY: Mike Carroll
Secretary
Department of Children and Families
DATE: 5/13/15

SIGNED BY: Janice Thomas
Assistant Secretary for Child Welfare
Office of Child Welfare
DATE: 4/23/2015
APPENDIX F

STD Protocols

Appendix F includes the following documents:

- **CPT STD Technical Assistance Guideline (TAG) 39**: provides guidance on the utilization of prophylactic STD medications and procedures for specimen collection.

- **CPT STD Prophylactic Medication Compliance Checklist**: contains the State and Federal requirements that each CPT must achieve prior to implementing this service. This checklist must be signed and dated by CPT staff. Other components included in the checklist are: CPT staff responsibilities, CPT staff that will be receiving STD medications and the facility address where medications will be delivered.

- **CPT STD Medical Provider Profile**: The profile must be completed by the CPT Medical Director and any CPT medical providers that will be ordering medications from the DOH pharmacy. The DOH pharmacy staff will utilize the profile to enter staff in the FDOH pharmacy secure online medication ordering system. This will give CPT staff authority to order the medications.

- **CPT STD Inventory Checklist**: This is the document that CPT staff must keep updated. It is an internal document to track the inventory of medications located at the CPT and must be kept for (6) years.

- **Prescription Return Form**: The form is located on the following DOH Central Pharmacy website: and is to be utilized when returning outdated STD medications. [http://dohiws/Divisions/Pharmacy/Forms/RxReturnForm.pdf](http://dohiws/Divisions/Pharmacy/Forms/RxReturnForm.pdf). Address for the Central Pharmacy is: 116A Hamilton Park Dr. Tallahassee, Florida 32304.

- **Directory for FDOH Laboratories**: [http://www.doh.state.fl.us/lab/addpages/BOL_Contacts.html](http://www.doh.state.fl.us/lab/addpages/BOL_Contacts.html)

- **DH1847 Form**: Laboratory Request: [http://www.doh.state.fl.us/lab/PDF_Files/DOH_Form_DH1847_1009.pdf](http://www.doh.state.fl.us/lab/PDF_Files/DOH_Form_DH1847_1009.pdf)

- **CPT STD Instructions for specimen collection and shipping of specimens**:

  APTIMA® Unisex Swab Specimen Collection Kit for Endocervical and Male Urethral Swab Specimens

  APTIMA® Urine Specimen Collection Kit for Male and Female Urine Specimens

  COLLECTION AND SHIPPING OF SPECIMENS FOR HERPES SIMPLEX VIRUS (HSV) EXAMINATION
CHILD PROTECTION TEAM (CPT)
PROVISION OF PROPHYLACTIC MEDICATION AND COLLECTION OF SPECIMENS FOR SEXUALLY TRANSMITTED DISEASE (STD)

Provision of prophylactic medications in the prevention of STD for sexual assault in adolescents and pre-pubertal children:

Under the Health Resources and Services Administration (HRSA) Pharmacy Affairs and 340B drug pricing program [http://www.hrsa.gov/opa/introduction.htm](http://www.hrsa.gov/opa/introduction.htm) in coordination with the Florida Department of Health (FDOH) STD program office and FDOH Pharmacy, prophylactic STD medications will be provided to the CPTs. The STD prophylactic medications will be administered to CPT clients who have been determined to be at risk for contracting a STD. The recommended treatment guidelines are located in: The TECHNICAL ASSISTANCE GUIDELINE: STD-39 (TAG) “Technical Assistance for the Provision of Unit of Use of Re-packaged Prophylactic Medicines to Child Protection Team Provider Sites in the Prevention of Sexually Transmitted Diseases (STDs) for Sexual Assault in Adolescents and Pre-pubertal Children”, which is located in Appendix F.

The TECHNICAL ASSISTANCE GUIDELINE: STD-39 (TAG) “Technical Assistance for the Provision of Unit of Use of Re-packaged Prophylactic Medicines to Child Protection Team Provider Sites in the Prevention of Sexually Transmitted Diseases (STDs) for Sexual Assault in Adolescents and Pre-pubertal Children”, (which is located in A.).

Guidelines include the following recommendations:

Adolescents:
- Adolescents should be prophylactically treated for STDs if they have had acute sexual activity within the previous 60 days.
- Adolescents should not be prophylactically treated for STDs when:
  - History of sexual activity occurs in the remote past (more than 60 days ago), without current sexual activity or discharge
  - No self-report or evidence of sexual activity

Pre-pubertal Children:
- Pre-pubertal children are at a very low risk to acquire an STD. The Centers for Disease Control and Prevention (CDC) and the AAP do not recommend routine prophylaxis for this age group in most instances. They recommend close follow up to determine if an infection is acquired. Nevertheless, children this age are sometimes infected, sometimes have asymptomatic infections, and follow up is not always assured.

Consider prophylactic treatment with the following:
- Acute sexual activity (oral, vaginal, anal) by an unknown person (e.g., stranger) and concern about possible infection
- Sex with a person known to have an STD
- Significant concern about and/or request for prophylactic antibiotic coverage following sexual contact

Pre-pubertal children do not need treatment if:
- Sexual activity occurred with the same known person and there is no discharge or other sign of infection
• Sexual activity occurred with an unknown person, it is more than 14 days later, and there is no discharge or signs of infection

**Medication Regimen:**

Administer in clinic:
- Azithromycin (Zithromax®) 1 gram x 1 (tablet)
- Prescribe Plan B – (if mature enough to have menstrual periods and female)

Guardian to administer four hours later:
- Cefixime (Suprax®) 400 mg x 1 (tablet)

Guardian to administer eight hours later:
- Metronidazole (Flagyl®) 2 grams x 1 (four 500mg tablets)

The purpose of spacing the medications is to decrease the likelihood of vomiting and other adverse effects.

**340B Drug Pricing Program:**

“The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. The 340B Drug Discount Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). 340B limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes and qualified disproportionate share hospitals. Participation in the Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services.”

Who is Eligible for the 340B Discount?
- Federally-qualified health center
- Family planning project
- Entity receiving a grant under subpart II of part C of Title XXVI of the Ryan White Care Act
- A state-operated AIDS Drug Assistance Program
- A black lung clinic
- A comprehensive hemophilia diagnostic treatment center
- A Native Hawaiian Health Center
- An Urban Indian organization
- Any entity receiving assistance under title XXVI of Social Security Act
- A disproportionate share hospital
- An entity receiving funds under section 318, relating to the treatment of sexually transmitted diseases or section 317, relating to the treatment of tuberculosis, through a State or unit of local government, but only if the entity is certified by the Secretary

It is under the STD program that CPT will receive medications.
How the CPT providers are eligible to receive 340B priced medications

• In the cases where sexual abuse is suspected and prophylactic treatment is appropriate, these clients are considered STD clients and are managed according to STD program treatment guidelines.
• Therefore, these clients are eligible for the discounted medications through the 340B Drug Pricing Program.
• The Florida STD Program is providing these medications free of charge to CPT providers that complete their registration through the compliance check-list.

Child Protection Team (CPT) Sexually Transmitted Disease (STD) Prophylactic Medication Compliance Checklist

This form must be completed and returned to CPT central office staff prior to the CPT receiving authorization to order STD medications from FDOH pharmacy. The following requirements are included in the compliance checklist:

- CPT has a locked cabinet to store the STD prophylactic medications
- STD prophylactic medications are stored separately from any other medications
- CPT has a Log Book to sign medications in and out and record prescription information (CPT STD Prophylactic Inventory Log, which is located in Appendix F)
- Method to record patient information (CPTIS)
- Protocols for specimen collection (located in Appendix F)
- Protocol for shipping specimens (Instructions for shipping specimens to the DOH State Laboratory located in Appendix F)
- CPT medical providers add facility address to their license registration with MQA as additional place of practice (MQA staff will add the facility address to medical provider profile)
- Policy for the disposal of expired medications (Disposal Form located in Appendix F)

Also included on the Compliance Checklist are the CPT staff responsibilities:

- Sending completed medical provider profile, including address of CPT, to designated DOH headquarters staff. The facility address must be added the as an additional place of practice to the MQA medical provider profile. (MQA staff will add the facility address to medical provider profile)
- Maintaining the CPT STD Prophylactic Inventory Log
- Ordering STD prophylactic medications from the DOH State Pharmacy
- Ordering laboratory supplies from the DOH State Laboratory
- Adhering to procedures for collecting, packaging, and shipping specimens to the DOH State Laboratory
- Entering data into CPTIS on all patients receiving STD prophylactic medications
- Adhering to procedures for checking medication expiration dates and returning expired medications to the DOH pharmacy
A. Technical Assistance for the Provision of Unit of Use of Re-packaged Prophylactic Medicines to Child Protection Team Provider Sites in the Prevention of Sexually Transmitted Diseases (STDs) for Sexual Assault in Adolescents and Pre-pubertal Children

I. TITLE: Technical Assistance for the Provision of Unit of Use of Re-packaged Prophylactic Medicines to Child Protection Team Provider Sites in the Prevention of Sexually Transmitted Diseases (STDs) for Sexual Assault in Adolescents and Pre-pubertal Children

II. TYPE OF STANDARD: Disease Management/Service

III. OUTCOME: Successful prevention of STDs and their complications in children and adolescents that are victims of sexual assault

IV. PERSONNEL: M.D.s, D.O.s, A.R.N.P.s, and P.A.s within the constraints of their practice acts and protocols

V. COMPETENCIES: Healthcare professionals should have demonstrated knowledge, judgment, and performance of the responsibilities related to the medical management of sexual assault in adolescents and pre-pubertal children. Professional personnel records should have documentation of appropriate training for their individual practice acts.

