LEGISLATIVE RESEARCH COMMISSION

PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

Medically Fragile Foster Children

Research Report No. 437

Prepared By

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Medically Fragile Foster Children

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Abstract

As of May 2012, there were 116 medically fragile foster children in Kentucky. These children have medical conditions that require special services, support, and monitoring from foster parents. Such parents require additional training, and the children require heightened oversight. These homes receive higher per diem payments than do other foster homes. A nurse administrator in the Cabinet for Health and Family Services designates a foster child as medically fragile in consultation with other foster care and health professionals. The cabinet contracts with private placing agencies for additional foster homes as needed. Electronic tracking of the children's status either is nonexistent or is through computer systems that are not linked. Payment for the children's medical services is through Medicaid. Total medically fragile per diem costs for FY 2010 were nearly $2.9 million, reimbursed from federal and state contributions. The report has recommendations for the cabinet to create an electronic medical records system and to consider adding staff to help the nurse administrator.

Foreword

Many individuals provided valuable assistance. In particular, Program Review staff acknowledge those from state agencies who helped during this study: James Grace, Diane Glenn, Rick Peck, Jennifer Blair, Darlene Cain, and Jackie Richardson from the Cabinet for Health and Family Services; Susan Bunch, Jessica Day Fletcher, and Melissa Segress from the University of Kentucky Training Resource Center; and Mary Bratcher from the University Training Consortium, Eastern Kentucky University.

Staff thank associations and individuals for their assistance in this study including Irene Clements of the National Foster Parent Association, Shirley Hedges of the Kentucky Foster/Adoptive Care Association, Lydia Akin and Peggy Arvin of Specialized Alternatives for Families and Youth, and Kenneth Williams of Sunrise Children's Services.

Bobby Sherman
Director

Legislative Research Commission
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Summary

At its February 2012 meeting, the Program Review and Investigations Committee voted to initiate a review of the medically fragile portion of the foster care system. This report covers the circumstances in which a child enters the medically fragile system, the system's oversight and documentation requirements, placement and training requirements for medically fragile foster parents, the number of medically fragile placements, and program costs.

Medically Fragile Designation

The medically fragile designation is reserved for children with life-threatening illnesses who need a heightened level of care from their foster parent or parents. A specialized medically fragile designation is used for those needing an even higher level of monitoring and care. The medically fragile designation is based not on a particular diagnosis but on the level of care the foster parents must provide. In May 2012, there were 116 medically fragile foster children in Kentucky. Staff of the medically fragile system stressed that the number of medically fragile children in the foster program fluctuates frequently.

The Department for Community Based Services (DCBS) within the Cabinet for Health and Family Services manages the foster care system. A Medical Support Section nurse administrator oversees the medically fragile portion and makes the final determination as to which children are designated as medically fragile. A child is usually determined to need medically fragile care in one of three circumstances: upon entering the court system as a foster child who seems to have medically fragile needs, upon the recommendation of a physician who treats the child, or upon development of a medically fragile condition while in regular foster care.

Medically Fragile Care Process

When it appears that a foster child might be medically fragile, the nurse administrator collects all available information on the current health status of the child. State and federal laws mandate that all medical care given to each foster child be documented. Kentucky uses a medical passport binder that is a repository of all the child's health information. The passport also serves as verification that all necessary medical services are provided. Foster parents are responsible for maintaining the medical passport.

Recommendation 1.1
The Cabinet for Health and Family Services should facilitate the creation of an electronic system that would replace all or part of the current paper medical passport. If such a system is created, the cabinet should develop policies and protocols as to how information can be accessed and maintained.

The nurse administrator coordinates with others who oversee a child's care, such as caseworkers, DCBS liaisons, physicians, the courts, home certification teams, medically fragile liaisons, and

Commission for Children with Special Health Care Needs (CCSHCN) nurse consultants. The development of an individual health plan is required shortly after a child is designated medically fragile. Follow-up plan assessments are required every 6 months thereafter. A copy of the initial plan is placed in the medical passport.

Timeliness of the initial production of the individual health plan, follow-up, and report filing has been a concern. In August 2012, DCBS revised its relevant standard of practice. The CCSHCN nurse consultant, rather than the medically fragile liaison, now schedules the individual health plan meetings. The nurse consultant is now also required to timely file a copy of the plan with the nurse administrator.

Regular visits must be made to a medically fragile foster home by a combination of caseworkers and nurse consultants. The nurse administrator is the only employee of the Medical Support Section who works with the medically fragile portion of the foster care system. Additional staff would be helpful. The nurse administrator would also benefit from increased managerial authority to compel prompt information sharing.

Recommendation 1.2
The Cabinet for Health and Family Services should consider adding staff to the Department for Community Based Services Medical Support Section to increase the section's capacity to be involved in decision making in a timely fashion and to facilitate recordkeeping for medically fragile children and foster homes.

Placement And Training Requirements

Foster parents of medically fragile children must meet special requirements. These include being located near appropriate medical facilities, being a stay-at-home parent, having fewer children living in the home than in regular foster homes, and receiving special training about the medically fragile condition. When DCBS public medically fragile homes are unavailable or do not meet the special medical needs of a child, DCBS may seek placement through a private agency. In general, private placement agency medically fragile foster parents must follow the same regulations and requirements as those for public DCBS homes. In addition, recruiting and maintaining respite care providers for foster parents of medically fragile children can be difficult.

Annual required training sessions for foster parents of medically fragile children are conducted by the University of Kentucky's College of Social Work Training Resource Center. Some concerns have been expressed about access to the training by private placement agency foster homes and respite care providers. DCBS and the Training Resource Center are working on plans to alleviate these concerns.

Placements And Program Costs

Medical services for medically fragile foster children are covered through Medicaid. Expenditures by DCBS for medically fragile children are for maintenance of the foster home (per

diem payments), training, and administration. Some medically fragile children are eligible for federal Social Security Title IV-E funds, so the cost for their care is shared by the federal government and the state. Some medically fragile children are also eligible for Social Security Supplemental Security Income (SSI). Some also receive various other sources of funding, such as support from the family of origin. DCBS' Division of Administration and Financial Management automated system does not separate the costs of training and administration associated only with medically fragile foster care from the costs for the entire foster care program.

Maintenance spending fluctuates depending on the number of children designated medically fragile and the level of care they require. Per diem rates vary depending on the level of care required. The levels (and per diem rates) are basic ($40), advanced ($45), degreed ($48), advanced specialized ($56.40), and degreed specialized ($91.55). Private placement agencies are paid by the level of care that the child must receive, ranging from Level III to Level V (highest). Based on expense reports, the total cost of per diems paid to medically fragile foster homes incurred in FY 2010 was $2.86 million. Of this total, 32 percent was from federal Title IV-E funds, 39 percent was from state general funds, and 29 percent was from restricted funds. Restricted funds included SSI and child support payments from families of origin.

FY Chapter 1

Overview Of The System

Medically fragile foster children have chronic illnesses or medical conditions that may become unstable and change abruptly or require specialized services and support. Some improve and move out of the medically fragile category; others do not. Examples of medically fragile situations include dependence on a ventilator and conditions requiring frequent suctioning of lungs and throat, home oxygen therapy, or intravenous lines. As of May 2012, 116 children were in medically fragile foster care in Kentucky.

As of May 2012, 116 children were in medically fragile foster care in Kentucky. Medically fragile children have chronic illnesses or medical conditions that may become unstable and change abruptly or require specialized services and support. Some improve and move out of the medically fragile category; others do not. These children must be placed in foster homes that meet specified conditions and in which the foster parents are specially trained. Such foster parents receive a higher per diem payment for the care they must provide. Examples of medically fragile situations include dependence on a ventilator and conditions requiring frequent suctioning of lungs and throat, home oxygen therapy, or intravenous lines. Concerns related to the program include recruitment and monitoring of medically fragile foster parents and the need for people to provide respite care for the primary foster parents.

The Cabinet for Health and Family Services' Department for Community Based Services (DCBS) has primary responsibility for managing the foster care system.

The medically fragile foster program was created in 1988 in response to a federal mandate for state foster care systems to have a specialized program to care for children with exceptional health care needs. The Cabinet for Health and Family Services' Department for Community Based Services (DCBS) has primary responsibility for managing the foster care system.

State regulation sets the standard for designation as a medically fragile foster child. Such a child must be placed in a foster home that has been certified by the cabinet to care for medically fragile children.

By regulation, a child is designated medically fragile if the child has a

- medical condition documented by a physician that may become unstable and change abruptly, resulting in a life-threatening situation;
- chronic and progressive illness or medical condition;
- need for a special service or ongoing medical support; or
- health condition stable enough to be in a home setting only with monitoring by an attending health professional, registered nurse, or licensed practical nurse (922 KAR 1:350, Sec. 6).

A health professional is defined as a physician, a physician's assistant, an advanced registered nurse practitioner, or a registered nurse under the supervision of a physician (922 KAR 1:350, Sec. 1(3)).

