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Consent and Information Sharing Toolkit

Helping providers, counties and managed care plans better understand and apply rules of information sharing related to Medi-Cal services for families in child welfare

Center for Child and Community Health

UCSF

University of California San Francisco

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PART 1

Overview

About the Authors

PUBLIC WORKS ALLIANCE

The Public Works Alliance (PWA) changes the economic future of marginalized communities by building equitable public systems that take action with people and for people. PWA opens new career pathways for youth, increases healthcare access for families, and leverages the power of Medicaid to sustain positive community impact.

For more information, visit *publicworksalliance.org.*

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Acknowledgements

TONIC

This work was funded and done in partnership with **The Toxic Stress Network Improvement Collaborative (TONIC),** which brings together care coordination systems in San Francisco for children 0-5 and grounds them in lived expertise and aligns sectors around the following goals: promote health, including early relational health, and resilience; identify, prevent, and mitigate risk factors for toxic stress; and treat toxic stress and its negative associated health consequences.

FAMILY ACCOUNTABILITY BOARD

This toolkit benefits from input from the Family Accountability Board (FAB). The purpose of the FAB is to guide systemic change through sharing their experiences from being impacted by social systems and creating recommendations for the work of the Toxic Network Improvement Collaborative (TONIC).

OTHER PARTNERS

This toolkit was created with input from a many partners, including representatives from a Medi-Cal primary care clinics, public health physicians, Medi-Cal managed care plans, county child welfare agencies, and Enhanced Care Management (ECM) providers. We are grateful to the service and dedication of these individuals who toil in the difficult work of systems change to better support vulnerable children and their families.

Introduction

Children and families involved in child welfare are a priority population for better coordination of care under California's Medicaid transformation initiative, CalAIM. Realizing the full potential of CalAIM services—**Enhanced Care Management (ECM), Community Health Workers (CHWs)**, and **Community Supports**—requires the timely and appropriate sharing of personal information across systems.

Respecting a family's autonomy and building trust also are essential to effective care coordination—especially for families who may have experienced trauma or systemic inequities.

Balancing individual privacy rights while navigating the layers of federal and state privacy laws that govern what can be shared, with whom, and under what circumstances can be daunting.

This toolkit aims to help health care and social service providers, counties and Medi-Cal managed care plans better understand and apply rules of information sharing for children and families involved in the child welfare system so they can collectively serve them better.

It is divided into five sections. It is designed so you can review the content in order or skip between sections.

Introduction

OUR AUDIENCE

This toolkit is designed to help **health and social service providers, counties, and Medi-Cal managed care plans** better understand and apply the rules around **consent and information sharing**. By offering clear recommendations and real-world scenarios, we aim to show how information can be shared **lawfully and ethically**, in ways that support individual autonomy and improve service coordination.

OUR GOAL

To **increase the uptake and effectiveness** of Enhanced Care Management and related CalAIM services, helping to ensure that children and families involved in child welfare receive the comprehensive support they need.

DISCLAIMER

This toolkit is intended for educational purposes only. Nothing in this document should be construed to be legal advice.

CONTEXT SETTING

Acknowledging History & Complexity

Child welfare systems have complex historical roots, including connections to systems of control and family separation that disproportionately affect communities of color, indigenous communities, and families experiencing poverty.

This history demands sensitivity and care when determining how information is shared.

CONTEXT SETTING

Information Sharing Involves Critical Tensions

- Youth and families have privacy, autonomy and legal rights that must be respected.
- There is a power imbalance between systems and families.
- Families are wary that information may be used to surveil or control - not to support.

AND

- Good coordination across systems and amongst providers often requires sharing information speedily and easily.
- Fragmented information can lead to gaps in critical services.
- Youth and families grow tired and may be retraumatized by having to repeat their stories.

CONTEXT SETTING

How to Use This Toolkit

There is rarely a perfect, universal solution, especially for complex data sharing, which often is individual and fact specific, but this toolkit supports development of local best practices and highlights relevant law, policy, and ethical considerations.

GUIDE DECISION-MAKING

Use the scenarios to navigate real-world situations and strengthen care coordination.

APPLY GUIDING PRINCIPLES

Refer to the principles to help resolve challenging situations and ensure ethical, legal compliance.

ENSURE CONSISTENCY

Share the toolkit across teams (legal, privacy, program) to promote a unified approach to information sharing.

DEVELOP LOCAL SOLUTIONS

Adapt the provided examples to create workflows, policies, and training materials tailored to your community.

EMPOWER ACTION

Use the toolkit to support efforts that increase ECM uptake and improve services for children and families.

Acronym Glossary

CWA	Child Welfare Agency
MCP	Managed Care Plan
CHW	Child Health Worker
ECM	Enhanced Care Management
CS	Community Supports
FM	Family Maintenance
SUD	Substance Use Disorder
MH	Mental Health
CPS	Child Protective Services
HIPAA	Health Insurance Portability and Accountability Act
CMIA	California Confidentiality of Medical Information Act
CDSS	California Department of Social Services
DHCS	California Department of Healthcare Services
CIN	Client Index Number

Voice of Lived Experience

“Once information is shared, parents are treated differently. How are we going to address the biases? Once you do everything they tell you to do with CPS … when you are finally out of it … you still carry with you this label to the next appointments.

No matter what people say, they have biases.”