VI. AREAS OF RESPONSIBILITY:

1. ASSESSMENT
   A. Subjective Factors:
      1. Medical and Social History – A developmentally appropriate history should be obtained by the pediatrician before a medical examination is performed.
      a. Investigative interviews should be performed by social services and/or a law enforcement agency; however, this does not preclude the Physician from obtaining a detailed pediatric history and review of systems to include:
         i. Medical history
         ii. Past incidents of abuse or suspicious injuries
         iii. Menstrual history
      b. History of the absence of penile-vaginal penetration, penile-oral, or penile anal penetration is not always reliable. Clinical judgment must be used.

   B. Objective Factors:
      1. Developmentally appropriate assent should be obtained from the child victim before examination, specimen collection, and treatment administration.
      2. Obtain all appropriate specimens to test for STDs before giving prophylactic medications. For example:
         a. Nucleic Acid Amplification Test (NAAT) for Chlamydia trachomatis and Neisseria gonorrhoeae (urine, urethral and/or cervical swabs, anal swabs are acceptable options when submitted to state laboratory)
         b. Swabs to culture for herpes simplex virus and Chlamydia trachomatis
      3. Test for pregnancy in females who are sexually mature enough that fertility is possible
      4. Determination that the child has no allergies to the medications (Note: the recommended treatment options rarely cause allergic reactions.)
      5. HIV prophylaxis – use local guidelines for prophylaxis or refer to HIV center
6. HBV and HPV vaccines should be considered for patients who meet American Academy of Pediatrics (AAP) guidelines.

2. TREATMENT
   A. Adolescents:
      1. Adolescents should be prophylactically treated for STDs if they have had acute sexual activity within the previous 60 days.
      2. Adolescents should not be prophylactically treated for STDs when:
         a. History of sexual activity occurs in the remote past (more than 60 days ago), without current sexual activity or discharge (Note: this may be an opportunity for screening for chlamydia.)
         b. No self-report or evidence of sexual activity
   B. Pre-pubertal Children:
      1. Pre-pubertal children are at a very low risk to acquire an STD. The Centers for Disease Control and Prevention (CDC) and the AAP do not recommend routine prophylaxis for this age group in most instances. They recommend close follow up to determine if an infection is acquired. Nevertheless, children this age are sometimes infected, sometimes have asymptomatic infections, and follow up is not always assured.
         a. Consider prophylactic treatment with the following:
            i. Acute sexual activity (oral, vaginal, anal) by an unknown person (e.g., stranger) and concern about possible infection
            ii. Sex with a person known to have an STD
            iii. Significant concern about and/or request for prophylactic antibiotic coverage following sexual contact
      2. Pre-pubertal children do not need treatment if:
         a. Sexual activity occurred with the same known person and there is no discharge or other sign of infection
         b. Sexual activity occurred with an unknown person, it is more than 14 days later, and there is no discharge or signs of infection
   C. Medication Regimen:
      1. Administer in clinic:
         a. Azithromycin (Zithromax®) 1 gram x 1 (tablet)
         b. Prescribe Plan B – (if mature enough to have menstrual periods and female)
      2. Guardian to administer four hours later:
         a. Cefixime (Suprax®) 400 mg x 1 (tablet)
      3. Guardian to administer eight hours later:
         a. Metronidazole (Flagyl®) 2 grams x 1 (four 500mg tablets)
      4. The purpose of spacing the medications is to decrease the likelihood of vomiting and other adverse effects.
   D. Examples:
      1. A 14-year-old female is seen at noon. She was at a party the night before, drank some beer, and ended up in bed with a 16-year-old boy. She reported having penile-vaginal intercourse without a condom. This was her first sexual encounter.
         a. Obtain assent for examination. Collect specimens for STD testing, pregnancy testing, collection of clothing, evidence swabs (decreased utility if she showered or bathed).
         b. Obtain assent for prophylactic medications and determine if there are any medication allergies. (The recommended treatment options rarely cause allergic reactions.)
      c. Dispense re-packaged prophylaxis medications:
         i. Administer azithromycin immediately in the clinic
         ii. Prescribe Plan B
         iii. Four hours later, cefixime administered by guardian
         iv. Eight hours later, metronidazole administered by guardian
      2. A 15-year-old male arrives at the CPT at 1:00 am. He reports he was spending the night with his best friend. He said his friend’s mom and her boyfriend let them drink a beer with them before bed. After the adults went to bed, the boys drank six beers each. The alleged victim said he remembers throwing up and then fell asleep on the bathroom floor. When he woke up, the mom’s boyfriend was masturbating over him. He complains of pain in his rectal area and blood on the toilet paper after he defecated.
a. Obtain assent for examination and signed consent form.
b. Obtain rectal swab for gonorrhea and chlamydia. Also, collect clothing and evidence swabs.
i. Collect blood for HIV and RPR.
c. Dispense repackaged prophylaxis medications
   i. Administer azithromycin immediately in the clinic
   ii. Four hours later, cefixime administered by guardian
   iii. Eight hours later, metronidazole administered by guardian
d. Refer child for follow-up specimen collection to test for HIV and syphilis.

3. EMERGENCY: Refer to appropriate provider(s) for the presenting complication(s).

4. DOCUMENTATION: Document on appropriate state forms:
   A. CPT STD medical record
   B. CPT STD Prophylactic Inventory Log
   C. DOH Form 1847, Bureau of Laboratory Request Form

VII. SUPPORTIVE DATA:

5. DOH Collection and Shipping of Specimens for Herpes Simplex Virus Examination guidelines. See Attachment 1.
6. Aptimar Urine Specimen Collection Kit for Males and Female Urines Specimens Guidelines. See Attachment 2.
7. Aptima Unisex Swab Specimen Collection Kit for Endocervical and Male Urethral Swab Specimens. See Attachment 3.
B. CHILD PROTECTION TEAM (CPT) SEXUALLY TRANSMITTED DISEASE (STD) PROPHYLACTIC MEDICATION COMPLIANCE CHECKLIST

CPT: ___________________

<table>
<thead>
<tr>
<th>State and Federal Requirement</th>
<th>Requirement has been met</th>
<th>Date/Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT has a locked cabinet to store the STD prophylactic medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STD prophylactic medications are stored separately from any other medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT has a Log Book to sign medications in and out and record prescription information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CPT STD Prophylactic Inventory Log</strong> is located in the CPT Handbook)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Method to record patient information (CPTIS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocols for specimen collection <em>(located in the CPT Handbook)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocol for shipping specimens <em>(Instructions for shipping specimens to the DOH State Laboratory located in the CPT Handbook)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPT medical providers add facility address to their license registration with MQA as additional place of practice <em>(MQA staff will add the facility address to medical provider profile)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy for the disposal of expired medications <em>(Disposal policy and disposal form located in the CPT Handbook)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CPT staff responsibilities:**
- Sending completed medical provider profile, including address of CPT, to designated DOH headquarters staff. The facility address must be added as an additional place of practice to the MQA medical provider profile
- Maintaining the CPT STD Prophylactic Inventory Log
- Ordering STD prophylactic medications from the DOH State Pharmacy
- Ordering laboratory supplies from the DOH State Laboratory
- Adhering to procedures for collecting, packaging, and shipping specimens to the DOH State Laboratory
- Entering data into CPTIS on all patients receiving STD prophylactic medications
- Adhering to procedures for checking medication expiration dates and returning expired medications to the DOH pharmacy

**CPT staff that will be signing for receipt of STD prophylactic medications:**

<table>
<thead>
<tr>
<th>Staff Name</th>
<th>Profession</th>
<th>License Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Facility address (location medications will be mailed to):**

____________________________________________________________
____________________________________________________________
C. CPT STD Prophylactic Medications Medical Provider Profile

This form is to be completed and updated as appropriate by each medical professional that will ordering and receiving STD Prophylactic medications. The completed form will be sent to CMS central office staff to be utilized by FDOH pharmacy staff to enter CPT staff into the FDOH pharmacy secure online medication ordering system. The following information is collected on the medical provider profile form.

**User Information:**
- First Name:
- Last Name:
- Phone Number:
- Provider DEA Permit Number:
- Florida License Number:
- Email:
- DOH Email:

**Ship To Facility:**
- Facility Name:
- Address:
- City:
- State:
- Zip:
- County:
### STD Prophylactic Inventory Log

**CPT Location:** ____________________

**Month/Year:** ____________________

<table>
<thead>
<tr>
<th>Medication Description</th>
<th>Pkg Size</th>
<th>Beginning Inventory</th>
<th>Additional Received this period</th>
<th>Dispensed Medication</th>
<th>Quantity in Stock</th>
<th>Ending Inventory</th>
<th>Difference</th>
<th>National Drug Code *</th>
<th>Expiration Date *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azithromycin (Zithromax) 1 gram</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefixime (Suprax) 400 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metronidazole (Flagyl) 2 grams</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Log sheet must be maintained for (6) years**

*This information is found on the medication label*
COLLECTION AND SHIPPING OF SPECIMENS FOR HERPES SIMPLEX VIRUS (HSV) EXAMINATION*

Properly collected specimens for HSV isolation is one of the most important factors in successful laboratory diagnosis. Specimens should be collected as soon as possible after onset and transported immediately to the laboratory.