A specialized medically fragile foster home provides an even higher level of care. The home must have a foster parent who is a physician, a physician's assistant, an advanced registered nurse practitioner, a registered nurse, or a licensed practical nurse.

Such a child must be placed in a foster home that has been certified by the Cabinet for Health and Family Services to care for medically fragile children.

A foster home that has been certified as a specialized medically fragile child home provides an even higher level of care. The specialized home must have a foster parent who is a physician, a physician's assistant, an advanced registered nurse practitioner, a registered nurse, or a licensed practical nurse (922 KAR 1:350, Sec. 8; 922 KAR 1:350, Sec. 1(3)).

Care for both types of children is available from a DCBS foster home or a foster home provided through a private placement agency that contracts with DCBS.

Care for medically fragile and specialized medically fragile children is available from a DCBS foster home or a foster home provided through a private placement agency that contracts with DCBS. Because of the higher administrative costs involved in placing a child in a private placement agency home, DCBS homes are sought first.

The medically fragile designation is based not on a particular diagnosis but on the level of care the foster parents must provide in the home.

The medically fragile designation is based not on a particular diagnosis but on the level of care the foster parents must provide in the home. For example, a child with human immunodeficiency virus who exhibits no symptoms is not designated as medically fragile. A child in need of an organ transplant who needs an extraordinary level of care from the foster parents is designated medically fragile.

Because of staff reductions, the medically fragile portion of the Medical Support Section within DCBS' Division of Protection and Permanency now has one employee: the nurse administrator, who is the only person who can authorize the medically fragile designation for a foster child.

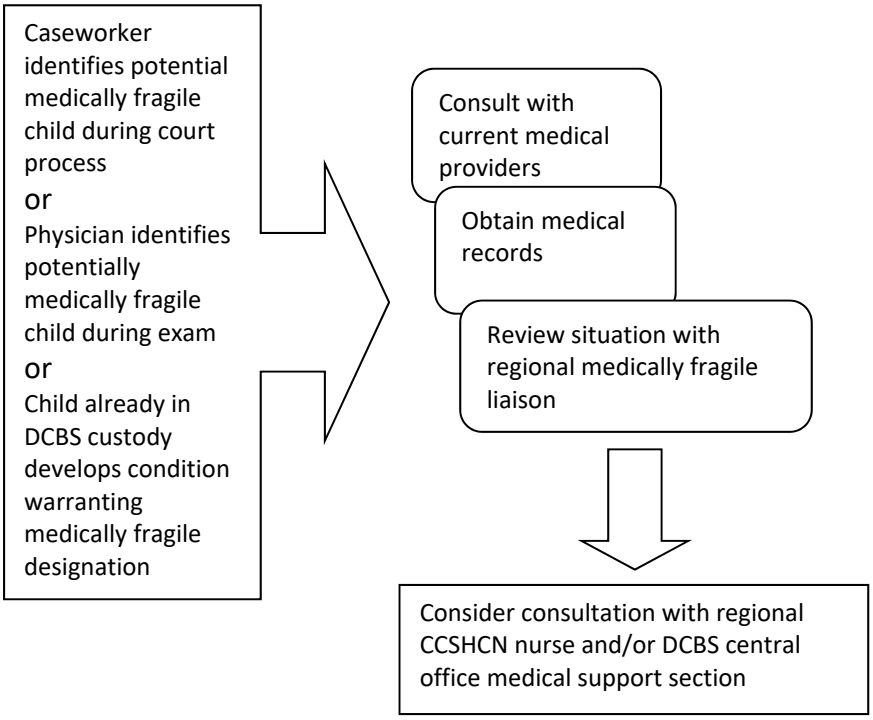
To ensure that frontline DCBS caseworkers have access to medical and mental health consultation, DCBS created a Medical Support Section within the Division of Protection and Permanency. The only employee of the medically fragile portion of the section is the nurse administrator. The nurse administrator is the only person who can authorize the medically fragile designation for a foster child. The nurse administrator handles the contact, paperwork, decision making, and monitoring of all potentially medically fragile children who enter the foster system. Previously, the Medical Support Section had two full-time nurses and a part-time consultant pediatrician/child psychiatrist in the department's central office in Frankfort.[1]

Initiation Of A Medically Fragile Case

A child enters the medically fragile foster system in one of three main ways.

A child enters the medically fragile foster program in one of three main ways. Figure 1.A illustrates the initial process in determining a potential medically fragile case.

Figure 1.A
Initiation Of A Medically Fragile Case



Note: CCSHCN is the Commission for Children with Special Health Care Needs.
DCBS is the Department for Community Based Services.
Source: Adapted by Program Review staff from Kentucky. Cabinet for Health and Family Services. "Medically Fragile Practice Flow Chart." June 19, 2007.

Referral By A Social Worker

1. A DCBS social worker for a child in the initial court phase of entering the foster system may identify the child as being potentially medically fragile. The nurse administrator approves or denies the official designation as medically fragile.

Children entering the foster care system are taken by order of the court. A DCBS social worker for a child who is in the initial court phase of entering the foster system may identify the child as potentially being medically fragile. While the child's case is still in the initial court phase, the social worker notifies the nurse administrator that a child coming into state care may be medically fragile. The nurse administrator formally requests the child's medical records, but the child's medical provider is also contacted immediately so that DCBS can determine the level of care needed by that child and whether he or she should be designated as medically fragile.

Referral By A Physician

2. A physician, while treating a child, might observe that the child's parents or guardians may not be capable of adequately serving the child's medical needs. The physician may contact DCBS.

During the course of administering medical services, a physician might identify, diagnose, or treat a child with a condition that requires an elevated level of care in the home. From interaction with the family of origin, the physician might observe compelling evidence that suggests a child's parents or guardian may not be capable of adequately serving the medical needs of the child away from medical facilities. When the child's condition could pose a life-threatening situation if a specific level of home care is not provided, doctors will inform DCBS officials of their concerns surrounding the particular case, prompting further investigation.

Change In Condition Of A Child Already In Foster Care

3. Children already in a foster home might develop a condition that warrants the medically fragile designation.

Children already placed in a foster home might develop a condition that warrants the medically fragile designation. Because the caseworker has repeated visits with the child and close examination of the health records, it is usually the caseworker who starts the process of seeking the medically fragile designation when a child is already in foster care.

A child who has been considered for the medically fragile designation but who has been found not to need that level of care is placed in a routine foster care setting. Caseworkers are advised to watch the child's condition and can request that the situation be reassessed by the nurse administrator.

Approximately 10 requests per month are made to designate a child as medically fragile. Most requests result in a medically fragile designation. Before rejecting a medically fragile designation, the nurse administrator involves other caseworkers and health professionals in the decision.

It is estimated that approximately 10 requests per month are made to designate a child as medically fragile. Most of the requests result in a medically fragile designation. Before deciding to reject a medically fragile designation, the nurse administrator involves other caseworkers and health professionals from the relevant DCBS region in the decision. If members of a region decide it is necessary, the decision can be appealed to regional management who could contact central office management.

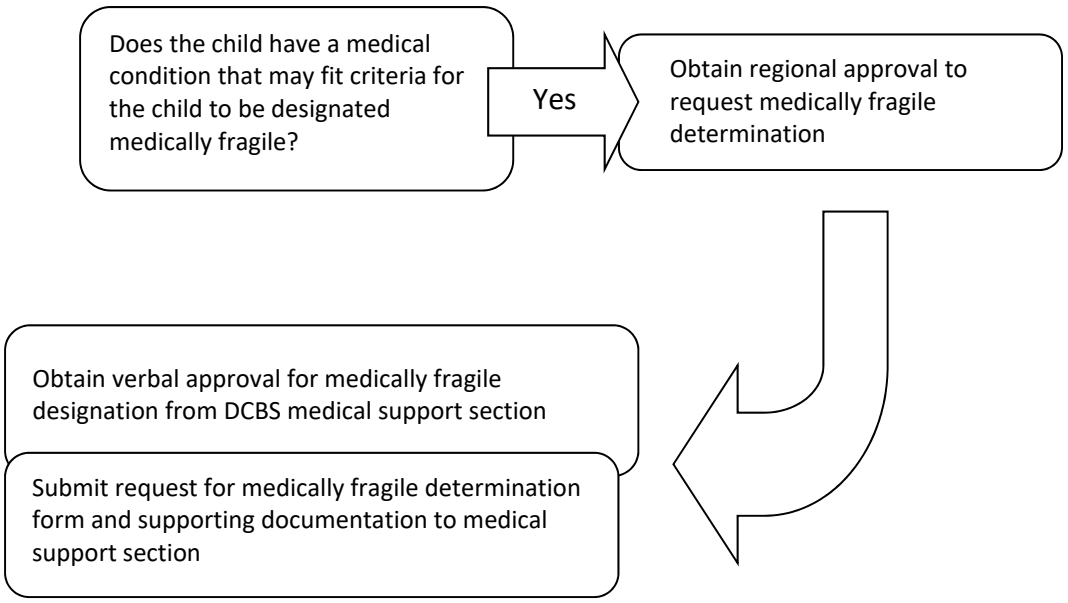
An example of a situation in which a medically fragile designation might be denied is that of a child diagnosed with seizures. If the child's condition is stable and medication is preventing active seizures, then the determination may be made that the child does not need a medically fragile designation at that time.[2]

Steps In The Medically Fragile Care Process

Information Gathering And Approval

Figure 1.B illustrates the information-gathering and approval process for potential medically fragile cases.