Member of the TONIC Family Accountability Board

PART 2

Care Coordination Case Example

- Family Maintenance & Enhanced Care Management
- ECM Care Plan Goals & Outcomes
- Information Sharing: Where to Begin
- Information Sharing: General Guidelines
- Information Sharing: Deeper Dive

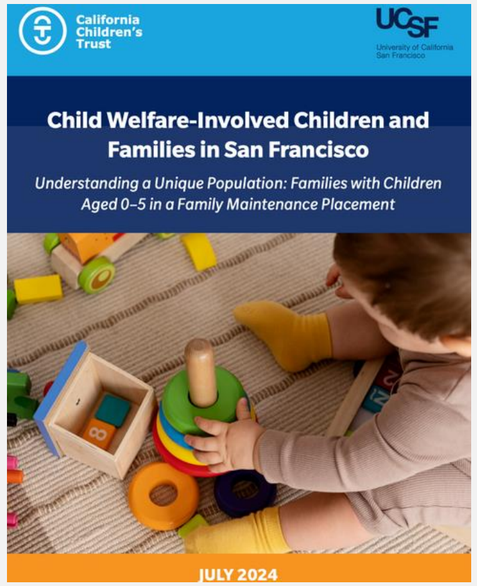
ECM & Family Maintenance Case Example

Information Sharing in a Real-World Scenario

This section builds on two prior reports that explored the child welfare system in San Francisco County and looked deeper into family maintenance services. The first report discussed the needs of children and families. The second report used a hypothetical case to highlight the potential for Enhanced Care Management to augment Family Maintenance services and support the child and family toward stability. That case scenario is used in the following slides to walk through information sharing permissibility.

Paper 1

Download here.



Paper 2

Download here.

Provider's Perspective

"As a pediatrician working in a busy clinic, usually I would not know if a family is involved in the county's child welfare system or receiving family maintenance services unless the child or parent told me. I also would not know if a parent was dealing with significant medical, mental health or addiction issues unless they told me or screened positive on a depression and social needs screener. I can see both sides of this – on the one hand the family has a right to privacy; on the other hand, it's a key piece of information to be able to support the child or youth as best we can."

Dr. Anda Kuo, pediatrician and Co-Director of the UCSF Center for Child and Community Health

Case Scenario: SUD & Unstable Housing Impact A Family's Stability

A 4-year-old girl who lives with her single parent was referred to child protective services after she was seen wandering the street. The child protective services investigation revealed a history of referrals for lack of supervision associated with the parent's substance use.

Through the safety planning process, the case worker noted that the parent and child had support from extended family.

The parent agreed to sign up voluntarily for Family Maintenance services that could help them improve stability and reduce safety risks to the child. As part of the Family Maintenance case planning process, the protective services worker referred the parent for a substance use disorder (SUD) assessment by County Behavioral Health.

County Behavioral Health determined that the parent qualified for SUD treatment and connected them to an outpatient program. Noting additional needs for housing support, guidance on safe parenting and general care navigation support, the CPS worker also suggested the parent receive ECM services.

The protective services worker received the parent's consent to send a referral via email to a central inbox at the child's Medi-Cal Managed Care Plan requesting ECM services.

ECM Care Plan Goals

CHILD'S HEALTH

The ECM Lead Care Manager notices that the child was past due on visits to the pediatrician and dentist. She helps the family make and attend those appointments.

SCHOOL

The child was enrolled in preschool through San Francisco's preschool for all program. Noting that the child would be eligible for kindergarten the following year, the care manager links the parent to a resource to understand the public school enrollment process. The care manager also provides the parent with a list of nearby, affordable weekend programming options for the child.

HOUSING

The care manager links the family to a Housing Transition Navigation Services provider to help the parent find permanent housing.

FAMILY MAINTENANCE PLAN

The care manager helps the parent connect to parenting classes at a Family Resource Center.

PARENT'S HEALTH

The care manager helps the parent get established with a primary care provider for the first time in over a year and encourages them to keep attending substance use service appointments.

ECM Outcomes

CHILD'S HEALTH

Child catches up on all primary care appointments, vaccinations and dental care.

SCHOOL

The parent received support to submit school enrollment paperwork and found a subsidized extended care program for weekend activities.

HOUSING

The Housing Transition Navigation Services provider helped the parent find permanent housing.

FAMILY MAINTENANCE CASE

The CPS case is successfully closed after about six months when the parent meets the CPS case plan requirements. The ECM care manager stays connected with the family for an additional five months to ensure they maintain connections to supports.

PARENT'S HEALTH

Parent continues engagement with SUD services. The parent reports feeling supported, knowing someone familiar with the family's situation is available to help navigate additional obstacles and build up the parent's confidence when they feel overwhelmed.

Information Sharing: Where to Begin

1. **Start with the right question: Not just *"Can we share?"* but *"Should we share?"***
2. **Focus on purpose: *Will sharing improve outcomes for the child/youth and family?***
3. **Consider *legal requirements* AND *ethical implications***
4. **Balance the need for coordination with respect for privacy**

Information Sharing: General Guidelines

WHO MAY CONSENT:

Circumstances impact the list below

1. Legal guardian (usually the biological parent unless rights were terminated/limited or adopted parent)
2. Child welfare agency with court authorization
3. Youth themselves for certain services (age 12+ for mental health, SUD and any age for certain services, *see slide 18*)
4. Court through valid and appropriate orders in specific circumstances

ELEMENTS OF VALID CONSENT MUST:

Circumstances impact the list below

- ✓ Be informed and voluntary
- ✓ Specify what information will be shared
- ✓ Identify with whom information will be shared
- ✓ Include purpose of disclosure
- ✓ Include an expiration date or event
- ✓ Be documented

GO DEEPER:

A grid created by the National Youth Law Center has more detailed scenarios on who may consent to treatment for minors in foster care by custody and placement (Jan 2021)

Information Sharing: From our Example

Consent requirements based on who is sharing what information and with whom they are sharing it.