Specimen Collection:
1. Using a dry, sterile polyester (“Dacron”) swab with a plastic shaft collect vesicular fluid, cervical and/or vaginal secretions. Place swab in viral transport medium (VTM). DO NOT USE SWABS WITH WOODEN SHAFT.
2. Using a second dry, sterile swab, collect vesicular fluid and cells from the base of the lesions. Make a dime-sized circle with the swab on a glass slide; label the end of the slide with the patient name and collection site. Allow the slide to air dry.
   
   AIR DRY! DO NOT SPRAY! DO NOT FIX!

Place slide in M. Jones Vaginal protective slide container

3. Complete laboratory history form DH1847 and include onset date, collection date(s), specific specimen collection sites, etc…
4. Place slide and swab in transport medium into a Styrofoam shipping container. Use 1-2 cold packs to maintain the temperature during transit. Ship in the most expedient manner, preferably overnight delivery.
5. Ship to: Virus Unit
   Florida Department of Health-Bureau of Laboratories
   1217 Pearl Street
   Jacksonville, FL 32202

   For additional information call: (904) 791-1540

*Adapted from: Laboratory Methods for Diagnosis of Herpes virus Infections
USPHA, Centers for Disease Control and Prevention, Atlanta, GA
December, 1979
APTIMA® Urine Specimen Collection Kit for Male and Female Urine Specimens

For in vitro diagnostic use.

**Intended Use**
The APTIMA Urine Specimen Collection Kit for Male and Female Urine Specimens is for use with APTIMA assays. The APTIMA Urine Specimen Collection Kit is intended to be used for the collection and transport of male or female urine specimens.

**Materials Provided**
50 APTIMA Urine Specimen Collection Kits for Male and Female Urine Specimens (Cat. No. 301040)
Each kit contains:

<table>
<thead>
<tr>
<th>Component</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pipette</td>
<td>1</td>
</tr>
<tr>
<td>Specimen transport tube</td>
<td>1</td>
</tr>
</tbody>
</table>

- Disposable transfer pipette.
- Tube containing 2.0 mL APTIMA urine transport medium.

**Warnings and Precautions**
A. Do not apply the transport medium directly to skin or mucous membranes or take internally.

**Kit Storage Requirements**
Store collection kit at room temperature (15°C to 30°C).

**Urine Specimen Performance**
The assay performance characteristics of the male and female urine specimens are provided in the appropriate APTIMA assay package insert. The APTIMA assay package inserts may be referenced online at www.gen-probe.com. The table below identifies the acceptable specimen types for each of the APTIMA assays.

<table>
<thead>
<tr>
<th>APTIMA Assay for</th>
<th>Male Urine Specimens</th>
<th>Female Urine Specimens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia trachomatis</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Chlamydia trachomatis and Neisseria gonorrhoeae (Aptima Combo 2 Assay)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Specimen Collection and Handling**
1. The patient should not have urinated for at least 1 hour prior to specimen collection.
2. Direct patient to provide a first-catch urine (approximately 20 to 30 mL of the initial urine stream) into a urine collection cup free of any preservatives. Collection of larger volumes of urine may result in rRNA target dilution that may reduce test sensitivity. Female patients should not cleanse the labial area prior to providing the specimen.
3. Remove the cap and transfer 2 mL of urine into the urine specimen transport tube using the disposable pipette provided. The correct volume of urine has been added when the fluid level is between the black fill lines on the urine specimen transport tube label.
4. Re-cap the urine specimen transport tube tightly. This is now known as the processed urine specimen.

**Specimen Transport and Storage**
After collection, transport the processed urine specimens in the APTIMA urine specimen transport tube at 2°C to 30°C and store at 2°C to 30°C until tested. Processed urine specimens should be assayed with the APTIMA assay within 30 days of collection. If longer storage is needed, refer to the appropriate APTIMA assay package insert.
Urine samples that are still in the primary collection container must be transported to the lab at 2°C to 30°C. Transfer the urine sample into the APTIMA urine specimen transport tube within 24 hours of collection. Store at 2°C to 30°C and test within 30 days of collection.

**Note:** Specimens should be transported in compliance with Federal regulations for transport of etiological agents. Please refer to HHS Publication No. CDC 93-8395 or latest revision.

**Limitations**

A. Use this collection kit only with the APTIMA assays. Performance has not been established with other products.

Gen-Probe Incorporated
San Diego, CA 92121 USA

U.S. and international contact information
Customer Service: +1 858 410 8002
customerservice@gen-probe.com
Technical Support: +1 858 410 8511
technicalsupport@gen-probe.com
Toll-free from U.S. and Canada
Customer Service: +1 800 523 5001

Technical Support: +1 888 484 4747
www.gen-probe.com
MLT Research Ltd
Attn. Dr Andrew Rutter
5 Chiltern Close
Cardiff
CF14 5DL
United Kingdom
© 2001-2010 Gen-Probe Incorporated
501936EN Rev. A

2009-11
**Intended Use**

The APTIMA Unisex Swab Specimen Collection Kit for Female Endocervical and Male Urethral Swab Specimens is for use with APTIMA assays. The APTIMA Unisex Swab Specimen Collection Kit is intended to be used for the collection of female endocervical or male urethral swab specimens.

**Materials Provided**

50 APTIMA Unisex Swab Specimen Collection Kits for Endocervical and Male Urethral Swab Specimens (Cat. No. 301041)

Each kit contains:

<table>
<thead>
<tr>
<th>Component</th>
<th>Quantity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unisex collection swab*</td>
<td>1</td>
<td>Swab for endocervical or male urethral swab specimens.</td>
</tr>
<tr>
<td>Cleaning swab*</td>
<td>1</td>
<td>Female cleaning swab.</td>
</tr>
<tr>
<td>Transport tube</td>
<td>1</td>
<td>Tube containing APTIMA swab transport medium (2.9 mL).</td>
</tr>
</tbody>
</table>

**Warnings and Precautions**

A. Do not apply the transport medium directly to skin or mucous membranes or take internally.

**Kit Storage Requirements**

Store collection kit at room temperature (15°C to 30°C).

**Swab Specimen Performance**

The assay performance characteristics of the female endocervical and male urethral swab specimens are provided in the appropriate APTIMA assay package insert. The APTIMA assay package inserts may be referenced online at www.gen-probe.com. The table below identifies the acceptable specimen types for each of the APTIMA assays.

**APTIMA Assay for**

**Female Urine Specimens**

**Male Urine Specimens**

*Chlamydia trachomatis*

*Chlamydia trachomatis and Neisseria gonorrhoeae (Aptima Combo 2 Assay)*

Neisseria gonorrhoeae

Yes

Yes

**Specimen Collection and Handling**

A. Endocervical swab specimens

1. Remove excess mucus from the cervical os and surrounding mucosa using the cleaning swab (white shaft swab in the package with red printing). Discard this swab.
Note: To remove excess mucus from the cervical os, a large-tipped swab (not provided) may be used.
2. Insert the specimen collection swab (blue shaft swab in the package with the green printing) into the endocervical canal.
3. Gently rotate the swab clockwise for 10 to 30 seconds in the endocervical canal to ensure adequate sampling.
4. Withdraw the swab carefully; avoid any contact with the vaginal mucosa.
5. Remove the cap from the swab specimen transport tube and immediately place the specimen collection swab into the transport tube.
6. Carefully break the swab shaft against the side of the tube at the scoreline and discard the top portion of the swab shaft; use care to avoid splashing of contents.
7. Re-cap the swab specimen transport tube tightly.

B. Male urethral swab specimens
1. The patient should not have urinated for at least 1 hour prior to sample collection.
2. Insert the specimen collection swab (blue shaft swab in the package with the green printing) 2 to 4 cm into the urethra.
3. Gently rotate the swab clockwise for 2 to 3 seconds in the urethra to ensure adequate sampling.
4. Withdraw the swab carefully.
5. Remove the cap from the swab specimen transport tube and immediately place the specimen collection swab into the transport tube.
6. Carefully break the swab shaft against the side of the tube at the scoreline and discard the top portion of the swab shaft; use care to avoid splashing of contents.
7. Re-cap the swab specimen transport tube tightly.

Specimen Transport and Storage

After collection, transport and store the swab in the swab specimen transport tube at 2°C to 30°C until tested. Specimens must be assayed with the APTIMA assays within 60 days of collection. If longer storage is needed, refer to the appropriate APTIMA assay package insert.

Note: Specimens should be transported in compliance with Federal regulations for transport of etiological agents. Please refer to HHS Publication No. CDC 93-8395 or latest revision.

Limitations
A. Use this collection kit only with the APTIMA assays. Performance has not been established with other products.