Figure 1.B
Medically Fragile Designation Process

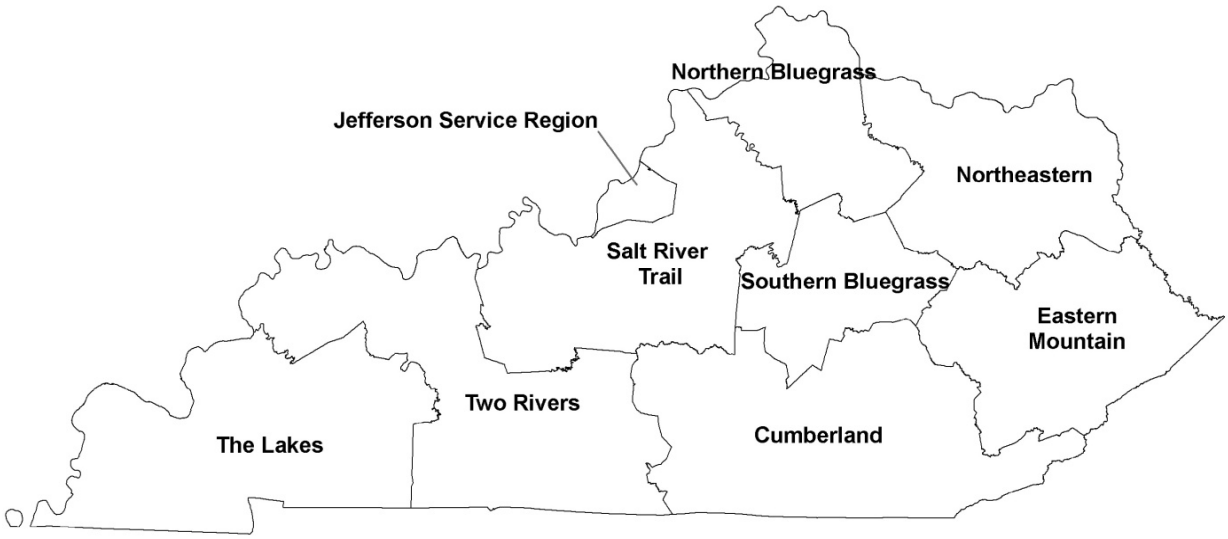


Adapted by Program Review staff from Kentucky. Cabinet for Health and Family Services. "Medically Fragile Protocol Flow Chart." June 19, 2007.

A medically fragile liaison in each of nine DCBS regions is a caseworker who has received training in matters concerning the medically fragile population. The liaison's principal role is to serve as a communications conduit among the stakeholders in medically fragile cases.

A medically fragile liaison in each DCBS region is a caseworker who has received training in matters concerning the medically fragile population. The liaison's principal role is to serve as a communications conduit among the stakeholders in medically fragile cases such as the child's caseworker, the foster parents, the medical providers, and the nurse administrator. The nine DCBS foster care regions are shown in Figure 1.C.

Figure 1.C
DCBS Regions



Source: Compiled by Program Review staff from data from Kentucky. Cabinet for Health and Family Services. "Directory of Service Regions." *Kentucky's Resource Parent Handbook.* Web. Oct. 10, 2012.

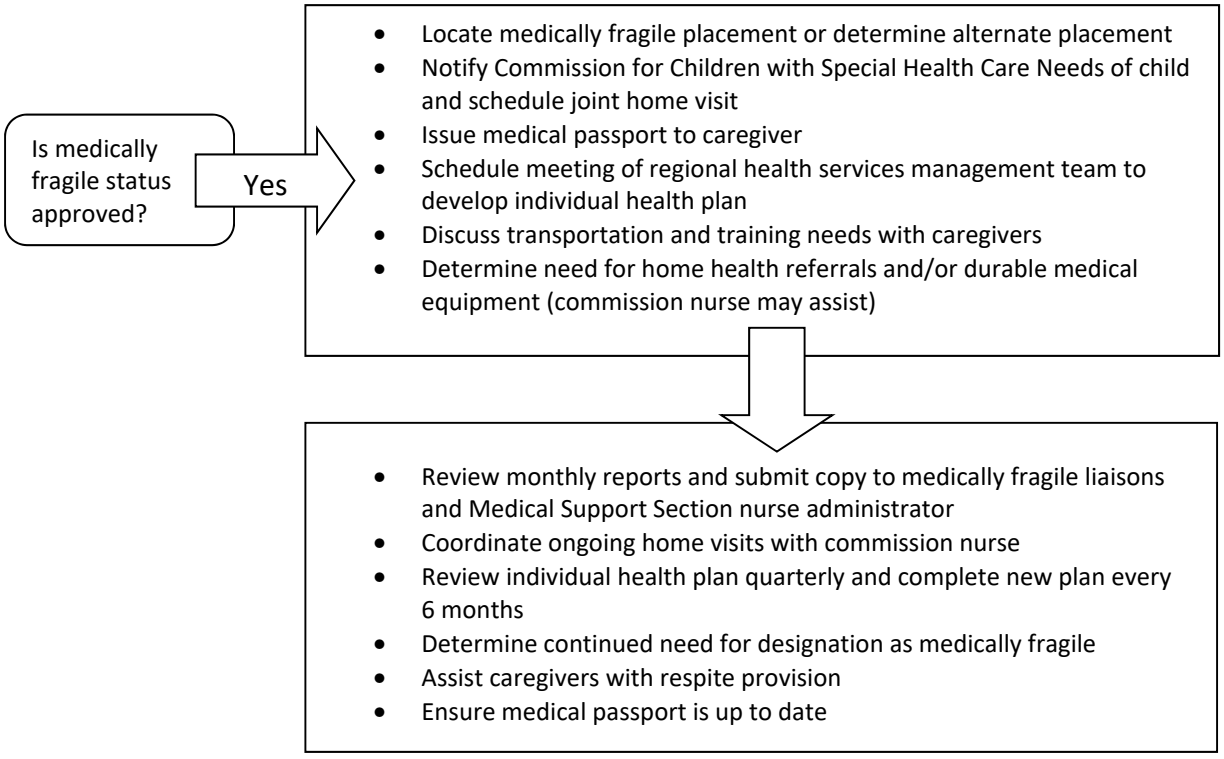
A caseworker dealing with a medically fragile child will seek the assistance of the medically fragile liaison in the child's DCBS region. Under the nurse administrator's supervision, the team gathers the child's medical records and may contact a physician.

In most instances, a caseworker dealing with a medically fragile child will seek the assistance of the liaison in the child's DCBS region early in the process. When it appears that a foster child should be designated medically fragile, the liaison or the caseworker informs the nurse administrator. The nurse administrator will seek to quickly collect all available information on the current health status of the child. The caseworker and the liaison forward any information they have about the child to the nurse administrator. The nurse administrator instructs the liaison to contact the child's physician and gather all medical records. If the child was not referred by a medical practitioner, the nurse administrator will also instruct the liaison or the caseworker to make arrangements for the child to receive a doctor's exam. The physician does not make the ultimate medically fragile designation; he or she advises on what kind of care the child needs. The nurse administrator decides whether the necessary level of care requires that the child be placed in a medically fragile foster home.

Locating Placement Homes

Figure 1.D illustrates the placement and review process after a child has been designated medically fragile.

Figure 1.D
Medically Fragile Placement And Review Process



Source: Adapted by Program Review staff from Kentucky. Cabinet for Health and Family Services. "Medically Fragile Protocol Flow Chart." June 19, 2007.

A recruitment and certification team will begin to identify possible residential foster homes soon after a child is referred to the nurse administrator for a possible medically fragile designation. The team will initially attempt to make placement arrangements for medically fragile children with an approved family member.

A recruitment and certification team will begin to identify possible foster homes soon after a child is referred to the nurse administrator for a possible medically fragile designation. Teams across Kentucky recruit homes for medically fragile foster children. The teams in every county include a social worker who helps approve and prepare families for such fostering.[3]

The team will initially attempt to make placement arrangements for medically fragile children with an approved family member.[4] Placing the child in a familiar setting with a family member is preferable to placement with someone who is not a relative.

If the child under consideration is designated medically fragile, the research and certification team will first consider DCBS-recruited foster homes. If no DCBS foster home is available, a private placement service or residential group home is sought.