	From	To	What	Consent Requirements
1	Social worker refers parent's case & contact information	ECM Community Provider contracted with the MCP	Parent name, contact info, reason for referral	Securing parent consent is a **best practice but not required** to make a referral on behalf of the child for CalAIM services. Securing consent builds trust and respects family autonomy.
2	ECM case manager at Community Agency/ Provider	County Child Welfare Agency	Notification that parent accepted or declined services to "close loop" on the referral	**Consent is NOT needed** to notify the initial referring party of acceptance/ decline on participation.
3	ECM case manager at Community Agency	Health care and behavioral health providers	Care and treatment to coordinate services, including medical and mental health information. No details on SUD or therapy notes.	**Consent is NOT needed** in accordance with HIPAA and AB 133. Important exceptions that require consent are substance use services, individual therapy notes and if a youth age 12 or older consented for themselves.
4	ECM case manager at Community Agency	County Child Welfare Agency	Details and information on the case	**Yes, parent consent is required** to share details about ECM/health care services with the CW Agency. Securing consent builds trust.

Information Sharing Deeper Dive

IS CONSENT ALWAYS NEEDED TO MAKE A REFERRAL FROM CHILD WELFARE AGENCIES TO COMMUNITY PROVIDERS OR AN MCP FOR SERVICES?

While it is **best practice** to obtain verbal or written consent from the family or youth (as appropriate) when sharing information to build trust and increase the likelihood of them accepting the voluntary service, making an initial referral can be done without consent under the following circumstances.

As defined in WIC 827(a)(K)), the law allows information to be shared with "members of children's multidisciplinary teams, persons, or agencies providing treatment or supervision of the minor." Counties define and deploy multidisciplinary teams differently. Some counties may add people to the multidisciplinary team to make referrals at all stages of the case. In practice, this could be emails or phone calls to refer out to a community-based organization.

IMPORTANT CONSIDERATIONS

- Any information shared should be **limited to what is necessary** to facilitate the referral and service coordination.
- If the provider is not directly involved in the child's care or does not meet the definition under the MDT guidelines (WIC 827(a)(K)) then obtaining consent is required.

Information Sharing for Coordinating Care: Deeper Dive

WHY IS NO CONSENT REQUIRED TO "CLOSE THE LOOP" ON THE REFERRAL?

Consent is not required to share minimal information needed to confirm that the referral was received and if the child or family was enrolled in services. In fact, MCPs are required to notify a referring entity of referral outcomes or ECM engagement status per the DHCS "closed loop" referral guidance. If the county made the referral for services, the MCP may tell the county the status of the referral.

KEY POINTS:

- **"Minimal information" includes confirmation of referral receipt, status of outreach, and basic enrollment outcome.**
- **Avoid disclosing any treatment details without proper authorization, including diagnosis, treatment plans, or service details.**

DO MEMBERS HAVE TO CONSENT TO PARTICIPATE IN ECM SEVICES?

Securing member consent for ECM participation is best practice. While *DHCS guidance* provides some flexibility in this area, ECM is a voluntary, person-centered service, and informed consent is a key component for success. For children in foster care, the authorized representative can provide consent. Examples below:

- **Family maintenance cases:** Consent is provided by the biological parent**.**
- **Current foster care placed with resource parents:** ECM, CHW and CS should be considered "ordinary services" for which resource parents can consent for children under age 18.
- **Adopted foster youth:** Adoptive parents' consent
- Youth age 18 and older consent for themselves.

PART 3

Legal & Regulatory Reference Section

- Health care consent for minors in California
- Child welfare and consent
- Resources / Source List

Voice of Lived Experience

“They went to the school and took my kids without me knowing. It felt like the whole school knew, and when I got my kids back I still had to go to back to that school. Once people know you are involved in the system, they hold it against you. It takes a really caring, loving and supporting person to hold parents with what they’ve gone through.”

Member of the UCSF Family Accountability Board

Information Sharing: Direction Flow Matters

CHILD WELFARE → HEALTHCARE

Governed By

State Law
(CA Welfare & Institutions Code)

Federal Law
(Code of Federal Regulations)

KEY CODE SECTIONS

- 45 CFR §1355.21(a) and 45 CFR 1355.52(e)(2)(iii)
- 45 CFR §205.50
- WIC § 827 (Juvenile court records confidentiality)
- WIC § 16010.4 (Foster care placement information sharing)
- WIC § 10850 (Confidentiality of public social services records)
- WIC § 5328 - Mental Health Records Confidentiality

HEALTHCARE → CHILD WELFARE

Governed primarily by

HIPAA
The **Federal** Health Insurance Portability and Accountability Act

CMIA
California's Confidentiality of Medical Information Act

Different exceptions apply in each direction
Court orders can authorize information flow in either direction

✳ **Always follow the minimum necessary standard:** Share only what is needed for the stated purpose ✳

Information Sharing: Special Considerations

- **Substance use disorder information (42 CFR Part 2)**
  Requires specific written consent that names the recipient, includes specific purpose and the exact information to be disclosed. Re-disclosure requires additional consent.

- **Mental health treatment information (WIC § 5328)**
  Providers may share information about mental health services to support treatment coordination. Specifically, psychotherapy notes cannot be shared without consent. Minors who consent for themselves must authorize disclosure for themselves.

- **HIV/AIDS information (California Health & Safety Code § 120980)**
  Requires specific written authorization to share information.

- **Minor consent services (Family Code §§ 6924-6929)**
  For services minors may consent to for themselves, the minor must also consent to disclosure, including to parents and guardians, and social workers/courts. Details on minor consent are on the next slide.

- **Sexual assault/reproductive health services (California Civil Code § 56.10(c)(1)**
  For services minors can consent to for themselves, the minor must also consent to disclosure, including to parents and guardians, and social workers/courts. Details on minor consent are on the next slide.