Gen-Probe Incorporated
San Diego, CA 92121 USA

U.S. and international contact information
Customer Service: +1 858 410 8002
customerservice@gen-probe.com
Technical Support: +1 858 410 8511
technicalsupport@gen-probe.com
Process for the online ordering of STD Medications from DOH Central Pharmacy:

FDOH central pharmacy staff will enter information from the CPT medical profile form (Appendix F) into the FDOH pharmacy secure online medication ordering system. After the CPT medical profile has been entered they will receive the following email:

"Welcome to the Pharmaceutical Forms System. To access the system, go to: [http://www.fdohcentralpharmacy.com/login.aspx](http://www.fdohcentralpharmacy.com/login.aspx). Enter your User ID and your password (which will be provided in the email received from the DOH pharmacy), reset the password and click 'Login'." After logging in the following screen will appear:

Step 1:
Click on Repack Pharmaceutical request (blue box)

![Pharmaceutical Forms System](image)

Step 2
The following screen will appear:
Complete the following fields:
Step 3
The completed screen
Step 4
After all the required fields are complete hit submit button located at the bottom of the screen.
CPT STD Prophylactic Inventory Log:

The following information must be collected on the Inventory Log:

- Medication Description
- Pkg Size
- Beginning Inventory
- Additional Received this period
- Dispensed Medication
- Quantity in Stock
- Ending Inventory
- Difference
- National Drug Code
- Expiration Date

National Drug Code and the Expiration Date are located on the medication label. Log sheet must be maintained by CPT for (6) years

Handling of expired STD medications:
CPT staff are responsible for developing a policy for routinely checking expiration dates on the CPT STD medications. Expired STD medications must be returned to DOH central pharmacy at the following address: 116A Hamilton Park Dr, Tallahassee, Florida 32304. The Prescription Return Form, which is included in Appendix F., must be completed for all expired STD medications returned to the DOH central pharmacy. The completed form is to be sent electronically to the DOH pharmacy and a copy of the form will accompany the returned medications.

Specimen collection and handling:

Specimens should be collected as soon as possible after onset and transported immediately to the laboratory. Each CPT provider site can use the laboratory of their choice to process specimens. Bureau of STD will only cover the laboratory costs if the DOH Laboratory is used.

STD specimens collected by the CPT staff can be submitted to the FDOH laboratory, www.doh.state.fl.us/lab/index.htm along with the laboratory request form DH1847, which is included in Appendix F.

Request form DH1847, urine collection kits, and swab collection kits for gonorrhea and Chlamydia testing can be ordered by faxing a request to Bureau of Laboratories’ supply department at (904)791-1637. The phone number for the state laboratory is: (904) 791-1571. Collection materials for herpes testing are not available through the state laboratory. Herpes Simples Virus (HSV) testing is only available in the Jacksonville and Tampa laboratories. Chlamydia trachomatis (CT) and Gonorrhea testing is available at all five Bureau of Laboratory locations.

CPT STD Instructions for specimen collection and shipping of specimens is included in the following attachments located in Appendix F:

- APTIMA® Unisex Swab Specimen Collection Kit for Endocervical and Male Urethral Swab Specimens
- APTIMA® Urine Specimen Collection Kit for Male and Female Urine Specimens
- COLLECTION AND SHIPPING OF SPECIMENS FOR HERPES SIMPLEX VIRUS (HSV) EXAMINATION
CPTIS STD DATA ELEMENTS:

Federal and State requirements include the collection of data elements which will be reported to the DOH STD office. These data elements will be collected in CPTIS. The data will be collected in CPTIS on the Assessment screen. The data elements will be collected on children served by the CPT who receive STD prophylactic medications. When a sexual abuse exam is performed and the child has finding, the attached screen will appear at the bottom of the assessment screen.

The CPTIS User’s Guide provides instructions for completing the data fields.
APPENDIX G:

MEDICAL NEGLECT AND MEDICALLY COMPLEX

1) Medical Neglect:
   a. The failure to provide or the failure to allow needed care as recommended by a health care practitioner for a physical injury, illness, medical condition, or impairment, or
   b. The failure to seek timely and appropriate medical care for a serious health problem that a reasonable person would have recognized as requiring professional medical attention.
   c. Medical neglect does not occur:
      o If the parent or legal guardian of the child has made reasonable attempts to obtain necessary health care services or the immediate health condition giving rise to the allegation of neglect is a known and expected complication of the child’s diagnosis or treatment, and
      o The recommended care offers limited net benefit to the child and the morbidity of other side effects of the treatment may be considered to be greater than the anticipated benefit; or
      o The parent or legal guardian received conflicting medical recommendations for treatment from multiple practitioners and did not follow all recommendations.

Note: Definition from the American Academy of Pediatrics and SB 1666 pages 24 & 25.

2) Medical Assessment:
   a. The child protective investigator (CPI) who has received a report alleging medical neglect and who has interacted with the child and child’s family shall promptly contact and provide information to the Child Protection Team (CPT).
   b. The CPT shall assist the CPI in identifying immediate responses to address the medical needs of the child with the priority of maintaining the child in the home if the parents will be able to meet the needs of the child with additional services.
   c. The CPI and CPT must use a family-centered approach to assess the capacity of the family to meet those needs.
   d. A medical assessment of the child must be completed by the CPT medical providers as soon as practicable.
   e. A medical assessment can be completed through a medical consultation or a medical exam. A CPT medical consultation is defined as: Medical consultation is an evaluation by review of the medical history, not including a physical examination, provided to render a medical opinion regarding abuse/neglect on a child(ren) that already has been evaluated by a non-CPT medical provider. Medical consultation involves situations where the CPI (or court) requests CPT to assist with a medical opinion. Consultation should not be a substitute for a CPT medical examination when appropriate, nor does it exclude the need for other CPT assessments. A medical consultation must result in a prepared report that references all the pertinent history, examination findings and laboratory/imaging studies used to reach the medical conclusions. The CPT medical record must include copies of the relevant records and reports used to arrive at the medical opinion. If a medical consultation rather than a medical exam was completed the CPT case file must include detailed written explanation of why this decision was made. For example: “Upon review of the records, it was determined that a CPT medical examination would not add any significant new medical information to what previously exists.”

3) Children with Medical Complexity (CMC):
   a. CMC have medical fragility and intensive care needs that are not easily met by existing health care models.
b. CMC refers to the extra time, expertise, and resources necessary to achieve optimal health outcomes.

c. CMC all have a severe (medically fragile), potentially lifelong (chronic) condition. To be classified in CPTIS as CMC they must be described as having a chronic condition and one or more of the following:

- A congenital or acquired multisystem disease,
- A severe neurological condition with marked functional impairment,
- Technologically – Dependent: Using a medical technology, usually embodied in a medical device, that compensates for the loss of normal use of a vital bodily function,
- Requires substantial daily nursing care to avert death or further disability (e.g. paraplegic, tracheostomy tube, feeding tube, wheelchair)
- High resource use (e.g. projected high utilization of health resources such as frequent and/or prolonged hospitalizations).
- Multiple service providers (e.g. ongoing involvement of multiple subspecialty services and providers).
- Significant impact on the family unit functioning (e.g. frequent providers visits, care coordination, time devoted to direct care, and financial burden)

d. See medically complex fields as they will appear in CPTIS.

---

**Medically Complex:**
- Yes
- No

**Medical Provider Consulted:**
- CMS Network Physician
- Other: [ ]

**Unable To Comply:**
- [ ]

**Obesity:**
- Yes
- No

**Nutritional counseling needed:**
- Yes
- No

**Included in Recommendation To DCF/SD:**
- [ ]

---

June 28, 2019
APPENDIX H:

CPT FORENSIC INTERVIEW PROCEDURE

Forensic interviews are meant to gather information in an open-minded way. They should be neutral, fact-finding and objective. The interviews should also consider multiple hypotheses, making the interviewer think about all of the possible reasons an allegation was made. Forensic interviews are typically used in court settings. The goals of forensic interviewing are to maximize accurate information from the child while maintaining the integrity of the interview process. In addition, the forensic interview is done in a manner that minimizes the negative effects that the interview process has on the child and minimizes the contaminating effects that the interview process has on the child’s memory.

The forensic interview should have organization and structure. DOH forensic interview training teaches a flexible structure for forensic interviewing. Best practices are taught using various models but focusing mainly on the American Professional Society on the Abuse of Children (APSAC) guidelines and Recognizing Abuse Disclosure types And Responding (RADAR) protocol, a modified National Institute of Child Health and Human Development (NICHD) protocol. Interviews are conducted using techniques that begin with a very broad exploration utilizing open-ended and non-leading questions. Questions may be narrowed down as needed to meet the needs of the child, but all explorations must follow an “hour glass” approach in which the exploration begins with broad questioning, narrows in as necessary and broadens out again. This process should be utilized throughout the interview as information is obtained. Different protocols, models and guidelines have different phases/stages of the interview, but typical components of the interview include 1) an introduction of the interviewer to the child, 2) rapport building, developmental assessment, and narrative practice, 3) interview instructions or “ground rules,” 4) transition to the topic of concern, 5) detail gathering, elaboration and clarification, and 6) closure. Some protocols, models and guidelines include a ritual to determine if the child understands the difference between a truth and a lie and appreciates the importance of telling the truth. Whether or not this is done by your CPT needs to be discussed and determined with your community stakeholders, especially your State Attorney’s Office.

Research has taught us that memory that comes from free recall is most accurate (¹) (²); therefore, the use of various media or “props” should be used with caution. Media or “props” should only be used when necessary to gather information, and it should always be followed up with an attempt at verbal elaboration from the child. Recent research on anatomically detailed drawings indicate that there is an increased risk of false reporting when anatomically detailed drawings are introduced to a child early in the interview, and especially when used to elicit an initial disclosure from the child (³) (⁴). DOH teaches forensic interviewers to only use body outlines without anatomical details when developmentally appropriate for clarification and elaboration purposes AFTER an initial disclosure is made. In addition, body outlines without anatomical details may be considered, if developmentally appropriate, for use as a last resort to focus the child on body parts when the suspicion for abuse is very high and all other efforts of eliciting an initial disclosure have been properly used and have not been successful. This practice must be followed up with an attempt at verbal elaboration from the child. Interviewers must know, however, that they must be prepared to defend their actions as being suggestive. DOH
does not teach the use of anatomical dolls in forensic interviewing and does not endorse their use due to the suggestive nature of their use and their invitation for the child to engage in fantasy. Likewise, DOH does not teach or endorse the use of other media, such as puppets and toy telephones, because of their invitation to engage the child in fantasy.