When DCBS must make placement arrangements with those who are not relatives, the research and certification team will first consider DCBS-recruited foster homes. If no DCBS foster home is available, qualified, and willing to accept a particular placement, a private placement service or residential group home is sought.[5]

Consulting With Medical Providers

The DCBS Medical Support Section nurse administrator discusses the child's condition with the child's physician. There is no list of diagnoses that a child must have to be considered medically fragile.

After reviewing available records, the DCBS Medical Support Section nurse administrator calls the child's physician to discuss the individual care needs of the child. Simply having a medical condition does not automatically warrant a medically fragile designation. The consulted physician does not determine whether the child should be designated medically fragile for the purposes of foster care placement. Doctors help the nurse administrator determine whether a child should be designated medically fragile by providing relevant medical information. There is no list of diagnoses that a child must have to be considered medically fragile.[6]

Requirements For Medically Fragile Foster Homes

The primary caretaker in a medically fragile foster home must not be employed outside the home. Medically fragile foster parents must complete additional training. The foster home must be within 1 hour of a hospital with an emergency room and within 30 minutes of a local medical facility.

A medically fragile foster home must meet requirements in addition to those for all foster homes. The primary caretaker must not be employed outside the home. The foster parents must complete additional training as described later in this chapter. The foster home must be within 1 hour of a hospital with an emergency room and within 30 minutes of a local medical facility. The setting must be the least restrictive and most family-like and should facilitate contact with the child's family. If more than one placement is possible, then the social service worker will default to the placement that is closest to the child's birth family.

A medically fragile foster parent must cooperate in carrying out an individualized health plan for the child.

A medically fragile foster parent must cooperate in carrying out an individual health plan for the child created in consultation with a variety of DCBS participants. Except for a foster sibling group, no more than four children, including the foster parents' own children, can reside in a medically fragile foster home. A one-parent medically fragile foster home cannot care for more than one medically fragile child. A two-parent medically fragile foster home cannot care for more than two medically fragile children. A medically fragile foster home must obtain annual reapproval by the cabinet (922 KAR 1:350, Sec. 6).

Private placing agencies have contracts with the cabinet. They must be licensed by the Office of Inspector General. In general, they follow the same requirements as DCBS foster homes.

When DCBS medically fragile foster homes are unavailable or a medically fragile child requires special care that available DCBS homes are not equipped to provide, the child's caseworker will seek placement through a private placing agency. Private placing agencies are organizations under contract with the Cabinet for Health and Family Services to provide private foster placement. As per regulation, private placing agencies are licensed by the cabinet's Office of Inspector General and must also be accredited by a nationally recognized accreditation organization. In general, medically fragile foster homes supervised by private placing agencies must follow the same requirements as homes sponsored by DCBS.

Consulting With The Commission For Children With Special Health Care Needs

The Commission for Children with Special Health Care Needs (CCSHCN) is a child health agency within the Cabinet for Health and Family Services. It provides nurse consultation services—not direct care—to medically fragile foster homes using nurse consultants/inspectors and clinical nurses.

The Medical Support Section nurse administrator instructs the medically fragile liaison to contact the Commission for Children with Special Health Care Needs (CCSHCN). The commission is a child health agency within the Cabinet for Health and Family Services that provides care for children with physical disabilities. Its mission is to enhance the quality of life for Kentucky's children with special health care needs through direct service, leadership, education, and collaboration. The commission has a memorandum of understanding with DCBS to provide nurse consultation services to medically fragile foster homes. The commission deploys its nurse consultants/inspectors and clinical nurses to visit medically fragile foster homes. Commission nurses do not provide direct care to the medically fragile child. They consult with the child's caseworker on medical matters and make recommendations as to the best care. The commission began serving medically fragile foster children statewide in 2006 after a pilot program in Owensboro the previous year.[7]

The commission has 10 nurse consultant/inspectors: one each assigned to eight DCBS service regions and two for the Two Rivers region.

The commission has 10 nurse consultant/inspectors: one each assigned to eight DCBS service regions, and two for the Two Rivers region. The commission would rather assign the nurse consultant/inspectors to medically fragile cases, but with a preferred caseload of 10 or fewer children. Subsequent medically fragile placements are assigned to clinical nurses.[8]

The caseworker and the commission nurse assigned to the child schedule an initial joint visit to the foster home. They conduct at least one joint visit with the child in the foster home every calendar month the child retains the medically fragile designation.

Once a medically fragile child is referred to the commission, a nurse consultant/inspector working in the DCBS region of placement is assigned to the child whether the placement is with a DCBS home or privately recruited home.[9] The caseworker and the assigned commission nurse schedule an initial joint visit to the foster home, and each conducts at least one visit with the child in the foster home every calendar month the child retains the medically fragile designation. Thus, each child receives at least two visits per month: one from the caseworker and one from the commission's nurse consultant.[10] The primary role of commission nurses is to educate the caseworker, interpret medical instructions, and serve as an advocate for the child. A visit by a commission's nurse consultant to evaluate a medically fragile child is entered into the commission's electronic Computer Utilization Project. The commission provides nurse consultants the opportunity to attend the DCBS Academy, a 6-month program, to familiarize them with the job responsibilities and terminology used by the DCBS social service workers.

Issuing And Maintaining A Medical Passport

Upon placement in foster care in Kentucky, a child is issued a "medical passport" three-ring binder, which is a repository of health information. Currently, the foster parents are responsible for updating and maintaining the medical passport. DCBS staff have urged the creation of an electronic component or a complete transition to a paperless medical passport.

State and federal laws mandate that all medical care given to children in foster care be documented.[11] Each child is issued a "medical passport" three-ring binder upon placement in foster care in Kentucky. This repository of health information includes DCBS medical policy and procedures, consent forms and procedures, pertinent health information, and forms to document the ongoing medical development of the child.[12] The main goal of the medical passport is to ensure that all medical information is kept in a single place, in a concise form, and is readily accessible to those who need the information. The passport also serves as verification that medical services are being provided. In cases of reunification, the medical passport provides the family of origin with a report on the type of care the child received while in foster care.

Foster parents are responsible for updating and maintaining the medical passport. The passport is to remain with the child throughout all foster placements and to accompany the child to any medical event.[13] DCBS staff have voiced concerns that this may not be the best way of ensuring that all necessary care is taking place or of allowing team members, including physicians, necessary access to the child's medical history. Creation of an electronic component or a complete transition to a paperless medical passport could help with these concerns. The nurse administrator indicated that an electronic system would allow her to efficiently alert doctors to medically fragile children who are in

danger of being overprescribed medications. It could allow doctors to enter information directly. It would also allow the nurse administrator to track such elements from the children's personal files as diagnoses, individual health plan dates, and other medical notes on the children and their care. Making the medical passport electronic, allowing doctors to enter information directly, and allowing the nurse administrator access and input would improve care and program oversight.[14]

Recommendation 1.1

Recommendation 1.1

The Cabinet for Health and Family Services should facilitate the creation of an electronic system that would replace all or part of the current paper medical passport. If such a system is created, the cabinet should develop policies and protocols as to how information can be accessed and maintained.

Developing The Individual Health Plan

Within 30 days of a foster child's receiving a medically fragile designation, a meeting should be scheduled to develop an individual health plan for the child. The plan addresses medical status, necessary treatments, and persons responsible for executing the care needed.

Within 30 days of a foster child's receiving a medically fragile designation, a meeting should be convened to create the child's individual health plan. The plan addresses the current medical status of the child, existing treatments, actions to address the child's medical needs, persons responsible for executing care, and creation of a follow-up plan to analyze the efficacy of care. Birth parents, foster parents, medical providers, the caseworker, the medically fragile liaison, and the designated commission nurse are among those invited to participate in the individual health plan meeting. In a placement through a private child placing agency, agency staff and family members other than the birth parents are invited when applicable.[15]

Program Review staff examined the initial individual health plan meeting date of each medically fragile case since 2007 that was still active as of May 2012. Overall, 55 percent of the cases met the 30-day standard.

Program Review staff examined the initial individual health plan meeting date of each medically fragile case since 2007 that was still active as of May 2012. Table 1.1 shows the number of days it took the service team to convene an initial meeting after receiving a medically fragile designation notice. Overall, 55 percent of the cases met the DCBS standard of practice for convening the initial individual health plan meeting within 30 days. In 21 percent of the cases, the initial meeting was 31 to 60 days after the medically fragile designation. In 13 percent of the cases, the initial meeting was more than 90 days after designation.

Table 1.1
Days Before Initial Individual Health Plan Meeting
For Active Cases As Of May 2012

Days After Designation As Medically Fragile	Cases	% Of Total	Cumulative %
Before designation	8	7.4%	7.4%
0 to 30 (DCBS standard)	51	47.2	54.6
31 to 60	23	21.3	75.9
61 to 90	12	11.1	87.0
91 to 275	14	13.0	100.0
Total	108	100.0%	

Note: Staff analyzed cases over the past 5 years. Of the 116 active cases as of May 2012, 8 cases were older than 5 years.
Source: Prepared by Program Review staff from data provided by DCBS' Division of Administration and Financial Management.