Health Care Consent for Minors

California law allows youth to consent to certain services and decide who should have access to that information (including limiting its sharing with parents or foster parents). **Being in the child welfare system has no impact on minor consent permissions.**

Age	Consent (without parent/guardian)
All minors at any age	• Reproductive services, including birth control and contraception but excluding sterilization • Abortions • Diagnosis of and treatment from sexual assault, including the collection of medical evidence • Treatment resulting from abuse/neglect for purposes of diagnosing child abuse or neglect or determining the extent of abuse
Minors over the age of 12	• Health care services listed above for “all minors” • Treatment and medical care related to the prevention of a sexually transmitted disease, such as HIV • Treatment related to injuries resulting from intimate partner violence • Some behavioral health services, including outpatient mental health treatment or counseling services if, in the opinion of a mental health professional, the minor is mature enough to participate intelligently in the treatment or services • Some medical care and counseling relating to the diagnosis and treatment of an SUD • Residential shelter services if (1) the provider determines the minor is mature enough to participate intelligently in the services; and (2) either (a) the minor would present a danger of serious physical or mental harm to themself or others without the services, or (b) the minor is the alleged victim of incest or child abuse
Emancipated minors & minors age 15+ who live apart from their parent/guardian and manage their own finances*	• All health care services

Foster youth live apart from their parents and there is legal precedent to treat them in this category.

Useful resource: Kaiser Permanente Teen’s Guide to Getting Services

Source: National Center for Youth Law, : Dec. 2023. *Minor Consent and Confidentiality Compendium of State and Federal Laws*.

Child Welfare & Consent

PART 1 of 2

Who may consent	Circumstance
Youth	Being in the child welfare system has no impact on a minor's ability to consent to services for which the minor has the legal right to provide consent. See Table 3 for more details on minor consent. Youth consent for several types of sensitive health care (reproductive health, sexual assault, STD, MH, SUD) often overrules consent from any other party involved. Learn more at *Teen Health Law*.
Parents / Guardians	If they retain parental rights, they retain the right to consent (or not) to health care services. This is the most common scenario for family reunification cases.
Relative caregivers / Kinship arrangements	Relative caregivers can consent to most medical and educational services – regardless if the child has been placed formally through the foster care or juvenile justice systems or there is no system involvement – by completing a *Caregiver's Authorization Affidavit Form*. When a formal court order placing a minor in a planned permanent living arrangement with a relative occurs the relative may provide consent for the receipt of health care services without the affidavit.
Foster Parents	Assuming the juvenile court placed the child with a licensed foster parent or the person with legal custody voluntarily placed the child with the foster parent, the foster parent may consent to **"ordinary medical and dental treatment for the child"** unless the juvenile court reserves the right to consent. Foster parents do not have the right to consent to health care services that are not "ordinary." **ECM and CHW services should be considered ordinary treatment under 1530.6(a)(3)**. Foster parents should make sure that the MCP has them listed in the child's record. They can do this by contacting the MCP member services and submitting a copy (via fax or secure email) of the foster care placement letter.
Residential treatment providers	A residential provider may consent to **"ordinary medical and dental treatment for the child"** unless the juvenile court reserves the right to consent. The residential provider does not have the right to consent to health care services that are not "ordinary." **ECM and CHW services should be considered ordinary treatment under 1530.6(a)(3).**

Source: DCHS, October 2023, CalAIM Data Sharing Authorization Guidance

Child Welfare & Consent

PART 2 of 2

Who may consent	Circumstance
Social workers NOT acting under court orders	A social worker may consent on behalf of a child without a court order only when: • The minor is taken into temporary custody, AND • An attending physician authorizes the performance of medical care, AND • Reasonable efforts were made to obtain parent/guardian consent, AND • Parent/Guardian does not affirmatively object to the care If the parent/guardian objects to the care, then an order for the juvenile court is required. Social workers should try to obtain authorization for the disclosure of PHI and for the consent for treatment and services from the parent/ guardian at the time of opening a new case or when a new need arises.
Social workers acting under court order	If the court believes that no parent/guardian is willing to make health care decisions on behalf of the minor, the court may declare the minor a dependent of the juvenile court and issue an order authorizing the social worker to provide consent for the minor's health care services. When placing the minor under the care, custody, or supervision of a social worker, the court must notify the parent/guardian of this decision.
Juvenile court judges	If a juvenile court judge believes the minor may need medical care recommended and authorized by a physician, the court may make this decision but must notify the minor's parent/guardian.

✳ **Note: A minor's own consent for several types of sensitive health care overrides a social workers reco**

Source: DCHS, October 2023, CalAIM Data Sharing Authorization Guidance

Child Welfare Aid Codes Can be Clues to Consent

Medi-Cal aid codes, which can be found during eligibility checks, can be clues to help identify in which subgroup a youth belongs. This informs consent that may be needed. These are **general guidelines** and not necessarily universal.

Who may consent	Aid Codes	General Consent Guidelines
Family Maintenance (FM)	No aid code. These children are not removed from parents and do not have Medi-Cal tied to foster care.	Children and youth in voluntary family maintenance, stay with their parents who retain all parental rights. The parent/guardian should provide consent to share information. For court-ordered family maintenance programs, the court has active jurisdiction while the children are living with parents. This means that the court may make orders related to consent and medical care, including making specific information available to the Child Welfare Worker. Minor consent exceptions apply.
Current Foster Care Population	4K, 40, 42, 45, 46, 5K, 5L, 2U, 2P, 2R, 2S, 2T, 43, 49, 4u, 4L	This category includes children in family reunification and permanent placement status. Resource parents (and/or CPS social workers with a court order) may consent to "ordinary health care services." If biological parents retain medical rights, their consent is needed for anything not considered "ordinary." For youth who exited care to guardianships, the legal guardians may consent. Youth ages 18 – 21 are legal adults who consent for themselves. Minor consent exceptions apply.
Former Foster Youth	4E, 4M	These youth turned 18 while in foster care. They are no longer in foster care but are eligible for Medi-Cal until age 26. These youth consent for themselves. Their consent is required to share any Personal Identifying Information (PII) about their child welfare involvement with a MCP or health care providers.
Adopted foster children	3, 4, 6, 7, 4A	Adopted parents are the parents. Their consent is required to share any information about the child or youth under age 18 unless minor consent exceptions apply.