Forensic interviews may be observed by members of the investigative team or by CPT persons who are training to be forensic interviewers. At the discretion of the Team Coordinators, advocates or any persons whose primary role is to support the family and/or provide referrals to community organizations may observe interviews after it has been determined that the child is a victim of abuse/neglect and is in need of advocacy.

DOH requires that the use of ear pieces by forensic interviewers may be used when the interviewer is being trained or supervised, and the supervising observer is a member of the CPT and is monitoring the interview for quality improvement or supervisory purposes. Any additional ear piece use must be approved by the DOH Program Office.

Accurate documentation of forensic interviews is very important. APSAC feels that electronic recording of the interview “is the most comprehensive and accurate method” for documenting the interview. DOH strongly encourages that all forensic interviews be electronically recorded and include, both video and audio recording. If video recording is not possible, audio recording should be done.

Following the completion of a forensic interview, a written report will be completed which summarizes the interview. The report must clearly identify and explore the allegations and related referral information. The report must also include a clear statement of events as told by the child, documentation of all identified safety and risk factors, a discussion of safety planning with the child, if applicable, and the findings regarding the maltreatments that were explored. The report will be documented in CPTIS. (For further details, please refer to the CPT Handbook)

Footnotes:


Bibliography


JSG 6/17/15
**APPENDIX I**

**SUBCONTRACT(S) AND SUBCONTRACT AGREEMENT**

| A | Did the Provider receive prior written approval from the Department to subcontract? | Found in Attachment I of the Provider’s Contract if any services are allowed to be subcontracted. This is written approval. Additionally, an Attachment I may specify that the Provider has permission to subcontract and that each individual subcontractor must be approved prior to commencement of services. |
| B | Did the Provider’s subcontracting agreement include the requirement to verify all new employees through the US Department of Homeland Security’s E-Verify system? | Page 1 of S.C. section I.C.f. the provider shall also include a requirement in subcontracts that the subcontractor shall utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor during the contract term |
| C | Did the Provider's subcontracting agreement include the requirement to comply with the prohibition of indoor smoking, pursuant to the Pro-Children Act of 1994? | Page 1 of S.C. section I.C.h. the provider and any subcontracts agree to comply with Pro-Children Act of 1994, Public Law 103-277…. |
| D | Did the Provider's subcontracting agreement include the provision for document retention? | Page 2 of S.C. section I.D.7 to include these aforementioned audit and record keeping requirements in all approved subcontracts and assignments. |
| E | Did the Provider’s subcontracting agreement include the provision of independent capacity of contractor per § I.O. of the standard contract? | Page 4 of S.C. section I.O.4 the provider agrees to take such actions as may be necessary to ensure that each subcontractor of the provider will be deemed to be an independent contractor and will not be considered or permitted to be an agent, servant, joint venture, or partner of the State of Florida |
| F | Did the Provider’s subcontracting agreement adequately identify the financial assistance award information? (CFDA/CSFA# and title, award year, name of awarding agency, award name/title) | 215.97,F.S.(7)(a) Please see the entire section. Bullets 1-4. 
OMB Circular A-133 § .400(d)(1) |
| G | Did the Provider's subcontracting agreement advise the sub-recipient of financial assistance of applicable laws, rules, regulations? | 215.97,F.S.(7)(a) Please see the entire section. Bullets 1-4. 
OMB Circular A-133 § .400(d)(2) |
| H | Did the Provider’s subcontracting agreement include the requirement that a financial and compliance audit be submitted to the Provider per f.s. 215.97 (FL Single Audit Act) and/or OMB Circular A-133 (Fed Single Audit Act)? | 215.97, F.S.(8) Please see the entire section. Specifically Bullets (a)-(d) 
OMB Circular A-133 § .400(d)(4) |
| I | Did the Provider have a process in place to monitor the activities of subrecipients to ensure that awards are used for authorized purposes and in compliance with laws, rules, regulations? | 215.97,F.S.(7)(b)-(d) Please see the entire section. 
OMB Circular A-133 § .400(d)(7) |
APPENDIX J

Assessing the Need for Post-Exposure Prophylaxis Against HIV
Assessing the Need for Post-Exposure Prophylaxis Against HIV Infection Following Sexual Assault

Non-Occupational Post-Exposure Prophylaxis (nPEP) is the use of a highly active combination of antiretroviral drugs as soon as possible after exposure (or suspected exposure) to HIV in order to prevent HIV infection. The risk of infection associated with sexual assault is based on a number of factors, with the risk for HIV transmission being greatest with receptive vaginal and anal intercourse. If the assault is traumatic or genital infection is present, the risk of HIV transmission is considered even higher. The duration and length of assault and whether the offender is known or suspected to have HIV are other high risk factors. Children may be at increased risk due to the fact that child sexual abuse is often associated with repeated assaults and trauma. The effectiveness of nPEP continues to be studied, but we know nPEP works best if taken immediately or within 72 hours after exposure.

For more information on nPEP, please see the CDC’s recommendations (Updated guidelines for antiretroviral post-exposure prophylaxis after sexual, injection drug use, or other nonoccupational exposure to HIV-United States, 2016) at the following website: https://www.cdc.gov/hiv/guidelines/preventing.html . (Accessed April, 2017)
Procedure for Prescribing Post-Exposure Medications to Prevent HIV Infection (nPEP)

If PEP indicated (See Chart):

If patient is less than 13 years of age, call your local Pediatric HIV consultant or the National Clinicians' Post-Exposure Prophylaxis PEPline at 888-448-4911, 9 AM-2 AM EST, for advice.

If patient is 13 years of age or older, follow the steps below:

1) Fill out following forms (all attached, below):
   a. Prescription for Post-Exposure Prophylaxis Against HIV: Assist the patient in filling in steps 1 and 2 as best they are able. Provider completes step 3 and signs the prescription. Of note, a Walgreens pharmacy has agreed to assist patients needing PEP and will provide this medication 24/7 at the location listed. If this is not convenient for the patient, the patient can take the prescription to another pharmacy but may not be able to fill it in a timely fashion. See follow up sheet, below, for contact info for participating Walgreens.
   b. Letter of Medical Necessity: Fill in date, patient name, date of exposure, provider signature, and agency name. This form directs the pharmacy to expedite provision of the medications.
   c. Authorization for Use and Disclosure of Protected Health Information: Fill out, review with patient, and obtain patient signature. This form authorizes the CPT to share patient information with the doctor’s office where he/she will be seen for follow up care.

2) FAX completed forms a and b, above (Prescription for Post-Exposure Prophylaxis Against HIV and Letter of Medical Necessity) to your local participating Walgreens Pharmacy, Attn: nPEP Protocol. Also give patient a copy of these forms to take with her/him to the pharmacy.

3) Dispense to the patient the following: Drug side-effects information sheets and clinic follow up information sheet.

4) Identify the physician or clinic where the patient will go for follow up. FAX the Authorization for Use and Disclosure of Protected Health Information to the selected clinic, if the patient consented to the release of information.

Additional information:

- It is recommended to have a packet of forms prepared prior to the patient visit, with the areas the patient needs to fill out highlighted to expedite the paperwork.
- If you have the means to do so, obtain a CBC and CMP along with the baseline HIV test at the initial visit with the patient. If this is not feasible, these labs will be obtained by the follow up clinic.

Follow Up Care

It is general CPT policy to see victims of acute sexual abuse and assault two weeks after their initial visit to assess how they are doing with regard to signs and symptoms of infection, emotional state
and linkage to support services and counseling. Patients started on nPEP should also be asked about adherence to the treatment plan and medication side effects.

Patients who have been started on nPEP require follow-up and testing for up to three months, a period of time that extends beyond the time the CPT can provide care. Therefore, all patients started on prophylaxis should be referred to a program with experience in the management of HIV exposure.

The CPT Program Office, working in conjunction with the HIV/AIDS Section of the Bureau of Communicable Diseases, will provide a list, periodically updated, of physicians or clinics that will provide follow up care for patients started on nPEP by the CPT. If your team does not already have an established relationship with such a provider, consult this list to identify one. If a follow up care provider cannot be immediately identified, this step can be completed prior the patient’s return for the 2-week CPT visit.

Once the source of follow-up care is identified, the patient/family should be provided contact information and instructed to schedule an appointment as soon as possible. Forms for this and to authorize release of medical information to the follow up provider are attached. The source of follow-up care should be requested to notify the CPT if the patient should fail to schedule or keep the appointment.