Timeliness is important in the production of the initial individual health plan because the plan serves as the anchor of the medical passport.

Timeliness is important in the production of the initial individual health plan because the plan serves as the anchor of the medical passport. A copy of the initial plan is placed in the medical passport and serves as a key component to ensure that the child is receiving the care that is due. During visits, the CCSHCN nurse will check the medical passport to monitor recent medical history, schedules, and appointments to ensure compliance with the child's health plan.[16]

Semiannual Reassessment Of The Individual Health Plan

Reassessment of a foster child's medically fragile designation occurs with the reassessment of the individual health plan. An individual health plan meeting should be scheduled every 6 months after the initial meeting to monitor the child's medical progress and determine whether a continuance of the medically fragile designation is warranted.[17] The liaison may schedule a meeting prior to the 6-month assessment if a significant change in health status emerges.

To examine compliance with the 6-month scheduling of a follow-up plan, Program Review staff reviewed the past 5 years of data for each medically fragile case active as of May 2012. For cases active less than 5 years, Program Review staff calculated from the date of the medically fragile designation to May 2012 to determine the number of individual health plan meetings required during that time. For cases older than 5 years, Program Review staff calculated from the 2007 calendar year to May 2012 to determine the number of meetings that should have occurred.

Of the 116 cases active as of May 2012, 24 (20.7 percent) lacked the required number of individual health plan assessment meetings that should have taken place from the initial meeting until May 2012.

Of the 116 cases active in May 2012, 24 (20.7 percent) lacked the required number of individual health plan assessment meetings that should have taken place from the initial meeting until May 2012. For example, a case designated medically fragile in March 2010 should have had a total of five individual health plan meetings on record as of May 2012—one initial and four reassessment meetings.

Maintaining the required 6-month assessment schedule is important. First, a medically fragile foster child's health status can fluctuate quickly. It should not only be up to the foster parent to perceive these changes and adjust care accordingly. Gaps between meetings of longer than 6 months can result in a plan of care that is not properly suited to the child's needs. Second, the higher daily rates paid to medically fragile resource families mean that timely assessments are needed to ensure that the medically fragile designation is used efficiently.

Even in cases that have the appropriate number of individual health plan meetings, more than 6 months sometimes elapsed between meetings. The elapsed time between meetings ranged from 7 to 12 months. The nurse administrator reported that in many situations such delays are most likely due to hospitalizations and discharges or scheduling conflicts due to other emergency duties on the part of required participants, such as court testimony.

In September 2012, DCBS revised its standards of practice regarding timely scheduling and reporting of individual health plans, both new and follow-up.

In September 2012, DCBS revised its standards of practice regarding timely scheduling and reporting of individual health plans, both new and follow-up. The CCSHCN nurse consultant, rather than the medically fragile liaison, now schedules the individual health plan meetings. The nurse consultant is now also required to timely file a copy of the plan with the Medical Support Section nurse administrator.[18]

Data And Information Systems

The data set used to analyze the performance of DCBS in complying with its standards of practice is a snapshot of one point in time. The number of children designated medically fragile varies over time. Since health is a major determinant as to whether a child is deemed medically fragile, a significant number of children will come into the program and leave the program multiple times before they age out of the system at 18.

Records gathered from The Workers Information System (TWIST) and reports forwarded by the medically fragile liaison are used by the nurse administrator to monitor issues surrounding individual health plan meetings. TWIST allows the nurse administrator to identify each child designated as medically fragile but does not contain pertinent time-sensitive or programmatic information for the administrator to access on demand. Individual health plan data, medical records, and other important information must be manually recorded into a local database from reports forwarded from the liaisons. The division's standards of practice do not address the transmission of information to the nurse administrator.

Oversight of the medically fragile liaisons and the CCSHCN nurses lie with other officials. Therefore, the nurse administrator does not have any managerial authority to compel prompt data sharing. With no clear data sharing mechanism between program coordinators and the sole medically fragile program administrator, execution of major program components can potentially be delayed or compromised.

Recommendation 1.2

Recommendation 1.2

The Cabinet for Health and Family Services should consider adding staff to the Department for Community Based Services Medical Support Section to increase the section's capacity to be involved in decision making in a timely fashion and to facilitate recordkeeping for medically fragile children and foster homes.

Computer Utilization Project Data System

The CCSHCN's electronic system tracks its nurse consultants' visits with medically fragile foster children.

CCSHCN operates the Computer Utilization Project electronic enrollment system in which its nurses track visits with medically fragile foster children. Officials indicate that the number of medically fragile foster children in the system reports fluctuates weekly as children are adopted, reunited with birth families, or remain in foster care but are no longer designated medically fragile.[19]

The information maintained in the system includes medical records for the children enrolled with CCSHCN and all demographic information, medical information, and home visit encounters for medically fragile children made by the assigned CCSHCN nurses.[20] It is unknown whether this is relatively substantive detailed information analogous to what would be entered into a

medical passport entry when a visit is made or whether the information simply indicates that a visit was made**.**

A better interface between the CCHSCN electronic system and DCBS' TWIST could improve the collaboration between the two agencies.

Commission staff also indicated that access to the Computer Utilization Project system has been made available to the nurse administrator for several years.[21] The commission's information technology staff also compiles weekly and monthly reports for delivery to DCBS staff.[22] Because the care of medically fragile foster care children requires greater access to detailed information, the nurse administrator indicated that a better interface between the commission's Computer Utilization Project system and the DCBS TWIST system would improve the collaboration between the two agencies.[23]

Training For Medically Fragile Foster Parents

According to the cabinet, recruitment of medically fragile foster parents is difficult. Encouraging existing foster parents to participate in medically fragile training is one way in which the cabinet tries to increase its number of resource homes. Recruitment at one private placement agency is conducted through word of mouth, churches, television advertising, and print. Medically fragile foster parent candidates must previously have been foster parents and must have solid references and performance records.

Foster parents of medically fragile children must be certified as are regular foster parents. They must also complete 16 hours of specialized training and become qualified in cardiopulmonary resuscitation (CPR) and first aid. The training is provided by the University of Kentucky College of Social Work's Training Resource Center.

Foster parents of medically fragile children must possess the same basic certification as do foster parents who provide regular care. Public DCBS and private agency medically fragile foster parents must also take special DCBS-sponsored training. Those seeking medically fragile home certification must complete specialized medically fragile training in addition to becoming qualified in cardiopulmonary resuscitation (CPR) and first aid. The training must cover child growth and development, nutrition, and medical disabilities (922 KAR 1:350, Secs. 6 and 8). The medically fragile training program requires 24 hours of coursework across three main modules: the 2-hour online prerequisite course, the 14-hour Join Hands Together program, and 8 hours of CPR/first aid. DCBS will waive the CPR/first aid coursework for those already certified. Foster parents must complete additional training each year.

The required training is provided by the University of Kentucky College of Social Work's Training Resource Center. UK also administers the Foster/Adoptive Support and Training (FAST) Center. The Training Resource Center is part of the larger University Training Consortium led by Eastern Kentucky

University. DCBS collaborates with the Training Resource Center and the FAST Center to deliver the medically fragile training program.

Join Hands Together And Subsequent Annual Training

Prospective medically fragile foster parents must first take a 2-hour, Web-only orientation. Foster parents completing the module may enroll in the subsequent Join Hands Together training program, which is scheduled for 14 hours over 2 days. Join Hands Together is offered five times per year at locations throughout the state.

Prospective medically fragile foster parents must first take a 2-hour, Web-only orientation module that provides an overview of medically fragile foster parenting. Completing the module allows foster parents to enroll in the subsequent Join Hands Together training program. This training, scheduled for 14 hours over 2 days, educates and certifies DCBS resource homes, private agency foster families, and respite providers. It is offered five times per year at locations throughout the state. Staff at two private placing agencies commented that foster parents from private agencies have trouble enrolling in the Join Hands Together program because they are placed on waiting lists behind DCBS foster parents. For FY 2011, DCBS standards of practice were incorporated into the training module.[24]

Medically fragile foster parents are required to take an additional 16 hours per year of DCBS-sponsored training and continue to hold a current certificate in CPR/first aid.

Each year, medically fragile foster parents are required to take an additional 16 hours per year of DCBS-sponsored training and continue to hold a current certificate in CPR/first aid (922 KAR 1:350, Secs 6 and 8). DCBS and the Training Resource Center hold advanced training sessions to meet these annual recertification needs. A 16-hour advanced training session is offered twice per year. Topics cover a number of medically fragile conditions and diagnoses.[25] Makeup training sessions are offered twice per year for foster parents who were unable to attend the conference-style annual events.