* A small percentage of youth in foster care may have a different aid code if their Medicaid is linked to a non-foster care benefit (e.g. Supplemental Social Security Income)

GUIDING PRINCIPLE

Involve young people in their care

- Youth can frequently consent to their own services and care.
- It is a best practice to involve young people in their own care, planning, and coordination – even when consent may be obtained through other means. Child and family team (CFT) meetings are a good place to make this happen.
- Be mindful of who can provide consent and have upfront conversations about who will be impacted by the sharing of any information.

Voice of Lived Experience

“When it comes to consent and information sharing, centering youth and families in their lived experience allows for authentic healing. The journey of healing is deeply sacred and collectively everybody has an impact on this journey, whether it is the state or county or providers, and centering youth minimizes the risks of re-traumatization.”

Former Foster Youth

Resource List for Data Sharing Guidance

Consent to treatment for minors in foster care by custody and placement (Jan 2021)
- Detailed grid created by the National Center for Youth Law

State Health Information Guidance (SHIG) 5.1
(April 2023)
- Comprehensive guidance on sharing behavioral health information with scenarios for child welfare

CalAIM Data Sharing Authorization Guidance
(April 2023)
- Focused on data sharing for Enhanced Care Management and Community Supports
- Includes specific provisions for foster youth and child welfare coordination

California Health Information Exchange Resources (2021)
- Tools for secure health information exchange in California
- Protocols for integrating child welfare with healthcare data systems

Sharing Health Information for Children in Foster Care
(Dec. 2019)
- Judicial Council Briefing on Information Sharing.

HIPAA and California Medical Privacy Resources. (2021)
- California Office of Health Information Integrity (CalOHII) interpretations of HIPAA

The Foster Friendly Healthcare Toolkit (2022)
- Reproductive Health Equity Project
- Includes authorization forms and coordination protocols

Safely Sharing Data Between Child Welfare and Medicaid
(2022)
- Federal agency joint guidance for implementing data sharing agreements

42 CFR Part 2 Resources
- SAMHSA guidance on SUD information and applying 42 CFR Part 2 in various setting

Useful Resources
from SF Family & Children's Services

- Chart – *Minor Consent and Release Rules*
- Chart – *Who May Consent to Treatment*
- Chart – *Who Can Authorize Release of Mental Health Information*
- Chart – *Consent and Release - Summary*
- *Letter to Medical Providers from FCS*

PART 4

Information Sharing for Administrative Coordination

- **MCPs and CWAs have information gaps**
- **CDSS and DHCS Global Data Sharing Agreement**
- **Specific Scenarios:**
    1. Identifying family maintenance population
    2. MCP needs correct contact information
    3. Notifying the MCP/ECM provider of a placement change
    4. Verifying county of jurisdiction

MCPs and Counties Both have Info Gaps

This section explores useful scenarios for managed care plans and county child welfare agencies to exchange information systematically at the population level. Both entities have data gaps.

MCPs have limited data

MCPs know which enrollees are in foster care because they receive individual-level aid code data on an eligibility file from DHCS.

MCPs do not get data about which children receive family maintenance services. MCPs cannot check a child's county of jurisdiction and confirm with which county they should coordinate. While the county of residence often aligns with jurisdiction, many foster children are placed out of county.

,Neither MCPs or their network providers have access to information that alerts them when a child's placement changes. This means they cannot update rights to limit or permit access to information in a timely way.

Counties have limited Data

County child welfare agencies can look up a child or youth's Medi-Cal enrollment, including in which MCP they are enrolled, in the online MEDS-LITE System.

However, the look up must be one-by-one. There are no reports on MCP enrollment for their entire population. This challenge is particularly relevant in Los Angeles County, which is home to one-third of children in foster care and has six Medi-Cal managed care plans.

Counties also don't have any aggregate data about the health outcomes of the children in their care.

CDSS & DHCS Global Data Sharing Agreement

CA DEPT OF SOCIAL SERVICES

Single state agency under Title IV of the Social Security Act that is responsible for oversight of county and community agencies in the implementation of child welfare services programs

COUNTIES

Responsible for the administration and provision of child welfare services. Many (but not all) counties signed onto the Global Data Sharing Agreement with DHCS

DHCS + CDSS

Have a Data Sharing Agreement, including a business associate's agreement, that allows exchanging confidential data for the following uses:

01 **Oversight of health care services** for children or non-minor dependents receiving child welfare services.

02 **Ensuring a coordinated strategy** to identify & respond to health care needs of children or non-minor dependents receiving child welfare services.

03 **Ensuring Medi-Cal enrollment** for former foster youth up to age 26.

04 **Analysis, reporting** and **auditing** for coordinated oversight and evaluation of health, mental health, and pharmaceutical services

05 **Sharing matched data** for reports, analysis and administration and provision of public social services.

DEPT OF HEALTH CARE SERVICES

Single state agency under Title XIX of the Social Security Act that is responsible for operating and overseeing the federal Medicaid program

Contracts and Business Associates Agreements allow DHCS to share confidential information with MCPs.

MEDI-CAL MANAGED CARE PLANS

- The agreement permits downstream sharing of confidential or de-identified data, including matched data, with authorized entities or contractors to enable administration, oversight, monitoring, evaluation, and reporting responsibilities related to providing services to children and youth in foster care, including non-minor dependents.

Source: Data Sharing Agreement accesses May 15, 2025 at https://www.cdss.ca.gov/pdf/GlobalDataSharingAgreement.pdf

Information Sharing for Administrative Coordination: Scenario 1

A Managed Care Plan (MCP) wants to identify which youth are enrolled in Family Maintenance (FM) services to support ECM outreach efforts. At the same time, the county child welfare agency wants to know how many children and youth in FM have received ECM services.

➢ Can the County share a list of children and youth in family maintenance cases with the MCP?