While this program will provide medications to patients regardless of their insurance status, those providing follow up care will expect to be paid. If the patient is uninsured, the patient’s family must be provided guidance or referred for assistance in signing up for Medicaid or other insurance coverage.
STEP 1: PATIENT INFORMATION

Patient Name: ___________________________ Phone: ___________________________
Street Address: ___________________________ Date of Birth: ___________________________
City, State, Zip: ___________________________ SS#: ___________________________
Drug Allergies: ___________________________ Gender: ___________________________
Other Medications: ___________________________ Alt. Contact: ___________________________

STEP 2: INSURANCE INFORMATION

[ ] Insurance information attached (front and back copy of insurance card) in place of below field
[ ] Not applicable – patient uninsured

Insurance Name and Type: ___________________________ RX Grp: ___________________________
Insurance Phone #: ___________________________ RX BIN: ___________________________
Member ID: ___________________________ PCN: ___________________________

STEP 3: (FOR PROVIDER TO FILL OUT)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose/Strength</th>
<th>Directions</th>
<th>Quantity</th>
<th>Providers Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Truvada (Emtricitabine/Tenofovir)</td>
<td>200mg/300mg</td>
<td>Take 1 tablet by mouth daily with or without food</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Tivicay (Dolutegravir)</td>
<td>50 mg</td>
<td>Take 1 tablet by mouth daily with or without food</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

Provider Name: ___________________________ NPI: ___________________________
Address: ___________________________ DEA: ___________________________
Phone: ___________________________ Office Fax: ___________________________
Contact: ___________________________

-------------------------------------------------------------
DISPENSE AS WRITTEN NAME PRINTED DATE

104
June 28, 2019
Letter of Medical Necessity for nPEP

Date: ______________________

To Whom It May Concern:

This letter, written on behalf of my patient, ______________________________________________, date of birth ________________, is to indicate the medical necessity of treatment with Post Exposure Prophylaxis (PEP) and to support my request for expedited approval and coverage of medications.

This patient was exposed to the Human Immunodeficiency Virus (HIV) on _________________. Please approve the immediate coverage of Truvada (tenofovir + emtricitabine), and Tivicay (Dolutegravir), so that the patient may begin treatment within the recommended 72-hour timeframe of potential HIV exposure.

Given the urgent nature of this timely request, please approve this medication immediately so that my patient will be able to prevent possible HIV transmission.

Sincerely,

__________________________________________

Signed

__________________________________________

Name (Printed)
INSTRUCTIONS

Complete all applicable sections of the Enrollment Form.

- **Section 1 (required):** Check the box next to each service you are requesting from Advancing Access.
- **Section 2 (required):** Write the name and dosage of the Gilead product you are requesting assistance with from Advancing Access.
- **Section 3 (required):** Complete all fields with the patient's information.
- **Section 4 (required):** Check the appropriate box to indicate if the patient is insured or uninsured.
  - If the patient is insured, fill in the patient's insurance information and fax a copy (front and back) of the patient's insurance card. If the patient has a secondary insurance, check the box to indicate this and fax a copy of the secondary insurance card.
  - If the patient is uninsured, complete Section 9 to apply to the Patient Assistance Program.
- **Section 5 (required):** Complete all fields with the prescriber's information.
- **Section 6:** A healthcare provider must provide the patient's diagnosis and medical information.
- **Section 7 (required):** The prescriber must sign and date this section for reimbursement support and the Patient Assistance Program.
- **Section 8 (required):** The patient (or the patient's representative) must sign and date this section.
- **Section 9 (required only if applying to the Patient Assistance Program (“PAP”)):**
  - Provide the patient's annual household income and household size and complete the additional insurance information portion.
  - The patient must sign and date this section if applying to the PAP.
  - Attach documentation for all sources of income and proof of U.S. residency.

Mail or fax the completed Enrollment Form and all required documentation to the Advancing Access at the address or fax number below. Both sets of information are necessary to ensure timely application review.

An Advancing Access reimbursement counselor will notify the requestor about the patient's coverage and benefits, alternate funding options and/or qualification for the PAP, depending on the requested service(s).

Patients who meet the eligibility criteria for the PAP will be prequalified for the program.

- The program will notify the patient and the prescriber of the prequalified status.
- The prescriber’s notification will also include a prescription form.
- The prescriber will have up to six months from the prequalified date to submit the completed prescription form to the dispensing pharmacy specified on the form.
- Once the dispensing pharmacy receives the completed prescription form, the patient will be enrolled in the PAP and will receive product free of charge from the pharmacy by mail. A toll-free telephone number is included if additional assistance is needed.

PATIENT CONFIDENTIALITY

Patient confidentiality is of primary importance to us. All patient information will remain confidential. Information may be provided to clinicians, social workers or family members when required to complete the enrollment process and coordinate patient assistance.

IMPORTANT REMINDER

Please be certain that all applicable pages of the Enrollment Form are completed and include all appropriate documentation when submitting the form. Incomplete forms slow the review process and, in some cases, may require a patient to reapply for the program.

Gilead Sciences, Inc. reserves the right to modify or discontinue the Advancing Access or terminate assistance at any time. Third-party reimbursement is affected by a range of factors; therefore, Gilead Sciences, Inc. cannot guarantee any coverage or reimbursement.
1. REQUESTED PATIENT SERVICE(S) (REQUIRED)  
- Benefits Investigation  
- Prior Authorization and Appeals Information  
- Co-pay Coupon Program Enrollment  
- Independent Co-pay Foundation Information  
- Patient Assistance Program (PAP) Eligibility Screening  

CHECK ALL BOXES THAT APPLY

2. GILEAD MEDICATION PRESCRIBED (REQUIRED)  
Product Name:  
If requesting TRUVADA®, please indicate for:  
- Treatment  
- PrEP

3. PATIENT INFORMATION (REQUIRED)  
Patient Name:  
Preferred Language:  
Address:  
City:  
State:  
Zip Code:  
Phone #:  
SSN (last 4 digits):  
Gender:  
M  
F  
Email:  
DOB:  
Alternate Contact Name:  
Phone #:  
Relationship:

CONTACT AUTHORIZATION

I authorize Advancing Access to leave a detailed message, including the name of my prescription, if I am unavailable when they call.  
Yes  
No

4. INSURANCE INFORMATION (REQUIRED)  
Patient is Insured (Please fill out all of the applicable insurance information below. Attach copy—front and back—of patient card)  
Patient is uninsured (ie, no health insurance through any public or private payer)  
SEE OPTIONAL "PATIENT FINANCIAL INFORMATION" SECTION BELOW  
Primary Insurance:  
Is this a Medicare Part D plan?  
Yes  
No  
Plan name:  
Payer Phone Number:  
Subscriber Name:  
Policy Holder Name:  
Policy Holder Relationship to Patient:  
Policy #:  
Group #:  
Rx Bin #:  
Rx PCN #:  
Check box if patient has secondary insurance coverage and fax a copy of insurance cards, if available.

5. PRESCRIBER INFORMATION (REQUIRED)  
Prescriber Name:  
Facility Name:  
Address:  
City:  
State:  
Zip Code:  
Office Contact:  
Phone #:  
Fax #:  
NPI #:  
Tax ID #:  
State License #:  

6. DIAGNOSIS/MEDICAL INFORMATION  
MUST BE COMPLETED BY HEALTHCARE PROVIDER  
Diagnosis (Please include ICD-10 code):
7. PRESCRIBER CERTIFICATION AND STATEMENT OF MEDICAL NECESSITY

By signing this form, I certify that I am prescribing Gilead medication for the patient identified in Section 3. I certify that this prescription medication is medically necessary for the patient and that it will be used as directed. I certify that I will be supervising the patient’s treatments and verify that the information provided is complete and accurate to the best of my knowledge. I agree that I shall not seek reimbursement for any Gilead medication dispensed to the patient through the Patient Assistance Program (PAP) or from any government program or third-party insurer.

If prescribing TRUVADA® for PrEP, I certify that the applicant has been tested for HIV infection and found to be HIV negative, and regular HIV testing will be conducted as part of the applicant’s care plan. As part of my applicant’s eligibility, I agree to periodically verify continued use of Gilead medication and resubmit current prescriptions.

I certify that I have received the appropriate written authorization from the patient, in accordance with the Health Insurance Portability and Accountability Act of 1996, applicable state health information privacy law(s), and any other applicable requirements, in order to release the patient’s personal and medical information to Gilead and its agents and contractors for the purposes of: 1) verifying the patient’s insurance coverage and eligibility for benefits; 2) seeking prior authorization if needed on the patient’s behalf; 3) providing financial assistance, support, and referral services as needed; 4) facilitating the provision of the patient’s prescription medication to the patient; 5) contacting the patient with educational materials about the patient’s prescription medication or to evaluate the effectiveness of the Advancing Access Program and/or the PAP; and 6) for Gilead’s internal business purposes.

PRESCRIBER SIGNATURE (REQUIRED): 

DATE:
I understand that I must complete this enrollment form before I can receive assistance through Gilead Sciences, Inc.’s Advancing Access ("Program") and the Patient Assistance Program ("PAP"). As part of this process, Gilead and its agents and contractors (collectively, "Gilead") will need to obtain, review, use and disclose my personal and medical information as described below. I hereby authorize my healthcare providers and health plans to disclose my personal and medical information as described below to Gilead in connection with the Program and/or the PAP, all in accordance with this authorization, and I authorize Gilead to use and disclose the information in accordance with the authorization.

**Information to Be Disclosed:** Personal health information ("PHI"), including information about me (for example, my name, mailing address, financial information, and insurance information), my past, current and future medical condition (including information about my HIV-related status or treatment with this prescription medication and related medical condition), and all information provided on this enrollment form.

**Persons Authorized to Disclose My Information:** My healthcare providers, including any pharmacy that fills my prescription medication, and any health plans or programs that provide me healthcare benefits. I understand that my pharmacy providers may receive remuneration for disclosing my PHI pursuant to this authorization.

**Persons to Which My Information May Be Disclosed:** Gilead, including the third party administrator responsible for the administration of the Program and the PAP.