Training expenses incurred by DCBS foster parents may be reimbursed. Mileage, babysitting of the foster child, and tuition fees are included in the reimbursement. For medically fragile homes, the maximum reimbursement for training costs is $200 per year. Private placement agencies pay for their foster parents' lodging and food as specified in their contract with DCBS.[26] The training sessions are presented by medical professionals who volunteer their time.

The Training Resource Center is revising the delivery method of training sessions to include a larger online component. This revision would reduce the 2-day schedule to 1 day.

Respite Care

Respite care is temporary care provided by another individual or family to provide relief to the medically fragile foster parent. For medically fragile foster homes, 3 days per month of respite care are provided. Four days are allotted to specialized medically fragile foster homes.

Respite care is temporary care provided by another individual or family to provide relief to the medically fragile foster parent. It is available to all foster parents in medically fragile foster homes (922 KAR 1:310, Sec. 1(22)). For medically fragile foster homes, 3 days per month of respite care are allotted. For specialized medically fragile homes, 4 days per month are allotted. All reimbursements for respite care are calculated at the level of care per diem rate of the child.[27]

When a foster parent selects a respite care provider, the research and certification worker evaluates the chosen provider to ensure that specific requirements are met. Requirements vary according to whether the respite care provider is also a foster home parent. Respite care providers who will provide care in the foster home, but who are not approved foster parents themselves, must meet several requirements including citizenship or legal immigrant status, background checks, a discipline policy form, and a confidentiality form. If the chosen respite care provider is to provide respite care outside the foster home, the provider must complete the home environment assessment established in Standard of Practice 12.13.[28]

Respite care providers must attend the Join Hands Together training session.

Families interested in providing respite care are also required to attend the Join Hands Together training session; however, lodging and food are not covered as part of their expenses. Since respite providers receive instruction specific to their medically fragile child, they are exempt from attending the annual reassessment training.

Lack of respite care providers may be a problem because required training is too general and associated costs are not reimbursed.

One medically fragile foster parent questioned the effectiveness of the current respite care training. She asserted that medically fragile foster parents are in particular need of more respite care. The current Join Hands Together training sessions held over a weekend are too general and have little benefit for respite care providers seeking instruction covering more specialized topics and diagnoses. In addition, these training sessions are often inconveniently located and the cabinet does not reimburse respite providers for expenses incurred. She asserted that the current structure of respite care training is not conducive to recruiting prospective providers. The lack of respite care providers appeared as a common theme throughout the research for this report.

Chapter 2

Medically Fragile Placements And Costs

Administrative and training costs could not be determined because the medically fragile category does not have its own designated budget within foster care. Per diem maintenance expenditures paid to medically fragile foster homes, which are known, vary depending on the number of medically fragile children and their levels of care. Total medically fragile per diem payments for FY 2010 were nearly $2.9 million, reimbursed from federal and state contributions. Expenditures for the children's medical services are through Medicaid.

This report covers medically fragile children in foster care. Cabinet staff noted that some medically fragile children could be better served if federal requirements regarding funding could be changed so that the children could be served in their home of origin and not through foster care.

This report covers medically fragile children in foster care. Cabinet staff noted that some medically fragile children could be better served if funding requirements could be changed. According to staff, a number of medically fragile children are in foster care through no fault of the parent of origin but because the parents do not have the resources to serve the child's needs in the home. Federal law governing funding and state reimbursement emphasize the more expensive and time-consuming option of establishing foster care. DCBS could establish care services in the home of origin in many cases, but the state does not have the funds to widely implement this program without sufficient federal matching support. DCBS is working with federal officials to change the amount of federal funding that can be spent on medically fragile children who stay in their homes of origin.

Placements

Program Review staff used two sets of data from DCBS officials to analyze medically fragile placements and their associated costs. The Medical Support Section nurse administrator provided data on medically fragile placements as of May 12, 2012. The data include the type of placement, placement by distance from county of origin, diagnosis, and number of months classified as medically fragile. The cabinet also provided an expense report based on records maintained in its TWIST automated payment system for fiscal years 2010, 2011, and 2012.

Foster Homes

Some foster homes are recruited, trained, and reimbursed directly by DCBS. As of September 2012, there were 136 DCBS homes certified to care for medically fragile children and 93 private agency homes licensed to care for medically fragile children.

DCBS public medically fragile foster care refers to all such foster homes recruited, trained, and reimbursed directly by DCBS. As of September 2012, there were 136 DCBS homes certified to care for medically fragile children and 93 private agency homes licensed to care for medically fragile children.[29] Many of both types of homes may be at capacity. Private agency foster care homes include medically fragile home placements that are licensed through a private child placing agency. Private agencies are community based and mostly nonprofit, often taking the more difficult cases, such as the most medically fragile children who also have emotional problems. The private agency receives a negotiated rate from DCBS; the foster parent is reimbursed a percentage of that rate based on performance.[30]

Group facilities and hospitals are options for more severe medically fragile children for whom, in the short term, a residential placement might not be appropriate.

Group facilities and hospitals are options for more severe and emergent cases when a residential placement might not be appropriate in the short term. Residential child-caring facilities are institutions or group homes providing 24-hour care for children who are in the custody of the cabinet when less restrictive placement is unavailable to meet specific mental health, physical, or behavioral needs (922 KAR 1:390, Secs. 1(16) and 3(3)(a)1). Pediatric convalescent centers are composed of teams of doctors, nurses, and therapists who provide short- or long-term residential care, crisis shelter services, therapeutic foster care services, and respite care services for children with severe developmental and physical disabilities, as well as ventilator dependency.[31]

Of the 116 medically fragile foster children as of May 2012, nearly one-half were in DCBS homes; more than one-third were in private agency foster homes.

Table 2.1 shows the type of placement for the 116 medically fragile foster children as of May 2012. Nearly one-half of the children were in DCBS homes; more than one-third were in private agency foster homes.

Table 2.1
Medically Fragile Child Placements As Of May 2012

Placement	Children
DCBS/public agency foster care (all levels)	55
Private agency foster care (all levels)	40
Residential child-caring facility	7
Supports for Community Living*	6
Psychiatric hospital/in state	3
Pediatric convalescent center	2
Psychiatric hospital/out of state	2
With mother in independent living**	1
Total	116

*This is a special arrangement for children who do not have placements and are close to aging out of the foster system. Using state funds, DCBS can place children in group homes or other community living options that are not traditional foster homes.
**A foster child had a medically fragile baby, and they were placed together in independent living.
Source: Compiled by Program Review staff from data provided by the DCBS Medical Support Section nurse administrator.

Diagnoses

Medically fragile children have a range of medical conditions that require close supervision. As of May 2012, the two most common diagnoses were diabetes (23 percent of children) and epilepsy (20 percent).

Medically fragile children have a range of medical conditions that require the close supervision of a foster parent. Table 2.2 shows the main diagnoses for the medically fragile foster children as of May 2012. The two most common diagnoses were diabetes (23 percent of children) and epilepsy (20 percent).

Table 2.2
Main Diagnosis For Medically Fragile Child Placements As Of May 2012

Main Diagnosis	Children	Main Diagnosis	Children
Diabetes	27	Hypothyroidism	3
Epilepsy	23	Reactive airway disorder	3
Neurological diseases and conditions	7	Amino acid disorder	2
Heart diseases and conditions	6	Apnea episodes	2
Cancer	5	Cerebral palsy	2
Multiple diagnoses	5	Drug-exposed newborn	2
Traumatic brain injury	5	Scoliosis	2
Chronic lung disease	3	Other diagnoses	16
Cleft lip/palate	3		
Total			116

Source: Compiled by Program Review staff from data provided by the DCBS Medical Support Section nurse administrator.

Of the 116 children, 29 had been classified as medically fragile for 6 months or less, 25 for 7 to 12 months, and 21 for 13 to 24 months. The median was 14 months.

Table 2.3 shows the length of time the May 2012 cohort of medically fragile children had spent in medically fragile foster care. Of the 116 children, 29 had been classified as medically fragile for 6 months or less, 25 for 7 to 12 months, and 21 for 13 to 24 months. The median was 14 months.

Table 2.3
Months As Medically Fragile For Medically Fragile Child Placements As Of May 2012

Months	Children
0 to 6	29
7 to 12	25
13 to 24	21
25 to 36	12
37 to 48	13
49 to 60	9
61 to 72	2
More than 72*	5
Total	116
Median=14 months	

Note: Children who had been designated as medically fragile for 6 months and 1 day would be categorized in the 7 to 12 months group. Many of the children in the 7 to 12 months category were just past the 6-month mark and awaiting their health reassessment.
*Children who had been designated medically fragile for more than 72 months had diagnoses of cerebral palsy, Menkes disease, reactive airway disorder, scoliosis, or traumatic brain injury.
Source: Compiled by Program Review staff from data provided by the DCBS Medical Support Section nurse administrator.