UNLIKELY

- Unlikely. While AB 133 permits Medi-Cal Partners (which include MCPs and potentially county social services agencies acting in a coordinating role) to disclose PII for purposes of coordinating care under CalAIM, this provision does not explicitly authorize sharing lists of entire child welfare populations for outreach.

POSSIBLE WORKAROUND

- CDSS and DHCS can explore creating a matching list of FM children and youth with Medi-Cal. DCHS could give each MCP a monthly file of children receiving FM services. This may be permitted under the global data sharing agreement.

➢ How can the county child welfare agency know which children are enrolled in ECM?

- The MCP is required to notify a referring entity of a referral outcome and ECM engagement status per DHCS' closed loop referral guidance. If the county made the referral for services, the MCP may tell the county the status of the referral.
- If the MCP and County execute a data use agreement that mirrors the CDSS and DHCS global data sharing agreement, including having an attached Business Associates Agreement, the MCP likely could share a list of names of children and youth receiving ECM services.

Citation: "SHIG 5.1" (CHHS, April 2023), p.57-59, Global Data Sharing Agreement. and CalHHS Data Exchange Framework (DxF)

Information Sharing for Administrative Coordination: Scenario 2

A Managed Care Plan (MCP) wants to conduct outreach to a youth in foster care to offer Enhanced Care Management (ECM). However, the MCP's enrollment file has either old contact information or lists the address and phone number of the county social services agency.

- **Can the MCP share with the County the names of enrollees who have a foster care aid code and have outdated contact information or the county social services agency is listed as their address?**
- **How can the MCP obtain the correct contact information?**

YES, WITH IMPORTANT QUALIFICATIONS:

- AB 133, a law passed in July 2021, permits Medi-Cal Partners to exchange PII and PHI so long as such disclosures improve care coordination and health outcomes and are consistent with federal law, including HIPAA and Part 2. The HIPAA treatment exception (45 CFR § 164.506(c)(1)) allows covered entities to disclose protected health information (PHI) for treatment, payment and health care operations. A broad interpretation of treatment for the "provision, coordination or management of health care and related services" could be extended to a social service agency — such as county child welfare agencies—for treatment and care coordination purposes, including locating appropriate caregivers for outreach and service delivery.
- **Minimum necessary standard:** MCPs must ensure that the information shared is limited to what is necessary to facilitate contact—such as name, date of birth, Medi-Cal ID, and concern about inaccurate contact data. No treatment or clinical information should be shared without separate authorization.
- **Jurisdiction Check:** MCPs should initially share the list with the child's county of residence, which may or may not be the same as the county of jurisdiction (the one responsible for the foster care case). If the child is placed out-of-county, the county of residence should redirect the MCP to the correct county of jurisdiction.

- **Can the county share back the correct contact information with the MCP?**

LIKELY, YES.

- AB 133 permits Medi-Cal Partners (potentially including both county agencies and MCPs) to disclose PII for CalAIM implementation, specifically coordinating care. This broad authority might cover the sharing of contact information necessary for ECM outreach as a component of care coordination under CalAIM, especially because the MCP already knows the identify of the child/youth and the fact that they are in child welfare based on their aid code. The county is not disclosing any information from the juvenile case record.

Citation: 45 CFR § 164.506(c)(1) (HIPAA); "CalAIM Data Sharing Authorization Guidance" (DHCS, April 2023), p.18-19; "SHIG 5.1" (CHHS, April 2023), p.69-70

Information Sharing for Administrative Coordination: Scenario 3

A foster child enrolled in an MCP experiences a placement change and moves to a new resource family. The MCP is unaware of the placement change unless specifically notified.

➢ Can the county notify the MCP and/or the ECM provider so they can plan accordingly?

Yes. The **county child welfare agency should notify the MCP and other key health care providers**, including the **ECM provider**, of the placement change to support care coordination and avoid disruption in services.

- **Welfare and Institutions Code (WIC) § 16010.4** requires child welfare agencies to share information necessary to coordinate services and ensure **continuity of health care and education** during placement changes.

What to Share:
- New caregiver contact information (name, phone number, address)
- Effective date of the placement change

What not to share:
- The reason for the placement change or any details about the child welfare case

Citation: WIC § 16010.4; "SHIG 5.1" (CHHS, April 2023), p.61-62

Information Sharing for Administrative Coordination: Scenario 4

The MCP wants to verify the county of jurisdiction for foster youth enrolled in the MCP in order to coordinate with the correct county child welfare agency.

Example: A child in San Francisco jurisdiction (which places about 2 in 3 kids out of county) is placed with a relative in Alameda County. Alameda is a single plan county where managed care enrollment is mandatory. The child shows up as a new enrollee for the Alameda Alliance and can be identified as being in foster care, but no one at the MCP knows the child's jurisdiction county is San Francisco and not Alameda.

➢ Can the MCP share with the county of residence a list of youth with foster care aid codes to determine which are under that county's jurisdiction?

YES, WITH APPROPRIATE SAFEGUARDS:

- AB 133, a law passed in July 2021, permits Medi-Cal Partners to exchange PII and PHI so long as such disclosures improve care coordination and health outcomes and are consistent with federal law, including HIPAA and Part 2. The HIPAA treatment exception (45 CFR § 164.506(c)(1)) allows covered entities to disclose protected health information (PHI) for treatment, payment and health care operations. A broad interpretation of treatment for the "provision, coordination or management of health care and related services" could be extended to a social service agency—such as county child welfare agencies—for treatment and care coordination purposes.

Information should be limited to the minimum necessary to confirm jurisdiction (name, date of birth, client index number (CIN), foster care code)

Purpose Limitation: The information must be used solely for the purpose of identifying the correct county of jurisdiction to engage in care coordination.

➢ Can the county respond and confirm with the MCP which youth are under their jurisdiction?