**Purposes for Which the Disclosures Are to Be Made:** Disclosures of PHI may be made to Gilead so that Gilead may use and disclose the PHI for purposes of: 1) completing the enrollment process and verifying my enrollment form; 2) establishing my eligibility for benefits from my health plan or other programs; 3) providing financial assistance, support, and referral services, and communicating with my healthcare providers, including, but not limited to, facilitating the provision of my prescription medication to me; 4) contacting me to evaluate the effectiveness of the Program and/or the PAP; 5) for Gilead’s internal business purposes, including quality control and service enhancing surveys; and 6) to send me marketing information, offers, and educational materials related to my treatment and/or my prescription medication, including the customer relationship marketing program (this use of my personal information is optional and by checking the box under the signatures below, I may opt in).

I understand that once my PHI has been disclosed hereunder, federal privacy law may no longer restrict its use or disclosure. I understand further that I may refuse to sign this authorization and that if I refuse, my eligibility for health plan benefits or ability to obtain treatment from my healthcare providers will not change, but I will not have access to the services offered by Program and/or the PAP. I also understand that I may cancel this authorization at any time by notifying Gilead in writing at Advancing Access, PO Box 13185, La Jolla, CA 92039-3185. If I cancel, Gilead will stop using this authorization to obtain, use or disclose my PHI after the cancellation date, but the cancellation will not affect uses or disclosures of any PHI that have already been made pursuant to this authorization before the cancellation date. I am entitled to a copy of this signed authorization, which expires the earlier of two (2) years from the date it is signed by me or other time period required under the laws of the state in which I reside.

June 28, 2019
By checking this box, I agree to receive marketing information, offers and educational materials related to my medical condition, treatment, and/or my prescription medication, including the customer relationship marketing program.

**SIGNATURE of PATIENT or PATIENT’S REPRESENTATIVE (REQUIRED):**

**DATE:**

**Patient Representative’s Name** (if signing for the patient):

**Patient Representative’s Relationship to Patient:**

---

**FAX COMPLETED FORM TO ADVANCING ACCESS AT 1-800-216-6857**

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ADVANCING ACCESS ENROLLMENT FORM    PHONE: 1-800-226-2056    FAX: 1-800-216-6857

**PATIENT NAME: ___________________________ DATE OF BIRTH: ___________________________**

9. **PATIENT FINANCIAL INFORMATION** (OPTIONAL)  
   REQUIRED ONLY IF APPLYING FOR THE PATIENT ASSISTANCE PROGRAM (PAP)

<table>
<thead>
<tr>
<th>Current Annual Household Income: $</th>
<th>Required only if applying for the Patient Assistance Program (PAP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of People in Household:</td>
<td>1 2 3 4 5 6 Other:</td>
</tr>
</tbody>
</table>

Please submit current documentation for all sources of income (e.g., tax return, W2, last 2 pay stubs, etc.) and proof of U.S. residency (e.g., utility bill, bank statement, etc.).

---

**ADDITIONAL INSURANCE INFORMATION**

Social Security Number:

<table>
<thead>
<tr>
<th>Has the patient applied for ADAP?</th>
<th>Yes</th>
<th>No</th>
<th>If Yes, date of application:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the patient applied for Medicaid?</td>
<td>Yes</td>
<td>No</td>
<td>If Yes, date of application:</td>
</tr>
<tr>
<td>Is the patient eligible for Medicaid?</td>
<td>Yes</td>
<td>No</td>
<td>If No, state reason:</td>
</tr>
<tr>
<td>Is the patient eligible for VA benefits?</td>
<td>Yes</td>
<td>No</td>
<td>If Yes, has the patient tried to obtain the medication through the VA? Yes No</td>
</tr>
<tr>
<td>Has the patient applied for an insurance plan offered through a state insurance marketplace (also known as an exchange)?</td>
<td>Yes</td>
<td>No</td>
<td>If Yes, date of application:</td>
</tr>
<tr>
<td>Is the patient eligible for an insurance plan offered through a state insurance marketplace (also known as an exchange)?</td>
<td>Yes</td>
<td>No</td>
<td>If No, state reason:</td>
</tr>
</tbody>
</table>

---

**TRUVADA® FOR PEP MEDICATION ASSISTANCE PROGRAM**

If enrolling in TRUVADA for PEP Medication Assistance Program for uninsured patients, please select one:

- [ ] Ship medication to prescriber’s office
- [ ] Patient will pick up medication from local pharmacy

---

**APPLICANT DECLARATIONS AND AUTHORIZATIONS (REQUIRED ONLY IF APPLYING FOR THE PAP)**

I certify that all of the information provided in this application, including household income, is complete and accurate. I understand that program assistance will terminate if Advancing Access becomes aware of any false or inaccurate information or if this medication is no longer prescribed for me. I understand that completing this application does not ensure that I will qualify for patient assistance. If I receive free product through the PAP, I certify that I will not seek reimbursement or credit for this medication from any insurer, health plan, or government program. If I am a member of a Medicare Part D plan, I will not seek to have this medication or any cost for items associated with it counted as part of my out-of-pocket cost for prescription drugs. I understand that the PAP reserves the right to modify the application form, modify or discontinue this program, or terminate assistance at any time and without notice. I authorize the PAP and its administrator to forward my prescription to a dispensing pharmacy on my behalf.

**SIGNATURE OF PATIENT/PATIENT REPRESENTATIVE:**  
*(REQUIRED ONLY IF APPLYING FOR PAP)*

**DATE:**

---

**FAX COMPLETED FORM TO ADVANCING ACCESS AT 1-800-216-6857**
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION, INCLUDING HIV RECORDS

To the Patient: This form permits the Child Protection Team to share information about your possible exposure to HIV with the medical facility that will be providing your follow up care.

Patient Name: ___________________________________________ Birthdate: ____/____/____
Phone Number: ________ ________________________________

Clinic/Physician Name: __________________________________________________________

Clinic/Physician Address: ______________________________________________________________

Clinic/Physician Phone/FAX number: ____________________________________________________

I understand it is important for me to call the clinic indicated above to schedule a follow up appointment to continue the treatment we started at this visit. I give my permission for my records from this visit to be sent by the clinic listed above to use in my follow up care. I understand these medical records may have information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection. If necessary, the follow up clinic might also need to share my health information with other health care professionals for my continued care. I can ask to see or receive a copy of anything released. The clinic can contact me at the telephone number I listed above to help me arrange follow up care.

You have my permission to release all medical records and information related to the care I received, including any testing for HIV to the clinic listed above. I understand that I do not have to sign this Authorization form in order to receive treatment from Child Protection Team or the clinic where I am to schedule my follow up appointment.

*Patient/Guardian Signature: __________________________ Date: ______________

Relationship to Patient: __________________________________________________________

*I may revoke this authorization at any time by notifying the above-referenced records custodian at the location listed at the top of this page. I may revoke by sending a copy of this form with the word “revoked” on it, and signed and dated by me. I understand that such revocation will not have any effect on any information already used or disclosed. This authorization form expires not later than one year from the date of my signature above.
may receive a copy of the information to be disclosed. I understand I am not required to sign this form in exchange for receiving treatment. I understand that payment for care, enrollment in a health plan or eligibility for benefits will not be conditioned upon signing the form. I understand that I may refuse to sign this form.
Truvada Information Sheet

**Truvada**

Drug Prescribed: TRUVADA 200-300 MG TAB

Generic Name: EMTRICITABINE/TENOFOVIR TAB 200-300 MG

**WARNING:** Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported. Please see additional information below.

**WARNING:** If you are infected with Hepatitis B: Truvada is NOT approved for the treatment of chronic Hepatitis B Virus (HBV) infection and the safety and efficacy of Truvada have not been established in patients co-infected with HBV. Severe acute exacerbations of HBV have been reported in patients who have discontinued the components of Truvada. If there is risk of or known HBV infection, hepatic (liver) function should be monitored closely with both clinical and laboratory follow-up.

**WHY IS IT PRESCRIBED?**
The reason you are being prescribed this medication today is for the prevention of HIV infection in combination with other antiretroviral agents. This medication is not a cure if you are already infected with HIV.

**HOW SHOULD THIS MEDICATION BE TAKEN?**
Use this medicine exactly as directed on the label, unless instructed differently by your doctor.

*This medicine may be taken with or without food. Taking with food may decrease stomach upset. Take at the same time each day.

**WHAT TO DO IF YOU MISS A DOSE?**
If you miss a dose, take it as soon as you remember. But if your next scheduled dose is soon, skip the dose you missed and take the next one at the usual time. Then, continue your doses as normal. Do not take a double dose to make up for the missed dose.

**HOW SHOULD THIS MEDICATION BE STORED?**
Keep in original closed container in a dark, cool, dry place at room temperature and away from children. Discard unused or expired medicine. Do not discard of medications by flushing them down the toilet or in regular household waste. Ask your pharmacists of ways to discard unwanted medications.

**BEFORE USING THIS MEDICINE:**
Tell your doctor:

*If you are pregnant, if pregnancy is suspected, or if you intend to become pregnant.
*If you are having any of the following conditions: bone disease, liver problems, or kidney disease.
*If you are a nursing mother
*Because of INTERACTIONS, report the use of any other prescription or nonprescription medications, including natural/herbal remedies, to your doctor.

**WARNINGS/PRECAUTIONS:**
*Notify doctor IMMEDIATELY of symptoms of LACTIC ACIDOSIS (malaise/extreme fatigue, muscle pain, respiratory distress, increased sleepiness, & abdominal distress). LACTIC ACIDOSIS is a medical EMERGENCY that must be treated in a hospital setting. STOP taking the drug and seek emergency treatment immediately.
*Notify doctor of any signs suggesting LIVER problems (e.g., unusual fatigue, loss of appetite, nausea, vomiting, yellowing of eyes, dark urine).
*DO NOT DRINK alcoholic beverages or take alcohol-containing preparations while being treated with this medicine.