DCBS attempts to place medically fragile children in a foster home within their county of origin, a neighboring county, or the local DCBS region. As of May 2012, 88 of 116 children were so placed: 33 in the county, 29 in a neighboring county, and 26 within the region.

DCBS attempts to place the majority of medically fragile children in a home within their county of origin, a neighboring county, or the local DCBS region. Table 2.4 shows that as of May 2012, 88 of 116 children, or 75.9 percent were so placed: 33 in the county, 29 in a neighboring county, and 26 within the region.

Table 2.4
Distance Placed From County Of Origin
For Medically Fragile Child Placements
As Of May 2012

Placement	Children
Within county of origin	33
Neighboring county	29
Within DCBS region	26
In state	26
Out of state (psychiatric hospital)	2
Total	116

Source: Compiled by Program Review staff from data provided by the DCBS Medical Support Section nurse administrator.

Maintenance Payments

Maintenance payments cover room and board costs. Because of the extra demands on medically fragile foster parents, their per diem rate is higher than for other foster homes. The federal government pays some of the costs through Title IV-E of the Social Security Act.

Maintenance payments cover the room and board costs to licensed foster parents, group homes, and residential child care facilities. Because of the extra demands on medically fragile foster parents, the medically fragile per diem rate for maintenance is higher than that for other foster parents. Through Title IV, Part E of the Social Security Act, the US Department of Health and Human Services pays to states a portion of costs associated with care of foster children who meet its eligibility requirements.[32]

Medically Fragile Per Diem Maintenance Payments

The per diem maintenance reimbursement covers

- housing expenses;
- food-related expenses;
- nonmedical transportation;
- clothing;
- an allowance;
- incidentals;
- babysitting;
- sports, recreation, and school activities;
- respite care; and
- school expenses (922 KAR 1:350, Sec. 13(1)(k)).

These uses mirror the federal requirements for use of Title IV-E funds for the cost of maintenance of foster children (42 USC 675(4)(A)) .

The five types of medically fragile foster homes (and their per diem rates) are basic ($40), advanced ($45), degreed ($48), advanced specialized ($56.40), and degreed specialized ($91.55).

Table 2.5 shows the per diem maintenance rates for foster homes. It shows the higher per diem rates paid to the five types of medically fragile foster homes: basic medically fragile, advanced medically fragile, degreed medically fragfile, advanced specialized medically fragile, and degreed specialized medically fragile.

Table 2.5
Foster Care Per Diem Rates
2012

	Basic	Advanced	Degreed
Birth to age 11	$22.70	$24.90	N/A
Age 12+	24.70	26.90	N/A
Emergency Shelter home	33.00	N/A	N/A
Care Plus home	40.00	45.00	N/A
Medically fragile	40.00	45.00	$48.00
Specialized medically fragile	N/A	56.40	91.55
Supplemental Services Rate	N/A	68.00	N/A

Note: "Advanced" means the caretaking parent is a licensed practical nurse. "Degreed" means the caretaking parent is a registered nurse or other degreed health professional.
Source: Kentucky. Cabinet for Health and Family Services. *Standards of Practice Online Manual (SOP)* 12.24. Web. Sept. 19, 2012.

The reimbursements for the different types of foster homes described below are in regulation and DCBS' standards of practice (922 KAR 1:350, Secs. 13(1)(d), (e), (f), (i), and (j)).[33] A basic medically fragile per diem reimbursement of $40 is made to a foster home that provides for the care of a medically fragile child. An advanced medically fragile per diem reimbursement of $45 is made to a medically fragile foster home if the caretaking parent is a licensed practical nurse. A degreed medically fragile per diem reimbursement of $48 is made to a medically fragile foster home if the caretaking parent is a registered nurse or other degreed health professional. An advanced specialized medically fragile per diem reimbursement of $56.40 is made to the foster home of a specialized medically fragile child if the caretaking parent must be a licensed practical nurse. A degreed specialized medically fragile per diem reimbursement of $91.55 is made to the foster home of a specialized medically fragile child if the caretaking parent must be a registered nurse or a physician.

Of the 55 children in DCBS homes as of May 2012, nearly two-thirds were in basic care. In fiscal years 2010, 2011, and 2012, fewer than five children per year were in DCBS specialized medically fragile homes.

Table 2.6 shows the placements in different types of DCBS/state medically fragile foster homes. Of the 55 children in these homes, nearly two-thirds were in basic care. During each of fiscal years 2010, 2011, and 2012, fewer than five children per year were in the specialized medically fragile category.

Table 2.6
Medically Fragile Children
In State Foster Homes As Of May 2012

Placement	Children
Public Agency Foster Care–Basic	36
Public Agency Foster Care–Degreed	14
Public Agency Foster Care–Advanced	4
Public Agency Foster Care–Specialized*	1
Total	55

*The specialized designation in this case is the degreed medically fragile category.
Source: Compiled by Program Review staff from data provided by the DCBS Medical Support Section nurse administrator.

Private Agency Placements

Payments made to private placement agencies are based on the level of care the child needs. Medically fragile levels range from III to V. DCBS pays the private agencies for administration and training as well as per diem maintenance allowances.

Payments made by DCBS to private placement agencies are based on the level of care that a foster child must receive. Levels of care range from I to V. The higher the level of care assignment, the greater the supports and services needed by a child. Medically fragile children receive a level of care assignment of at least III (922 KAR 1:360). The payments made by DCBS to the private agencies cover administrative, training, and maintenance costs.

DCBS tries to use its own foster homes before those in private agencies. Private agency placements are often made for the most severe cases involving behavioral disorders along with a medically fragile condition.

DCBS' policy is to use private placement agencies as a resource of last resort, usually requiring private agency placement services in the most severe cases when no DCBS resource home is willing to accept a particular placement. Based on the TWIST data, children in private agencies were placed at Level V more often than at Levels III or IV in fiscal years 2010, 2011, and 2012. Private agency Level V care also includes cases of behavioral disorder and emotional disturbance.[34]

Designations Of Medically Fragile Children

Table 2.7 shows the designations of medically fragile children by placement category in fiscal years 2010, 2011, and 2012. As reflected by the record of maintenance payments in the expense reports, a child may be counted in more than one category in a year if a change in placement occurred that altered the placement level

or the nurse administrator altered the level of care between regular and specialized during the fiscal year. For example, if a child's cancer symptoms intensify during the course of the year to the extent that the program administrator elevates the level of care from regular medically fragile to the specialized level, the child would be counted twice. The FY 2011 and FY 2012 totals are less than the FY 2010 total because of, in part, a lag in reporting in some of the maintenance payments. In subsequent years, the totals for FY 2011 and FY 2012 will be amended and are likely to approach a level consistent with FY 2010.

Table 2.7
Designations of Medically Fragile Children By Type Of Placement
FY 2010 To FY 2012

	Designations Per Fiscal Year		
Placement	**2010**	**2011**	**2012**
Public Agency Foster Care–Basic	89	70	55
Public Agency Foster Care–Advanced	23	23	19
Public Agency Foster Care–Degreed	25	25	13
Public Agency Foster Care–Specialized	4	3	1
Public Agency Foster Care–Degreed Specialized	37	26	13
Private Agency Placement Level III	2	4	4
Private Agency Placement Level IV	9	11	10
Private Agency Placement Level V	22	23	14
Total designations	211	185	129
Total children	186	168	115

Source: Prepared by Program Review staff from data provided by DCBS' Division of Administration and Financial Management.

Expenditures

No distinct line item in the foster care budget is designated specifically for medically fragile foster care. Spending fluctuates depending on the number of children designated medically fragile and the level of care they require.

According to DCBS' Division of Administration and Financial Management, no distinct line item in the budget is designated specifically for medically fragile foster care administration. No predetermined budget amount is set aside for medically fragile foster care services. Spending fluctuates depending on the number of children designated medically fragile and the level of care they require. All payments related to foster children are made through the TWIST automated payment system.

Kentucky receives Title IV-E federal foster funds. Title IV-E is an open-ended entitlement funded with federal funds and state and local matching.

The state receives funding through the Title IV-E federal foster care program. Title IV-E is administered by state and local public child welfare agencies that assist foster children. The program is an open-ended entitlement funded with federal funds and state and

local matching. It is authorized under Title IV-E of the Social Security Act for foster children who meet eligibility requirements.

Training Costs

Training costs include the cost of providing short- and long-term training at educational institutions and in-service training for personnel employed by or preparing for employment by the state or a local public agency. DCBS staff were unable to separate all the training costs specifically pertaining to medically fragile children.

Training costs include the cost of providing short- and long-term training at educational institutions and in-service training for personnel employed by or preparing for employment by the state or a local public agency. DCBS was unable to separate all the training costs specifically pertaining to medically fragile children. It did provide the cost of the annual required training for medically fragile foster parents.