- Yes, Counties can confirm jurisdiction status for youth enrolled in a MCP to support coordination between agencies. The MCP already knows who the children are and their involvement in child welfare because of their aid code. Notifying the MCP of the county of jurisdiction is not disclosing confidential information from the juvenile case file.
- No additional consent is required for this administrative function. This type of sharing is consistent with the WIC and HIPAA treatment exception and is intended to ensure that healthcare and child welfare services are properly coordinated. Only the minimum necessary information should be shared and should be used solely for confirming county of jurisdiction to coordinate care.

Citation: 45 CFR § 164.506 (HIPAA);; "SHIG 5.1" (CHHS, April 2023), p.63-64; "CalAIM Data Sharing Authorization Guidance" (DHCS, April 2023), p.20

Information Sharing for Administrative Coordination: Scenario 5

The MCP wants to show the county a dashboard with de-identified, population-level data that compares performance on statewide health care quality and outcome measures for foster youth and non foster youth.

➢ Can the MCP share these data reports and de-identified summary information with the county?

Yes, the MCP can share de-identified aggregate data with the county child welfare agency.

Legal Basis:

- Under **HIPAA**, de-identified data that meets the standards under 45 CFR § 164.514 is not considered protected health information (PHI) and can be shared without patient authorization.
- Sharing de-identified, population-level data supports joint quality improvement, program planning, and performance monitoring efforts across health and child welfare systems.

Important Considerations

1. **Data must be properly de-identified** according to HIPAA guidelines and presented in a way that prevents re-identification, especially in small cohorts (e.g., small counties or age groups).

2. **Purpose Limitation:** Data should be used solely for **care coordination**, **performance improvement**, or **system-level planning**, and not for punitive, marketing, or unrelated purposes.

Citation: 45 CFR § 164.502(d)(2) (HIPAA); WIC § 14184.102; "CalAIM Data Sharing Authorization Guidance" (DHCS, April 2023), p.25-26

Information Sharing for Administrative Coordination: Scenario 6

Children's Crisis Continuum Implementation, as described in WIC 16553, is designed to improve collaboration between county child welfare, county probation and county behavioral health plans to develop a highly integrated continuum of care for foster youth experiencing behavioral health crises.

Example: A youth in foster care experiences a psychiatric crisis and is admitted to an inpatient facility. An intensive transition planning (ITP) team is responsible for coordinating across the continuum of care so that youth can transition between different services (i.e. Psychiatric Health Facility, Crisis Stabilization Unit, Crisis Residential Program, home-based foster care placements) in a timely and seamless manner

➢ Can information be shared between county child welfare and amongst the multiple providers that compose the youth's care team to ensure seamless transitions between settings?

From mental health providers to the county child welfare:

- Yes, providers can share information with other providers involved in the youth's care and also with the county child welfare agency without written consent under HIPAA treatment exception (45 CFR § 164.506(c)(1)) that allows covered entities to disclose protected health information (PHI) for treatment, payment and health care operations. A broad interpretation of treatment for the "provision, coordination or management of health care and related services" could be extended to a social service agency —such as county child welfare agencies—for treatment and care coordination purposes.

Information should be limited to the minimum necessary to coordinate care. Therapy notes cannot be shared.

➢ Do providers need consent/release of information to share information?

- No. No written consent is required because as stated above this type of sharing is consistent with the WIC and HIPAA treatment exception and is intended to ensure that healthcare and child welfare services are properly coordinated.

Citation: 45 CFR § 164.506 (HIPAA);; "SHIG 5.1" (CHHS, April 2023), p.63-64; "CalAIM Data Sharing Authorization Guidance" (DHCS, April 2023), p.20

PART 5

Summary & Recommendations

- Recommendations for State leaders
- Recommendations for County & MCP leaders
- Recommendations for Providers
- Summary & Key Takeaway

Recommendations for State Leaders

1. **Continue aligning privacy frameworks.**

   Current guidance from DHCS addresses when health care providers can share information. Guidance on when child welfare agencies can share information with MCPs and health care providers is needed.

2. **Support local data sharing.**

   Provide instructions on how the *DHCS and CDSS Global Data Sharing Agreement* can apply at the local level or if it can be a model for local data sharing agreements. (Here is another example from Wisconsin.)

3. **Standardize data formats.**

   Create standardized data exchange formats and develop uniform minimum data sets for cross-system coordination.

4. **Share data with MCPs and counties in user friendly formats.**

   CDSS and DHCS can match data at the state level and share it with local partners. It must be shared in formats that can be used locally.

5. **Universal consent forms.**

   Consider adding child welfare to future iterations of the universal consent form that DHCS is piloting.

Recommendations for Local Leaders

All MCPs are required to execute a Memorandum of Understanding (MOU) with county child welfare departments. Counties must create accompanying data sharing agreements.