**ADVERSE REACTIONS:**

**Stop taking this medicine and get emergency help IMMEDIATELY if you experience:**
Lactic acidosis; liver toxicity (yellow eyes or skin); swelling of the face, lips, tongue, or throat

**Stop taking this medicine and notify your doctor AS SOON AS POSSIBLE if you experience:**
Burning pain, tingling, or numbness; itching; skin rash; severe skin itching with patches.

**Other Common Side Effects:**
High blood sugar level; anxiety; cough; fever; generalized pain; numbness or tingling in hands and feet; peripheral (arms/legs) nerve pain; headache; stomach discomfort or pain; back pain; muscle weakness; diarrhea; nausea; dizziness; darkening of skin; nasal congestion; decreased appetite; high triglycerides level; gas; vomiting; weight gain; depression; abnormal dreams; unusual tiredness or weakness; difficulty falling asleep, abnormal laboratory studies (eg, creatinine, liver function tests).

If symptoms are mild but do not go away or are bothersome, check with your doctor. IF ANY OF THE ABOVE SIDE EFFECTS IS SEVERE, CALL YOUR DOCTOR IMMEDIATELY.

Call your doctor for medical advice about side effects.

This information has been adapted from CliniDATA Source, Inc. and AIDSinfo.nih.gov.
Dolutegravir

Drug Prescribed: TIVICAY 50 MG
Generic Name: Dolutegravir 50 MG TAB

WHY IS IT PRESCRIBED?
The reason you are being prescribed this medication today is for the prevention of HIV infection in combination with other antiretroviral agents. This medication is not a cure if you are already infected with HIV.

HOW SHOULD THIS MEDICATION BE TAKEN?
Use this medicine exactly as directed on the label, unless instructed differently by your doctor.

WHAT TO DO IF YOU MISS A DOSE?
If you miss a dose, take it as soon as you remember. But if your next scheduled dose is soon, skip the dose you missed and take the next one at the usual time. Then, continue your doses as normal. Do not take a double dose to make up for the missed dose.

HOW SHOULD THIS MEDICATION BE STORED?
Keep in original closed container in a dark, cool, dry place at room temperature and away from children. Discard unused or expired medicine. Do not discard medications by flushing them down the toilet or in regular household waste. Ask your pharmacists about ways to discard unwanted medications.

BEFORE USING THIS MEDICINE:
Tell your doctor:
* If you are pregnant, if pregnancy is suspected, or if you intend to become pregnant
* If you are a nursing mother
* If you have had or currently have liver problems, including hepatitis B or C virus (HBV or HCV)
* If you are taking dofetilide (Tikosyn®), which is used to treat certain heart conditions
* Because of INTERACTIONS, report the use of any other prescription or nonprescription medicines, including natural/herbal remedies, to your doctor.

COMMON SIDE EFFECTS: Dolutegravir is usually very well tolerated. If side effects do occur, the most common ones are mild diarrhea, nausea, and headache. However, it can cause potentially serious, even life-threatening side-effects, as listed below (adverse reactions). Other possible side-effects include the following:

- Changes in liver function tests
- Changes in body fat (including loss or gain of fat)
- Trouble sleeping
• Tiredness

**ADVERSE REACTIONS:**

*Stop taking this medicine and call your doctor IMMEDIATELY if you experience:*

Liver toxicity:
• Yellowing of your skin or whites of your eyes (jaundice)
• Dark-colored urine
• Pale-colored bowel movements
• Significant and/or prolonged nausea or vomiting
• Loss of appetite
• Pain, aching, or tenderness of your right side below your ribs

Skin rash with any of the following symptoms:
• Fever
• General ill feeling
• Muscle or joint aches
• Blisters, sores in your mouth, or peeling skin
• Redness or swelling of your eyes
• Swelling of your mouth, face, lips, or tongue
• Trouble breathing

If symptoms are mild but do not go away or are bothersome, check with your doctor. IF ANY OF THE ABOVE SIDE EFFECTS IS SEVERE or you have any of the listed ADVERSE REACTIONS, CALL YOUR DOCTOR IMMEDIATELY.

Call your doctor for medical advice about side effects.

This information has been adapted from CliniDATA Source, Inc., AIDSinfo.nih.gov, and the Tivicay package insert.
Dear Colleague,

Your patient has been seen at our facility due to a sexual assault and/or other potentially high risk exposure to HIV, and was started on non-occupational Post Exposure Prophylaxis (nPEP). This medication regimen has been shown to be most effective if started immediately status post exposure, or within 72 hours, and so it was started by the patient’s emergency provider(s). It is very important that patients started on nPEP receive follow up care and monitoring while on medication as well as a short time after the 28 day treatment course ends. The patient has identified you as their follow up provider.

Laboratory testing is required to monitor for safety or toxicities from the medication regimen and to identify and clinically manage any conditions potentially resulting from the exposure. Additionally, some medications used for nPEP are active against Hepatitis B Virus, and, in patients with active HBV infection, reactivation “flare ups” can result when nPEP is discontinued. Please see the table below with a recommended laboratory testing schedule. We ask that you obtain a release of information from your patient, if it was not already done, to request any laboratory testing done by the emergency provider(s). Additionally, if nPEP fails, your patient may experience signs and symptoms of acute HIV infection while on nPEP; these include fever, fatigue, myalgias, skin rash, headache, pharyngitis, cervical lymphadenopathy, arthralgias, night sweats, and diarrhea, and should prompt immediate HIV 1-2 Antigen/Antibody combination testing and consideration for HIV viral load testing. If your patient is confirmed to have acute HIV infection while on nPEP, it is important to rapidly transfer your patient to an HIV treatment specialist, and NOT to discontinue the 3-drug regimen until the patient has been evaluated and a treatment plan initiated by the HIV care specialist.

Many patients who receive nPEP continue to be at risk of HIV transmission, and should be considered for ongoing Pre-Exposure Prophylaxis (PrEP). Please assess your patient for ongoing risk and, if indicated, either initiate PrEP or refer to a provider experienced in its provision. Your local county health department HIV/AIDS Program Specialist can assist you in finding PrEP providers in your area. Similarly, STI risk may continue to be elevated, so assessment of risk, screening for STIs, and high-intensity prevention services are recommended. Finally, in cases of sexual assault, ongoing assessment of mental health and referral for related services is also indicated.

Thank you so much for your continued care and support of “our” mutual patient. For more information on nPEP, please see the CDC’s recommendations (Updated guidelines for antiretroviral postexposure prophylaxis after sexual, injection drug use, or other nonoccupational exposure to HIV-United States, 2016) at the following website: https://www.cdc.gov/hiv/guidelines/preventing.html (Accessed April, 2017).

(Signed)                                                                                                 (Print Name Here)
Medical Director, Child Protection Team
HIV Post-Exposure Prophylaxis (PEP) for Medical Providers Responsible for Follow-up Care

Will you know what to do if a patient is referred for follow up care after PEP is started at an Emergency Department (ED) or Urgent Care?

PEP is a safe 28-day regimen that is generally initiated in the ED. Emergent care for non-occupational exposure covers initial tests, the first few days of medication and referral for follow up medication and testing. The NYS HIV Guidelines for PEP contain the specific clinical information that allows you to confidently manage PEP follow-up care.

What information is available for the provider who is not experienced with PEP?

The NYSDOH HIV Guidelines website provides detailed guidance on what you need to do to ensure your patients are treated appropriately to prevent HIV, HBV and HCV infection. These guidelines are located on www.hivguidelines.org

- HIV Prophylaxis Following Occupational Exposure
- HIV Prophylaxis for Victims of Sexual Assault
- HIV Prophylaxis Following Non-Occupational Exposure

Specialists are available to answer clinician’s case-specific questions regarding PEP, HIV, PrEP, HCV or STD’s through the CEI Clinical Consultation Line: 866-637-2342

What type of information is needed to follow up PEP?

- The names of the antiretroviral medications that were started as PEP in the ED.
- Whether the exposed person (EP) is tolerating medication or experiencing any adverse effects.
- Results of tests that were done on the exposed person and test results of source patient.

What interventions are expected to have occurred in the ED?

- First aid of the exposure site.
- Determination of significant exposure. This case by case evaluation is based on the type of exposure and the amount of fluid involved. The HIV guidelines include tables to assist with this determination.
- Once a significant exposure is determined, PEP is promptly initiated:
  - 1st dose is to be offered ASAP, even while EP testing is underway.
  - A starter pack of medication should be dispensed to ensure EP is able to continue treatment as ordered until a prescription can be filled for the balance of the 28 day treatment period.

Exposed persons receiving PEP are to be discharged with a medical appointment for follow up care within 3 days of exposure. Often this referral is for follow up with the individual’s primary care provider.

What is your role as the “referred to” provider?

- The first follow up visit, ideally occurring within 3 days of the exposure, is to:
  - Further clarify the nature of the exposure
  - Provide an opportunity to review available source person data
  - Evaluate adherence to PEP regimen
  - Monitor toxicities associated with the PEP regimen

- The exposed person should be evaluated weekly while receiving PEP to assess treatment adherence, side effects, interval physical complaints and emotional status.

- Clinicians should provide risk-reduction counseling to exposed persons to prevent secondary transmission during the 12 week follow up period:
  - Advise use of condoms to prevent potential sexual transmission
  - Avoidance of pregnancy and breastfeeding
  - Avoidance of needle-sharing
  - Abstain from donating blood, plasma, organs, tissue or semen