The Cabinet for Health and Family Services funds the University Training Consortium to provide various administrative and training support services for the cabinet.[35] The consortium provided $117,346 to the University of Kentucky Training Resource Center to fund training for medically fragile foster parents in FY 2013.[36]

Administrative Costs

The federal government pays 50 percent of eligible administrative costs under Title IV-E; Kentucky pays the remaining 50 percent. Administrative costs include activities necessary for the proper and efficient administration of the Title IV-E state plan. Reimbursable administrative activities under federal regulations include activities performed by the caseworker and the program administrator, service referrals, determination of Title IV-E eligibility, preparation for and participation in judicial determinations, placement of the child, development of the case plan, case reviews, case management and supervision, recruitment and licensing of foster homes and institutions, rate setting, costs related to data collection and reporting, and the proportionate share of related agency overhead. DCBS was unable to separate the administrative costs specifically pertaining to medically fragile children.

Per Diem Maintenance Payments

To calculate the annual costs for medically fragile children, Program Review staff used the DCBS per diem rates and the proprietary rates paid by DCBS to private placement agencies.

Program Review staff used TWIST expense reports to calculate the annual cost of per diems paid to medically fragile foster homes. Calculations were based on the per diem medically fragile maintenance rates assigned to DCBS foster homes and the proprietary rates paid by DCBS to private placement agencies on behalf of medically fragile children.[37] DCBS reimburses private placement agencies for medically fragile children assigned a III, IV, or V level of care.[38] Only rates that correspond with those levels of care were treated as medically fragile expenses.

Total per diem payments for medically fragile foster children were nearly $2.9 million in FY 2010, nearly $2.2 million in FY 2011, and nearly $1.7 million in FY 2012. At this time, the FY 2010 total is more likely to be accurate.

Table 2.8 shows that the total per diem payments for medically fragile foster children in DCBS and private placing agency foster homes were nearly $2.9 million in FY 2010, nearly $2.2 million in FY 2011, and nearly $1.7 million in FY 2012. The FY 2010 total is more likely to be accurate because payments are updated over time.[a] Only costs incurred in a specific fiscal year are represented for that year in the table.

Of the nearly $2.9 million in FY 2010, 32 percent was from federal Title IV-E funds, 39 percent was from state general funds, and 29 percent was from restricted funds.

Of the $2.9 million total cost incurred for per diems paid to medically fragile foster homes in FY 2010, 32 percent was from federal Title IV-E funds, 39 percent was from state general funds, and 29 percent was from restricted funds. Restricted funds include Supplemental Security Income (SSI) and child support payments from families of origin.[39]

Table 2.8
Total Per Diem Payments
FY 2010 To FY 2012

	2010		2011		2010	
Type Of Home	Payments	% Of Total	Payments	% Of Total	Payments	% Of Total
DCBS	$1,817,080	63.4%	$1,291,970	59.3%	$953,386	57.2%
Private placing agency	1,051,098	36.6	$887,266	40.7	$712,540	42.8
Total	$2,868,178	100.0%	$2,179,236	100.0%	$1,665,926	100.0%

Source: Prepared by Program Review staff from data provided by DCBS' Division of Administration and Financial Management.

For children who are eligible for Title IV-E, the federal government reimburses the state for the federal portion of the costs.

For children who are eligible for Title IV-E funds, the federal government reimburses the state for the federal portion of the costs. The Federal Financial Participation for Title IV-E foster care maintenance is the same rate as the Medicaid Federal Medical Assistant Percentage. For medically fragile children who are Title IV-E eligible, the federal government reimburses Kentucky for 71.18 percent of maintenance costs, and Kentucky covers the rest.[40]

[a] The expense report used to calculate the total annual cost for medically fragile foster care per diem payments reflects payments, or corrections to payments, disbursed during each fiscal year. Not all payments made in a fiscal year represent a cost that was incurred in that same fiscal year. If a delay in issuing a payment ensues, for example if a resource parent is late in submitting a monthly maintenance bill to DCBS, that payment might be issued and recorded in the next fiscal year. TWIST administrators also routinely adjust prior maintenance payments in subsequent fiscal years.

Eligibility for Title IV-E funding includes the following criteria.

- The family of origin must meet an income standard (1996 Aid to Families with Dependent Children requirements).
- The child must be a citizen of the US.
- The deprivation standard is met if at least one of the child's parents receives SSI, if one parent is unemployed for at least 30 days, or if the child lives in a single-parent household.
- The child must be under age 18.
- An order of removal must be produced by the court. The order must indicate that the child was removed because it is contrary to the welfare of the child to remain in the home or that it is in the best interest of the child to be removed from the home.[41]

SSI is a federal program with state matching that pays benefits to disabled adults and children who have limited income and resources. SSI maintenance payments for medically fragile foster children totaled $339,320 for FY 2010 to FY 2012. A child cannot receive funding from both Title IV-E and SSI, so DCBS determines which program will provide the most funding.

DCBS per diem maintenance costs for all medically fragile children totaled more than $6.7 million from FY 2010 to FY 2012. Nearly $2.9 million in payments was from Title IV-E funds, 43 percent of the total.

As shown in Table 2.9, DCBS per diem maintenance costs for all medically fragile children totaled more than $6.7 million from FY 2010 to FY 2012. Nearly $2.9 million in payments were from Title IV-E federal and state matching funds, 43 percent of the total. The remaining 57 percent of funding obligation was paid for from state funds or other sources such as SSI and mandated child support payments submitted by the parents of origin. TWIST mainly tracks IV-E payments and does not report details on any other available funding sources for foster children. Therefore, other matching/offsetting payments could not be determined from the data submitted to Program Review. The data can be used to analyze funding in terms of eligibility for Title IV-E, however.

Table 2.9
Per Diem Payments By Title IV-E Status
FY 2010 To FY 2012

Title IV-E Status	2010	2011	2012	Total	% Of Total
Title IV-E payments	$927,873	$605,710	$518,441	$2,052,024	30.6%
State IV-E matching	375,686	245,246	209,911	830,843	12.4
Eligible, not reimbursable	335,918	228,474	194,265	758,657	11.3
Not eligible	1,154,612	983,893	721,511	2,860,016	42.6
Pending start*	74,090	114,564	17,199	205,853	3.1
No status given	N/A	1,350	4,599	5,949	0.1
Total	$2,868,178	$2,179,236	$1,665,926	$6,713,341	100.0%

Note: Funding amounts are rounded to the nearest dollar, so totals may not exactly equal the sums of row or column entries.
*Pending start means that the child is recorded in TWIST as having been entered into care, but it is not yet known whether the child will qualify for Title IV-E funding.
Source: Prepared by Program Review staff from data provided by the DCBS' Division of Administration and Financial Management.

Over the 3-year period, $758,656 was paid in per diems for medically fragile children who would have been eligible for Title IV-E but for whom reimbursements were not made under the program. One reason for such ineligibility is that the court order did not document that reasonable efforts were made to keep the child in the home of origin.

Over the 3-year period, $758,656 was paid in per diems for medically fragile children who would have been eligible for Title IV-E but for whom reimbursements were not made under the program. One reason for such ineligibility is that the child qualified for higher payments through SSI and cannot be funded through both programs. Another reason is procedural. If a court order to remove a child from the home of origin does not indicate that reasonable efforts were made to keep the child in the home of origin, the social worker has 72 hours to go to court to get temporary custody of the child. The social worker has 60 days to ensure that reasonable efforts are made or that reasonable efforts were not documented in the original court order due to procedural error. If the 60-day requirement is not met, per diems for the foster child cannot be reimbursed using Title IV-E funds.[42]

Two other procedural problems with the court order may render a child ineligible for Title IV-E reimbursement.

Two other procedural problems with the court order may also remove Title IV-E reimbursement eligibility for a foster child who would otherwise be eligible. If the court order did not indicate that the child was removed because it is contrary to child's welfare to remain in the home or did not document that it is in the best interest of the child to be removed from the home, then the child is ineligible for Title IV-E.[43] These omissions are often the result of procedural error.

Table 2.10 shows the maintenance costs during FY 2010, FY 2011, and FY 2012 that were and were not eligible for reimbursement under Title IV-E and that could be addressed by DCBS. These amounts totaled more than $100,000 in FY 2012 but this is a significant decrease from previous years.

Table 2.10
Selected Types Of Payments Not Made Using Title IV-E Funds
FY 2010 To FY 2012

Reason	2010	2011	2012
Eligible, not reimbursable: reasonable efforts to keep child in home of origin not documented	$167,210	$24,878	$18,654
Not eligible: problems with court order	203,106	199,607	85,419
Total	$370,316	$224,485	$104,073

Source: Prepared by Program Review staff from data provided by DCBS' Division of Administration and Financial Management.

Cabinet officials address this concern through education programs for judges, court personnel, social workers, and others.

Cabinet officials note that this concern is addressed on an ongoing basis through education programs for judges, court personnel, social workers, and others involved in the process.[44]

Endnotes

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