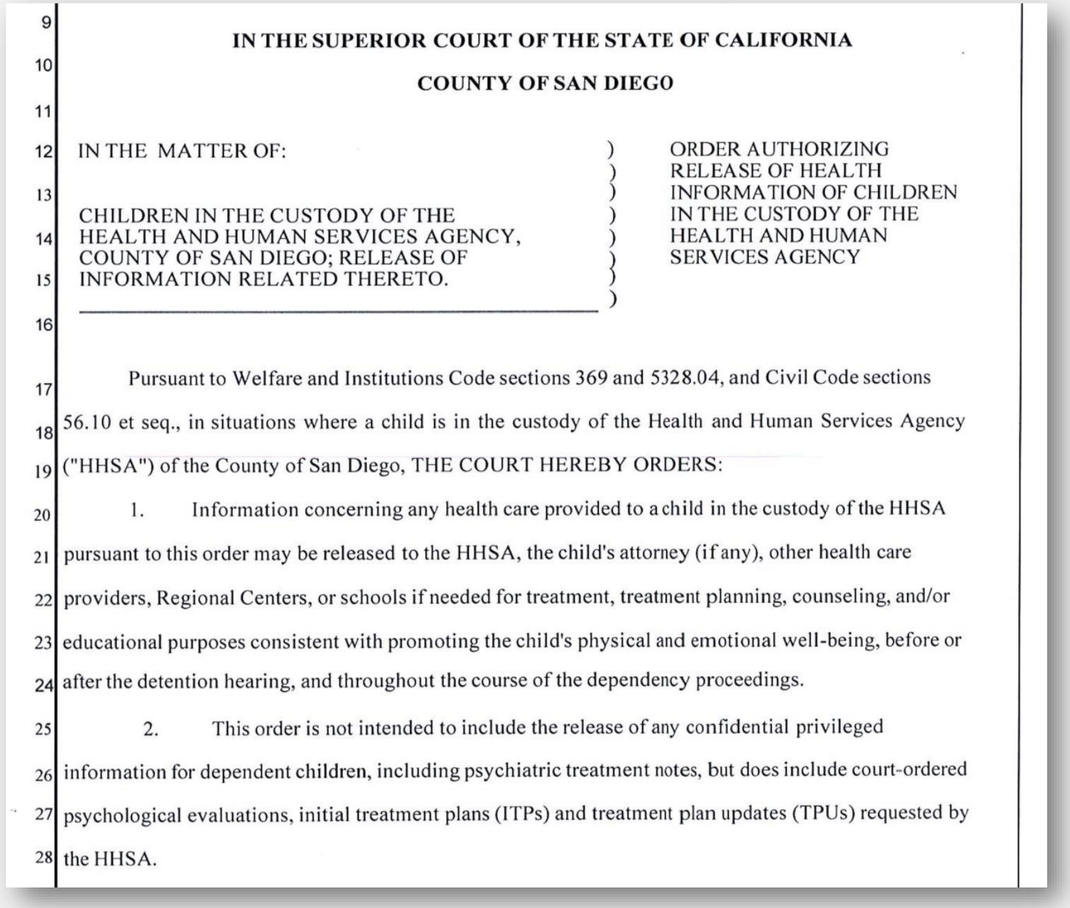
When local leaders meet to discuss data sharing, they should focus on:

1. **Clear protocols and workflows for special populations** and common care coordination challenges, such as:
    1. At-risk/voluntary cases in which the MCPs don't have a way to identify the population
    2. Probation-supervised youth
    3. Rapid response for urgent health needs
2. **Cross-county coordination procedures** for when youth are placed out of their county of jurisdiction. In some counties, this happens frequently. Often, it can happen suddenly.
3. **Frequency and timing** of data exchanges (e.g. monthly/quarterly)
4. **Format** for any data exchanges
5. **Purpose for data exchanges:** Will the information support routine care coordination and/or population health management and quality improvement strategies. Defining population-specific quality improvement goals and strategies. Develop shared dashboards using de-identified, data to analyze utilization trends, review referral patterns, and monitor health and social outcomes.

Best Practices for Local Leaders: Blanket Orders

San Diego County

The court created a **blanket Release of Health Information Court Order that** allows sharing of health care information between the County Health and Human Services Agency, child's attorney, regional centers, schools and health care providers, which extends to managed care plans.



IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN DIEGO

IN THE MATTER OF: CHILDREN IN THE CUSTODY OF THE HEALTH AND HUMAN SERVICES AGENCY, COUNTY OF SAN DIEGO; RELEASE OF INFORMATION RELATED THERETO.	ORDER AUTHORIZING RELEASE OF HEALTH INFORMATION OF CHILDREN IN THE CUSTODY OF THE HEALTH AND HUMAN SERVICES AGENCY

Pursuant to Welfare and Institutions Code sections 369 and 5328.04, and Civil Code sections 56.10 et seq., in situations where a child is in the custody of the Health and Human Services Agency ("HHSA") of the County of San Diego, THE COURT HEREBY ORDERS:

1. Information concerning any health care provided to a child in the custody of the HHSA pursuant to this order may be released to the HHSA, the child's attorney (if any), other health care providers, Regional Centers, or schools if needed for treatment, treatment planning, counseling, and/or educational purposes consistent with promoting the child's physical and emotional well-being, before or after the detention hearing, and throughout the course of the dependency proceedings.

2. This order is not intended to include the release of any confidential privileged information for dependent children, including psychiatric treatment notes, but does include court-ordered psychological evaluations, initial treatment plans (ITPs) and treatment plan updates (TPUs) requested by the HHSA.

Best Practices for Providers

1. Involve children, youth and families in their care and service delivery.
2. When in doubt, get client authorization.
3. Obtain client authorization early at the start of ECM services that includes permission to share information.
4. Develop clear, repeatable protocols for responding to information requests from child welfare, including who reviews and approves disclosures.
5. Train staff on the difference between information that can be shared under treatment exceptions and what requires consent.
6. Always consult legal counsel before responding to subpoenas, court orders, or ambiguous requests involving protected information.
7. Deploy secure methods for information exchange, such as encrypted emails, secure portals, or approved HIPAA-compliant platforms.

Summary and Key Takeaways

When navigating information sharing decisions, follow these guiding principles:

- **Share with purpose** - Only when it directly supports the health, safety or wellbeing of the child and family. Respect family and youth voice and autonomy.
- **Involve families and youth in decisions** - When possible engage young people and caregivers in conversations about how their information is shared
- **Be transparent** - Explain what information is being shared, with whom and for what reason
- Consider the **potential impact** - Weigh the effect of sharing on trust, engagement and therapeutic relationships
- Apply the **minimum necessary** standard - Share only what is needed and nothing more

Thank You

The **Public Works Alliance** aims to change the economic future of marginalized communities by building equitable public systems that take action with people and for people. PWA opens new career pathways for youth, increases healthcare access for families, and leverages the power of Medicaid to sustain positive community impact.
For more information visit www.publicworksalliance.org