

FFTA



LEVELS OF CARE *and* TREATMENT FOSTER CARE

Written for the Foster Family-based Treatment Association by Paul Stratton, Ph.D

PREFACE

The use of Levels of Care systems as a means of providing accountability and cost containment is a growing trend in foster care. Since the application of levels of care is relatively new in the field, there is not yet adequate information available for FFTA to either endorse or discourage its use. FFTA does however acknowledge that more and more states are considering LOC as a model of allocating funds for out-of-home care.

This paper examines some of the uses of levels of care in the child welfare system and attempts to identify the strengths and weaknesses of this model in serving children and youth in out-of-home care. The intent is to provide guidance to states that are considering the development or redesign of LOC systems.

FFTA will continue to monitor how levels of care is being applied in Treatment Foster Care and encourages providers to inform the association on how this model is working in their agencies.

INTRODUCTION

Making the best use of limited resources has prompted many states to examine the use of managed care methods for allocating funds for out-of-home care. Most often these methods involve preauthorization and periodic reauthorization (utilization review) of funding for out-of-home care services by using specific level of care definitions and structured assessment tools (FFTA Levels of Care Survey, 2005). This allows funding to be allocated proportional to the demonstrated level of need according to objective criteria for all children within specified groups and which apply to all service providers within defined service areas. Changes in children's needs result in changes in levels of care and funding. This allows providers to be paid for the service they perform for as long as that type of service and



intensity is needed. Changes in children’s level of care may also be used as outcomes and a method for provider accountability. Often levels of care represent a needs assessment by proxy, when assessment information is collected by persons other than those who translate the information into levels of care. Levels of care determine level of funding and also provide a support to decision-making for placement and service planning by state workers and providers.

The importance of front-end assessment to support such decision-making is emphasized by the reality that nearly half of all children in the child welfare system demonstrate clinically significant emotional and/or behavioral problems. By contrast, only about one fourth of those children have received specialty mental health care prior to or within six months of entering the social welfare system (Burns et al, 2004). Such high incidence of need has prompted some to regard the child welfare system as a “de facto public behavioral health care system” (Lyons & Rogers, 2004).

Providers of behavioral health care within the child welfare system, such as treatment foster care, may be reluctant to embrace managed care methods, such as levels of care. Psychologists, however, have had over 20 years of experience with managed behavioral health care, which, in addition to preauthorization and reauthorization of services, has emphasized time-limited, symptom-focused outpatient behavioral health care (Sanchez and Turner 2003). This has represented a dramatic shift from traditional service delivery patterns. In addition, by periodically reviewing consumers’ care and progress, a method for provider accountability was established. Despite provider concerns, research has indicated that objections to managed care have been based more on emotional reactions to perceived threats to professional prerogatives, power and autonomy and have not been based on empirically verified negative effects on consumers. Apparently these providers of behavioral health services have adapted to a changing work environment, and consumers have had their needs met, although often in different ways. Sanchez and Turner (2003) conclude that managed care, with its emphasis on empirically-based treatment, may actually serve as the impetus to establish the scientific foundations of training and practice in clinical psychology as originally conceived over 50 years ago.

LEVELS OF CARE INSTRUMENTS

The information necessary to determine the initial level of care (LOC) most often originates with the state worker who uses a variety of information collection tools. Once the child is in a placement, most of the information necessary to re-evaluate the LOC is furnished by the provider, with adjunctive information coming from other sources (FFTA Levels of Care Survey, 2005). There are many instruments available to make normative comparisons of specific behavioral or emotional patterns, such as the Achenbach Child Behavioral Checklist (CBCL, Achenbach & Rescorla, 2000), and may be used as part of the information needed for LOC assignments. Instruments that measure functional impairment are more often used to map observations onto specific LOC criteria. Winters et al (2005) provides a review of functional impairment scales, including those reviewed below.



The FFTA Levels of Care survey reports that 59% of the treatment foster care agency respondents use a diagnostic instrument. Three functional impairment instruments are most often used for LOC determinations, and these appear to have excellent psychometric characteristics (Winters et al, 2005). They are the Child and Adolescent Functional Assessment Scale (CAFAS, Hodges, 2000), Child and Adolescent Needs and Strengths (CANS, Lyons et al, 1999) and Child and Adolescent Service Intensity Instrument (CASII, AACAP, 2004). The latter was originally named the Child and Adolescent Level of Care Utilization System (CALOCUS). All require training to use properly, and periodic retraining is recommended. These instruments are descriptive, rather than norm-based, and are intended for defining needs and strengths at a point in time to be used for assessment, treatment planning and future comparisons.

The CANS has versions for child welfare, mental health, mental retardation and juvenile justice, each inquiring about issues important to needed treatment and placements in that domain. The user rates items on a four-point scale, and items inquire about specific narrowly defined issues, such as intellectual functioning, abuse experience, and psychotic symptoms. Each issue has detailed descriptors for each rating. It is unclear how the user translates this specific information into LOCs, although this may be individually negotiated during the development of local applications.

The CAFAS and CASII require the rater to consider specific issues to make inferences about general domains, such as “Role Performance” on the CAFAS and “Resilience” on the CASII. The CAFAS has eight child-specific domains that contribute to a total score and two caregiver domains. Of these three instruments the CAFAS has been in use the longest and is the most researched (Winters, et al, 2005). According to the FFTA Levels of Care Survey, the CAFAS is also the most frequently used instrument for making LOC decisions in treatment foster care. Of these three instruments the CAFAS is also the only one with a per use cost. The CASII has eight domains and specific decision-making recommendations for assigning LOCs according to the child’s needs and strengths. Daleiden (2004) assessed the CAFAS and the CASII in a large sample of children across a continuum of care. Although the instruments provided some of the same information, each made unique contributions to predicting outcomes for total costs, which were affected by intensity, duration and restrictiveness of services. The CAFAS was more strongly related to service intensity, and the CASII was more strongly related to service restrictiveness.

Often a commercially available instrument is not used to translate information into levels of care, with state or county agencies creating their own. For example, the Texas Department for Protective and Regulatory Services defined levels of care criteria through a committee of experts and contracted with Youth for Tomorrow to perform levels of care assessments (Leibgott & Foster, 2004). Information supplied by the state worker was used for the initial LOC and by the provider for subsequent LOCs. In 1996, the Kentucky Cabinet for Families and Children modified the Texas system to meet their needs and is discussed below. Both LOC systems report excellent reliability and validity, as well as cost savings.



KENTUCKY'S EXPERIENCE

The Kentucky (now) Cabinet for Health and Family Services, Department for Community-Based Services has used a levels of care system to determine funding level and to guide placement since 1996 through a contract with the Children's Review Program (CRP), which is a program of the Bluegrass Regional MH/MR Board, Inc, a community mental health center located in Central Kentucky. Currently levels of care are applied to all committed children ages four and above who are in or at risk of being placed in private residential or treatment foster care or in public foster care. Levels of care are assigned prior to admission and every three months (residential) or six months (foster care) thereafter. Five levels of care criteria have been defined, with level 5 reflecting the most intense needs. LOC definitions are periodically updated through a partnership between the Cabinet, CRP and providers. The LOC criteria and "gatekeeper" responsibilities are codified in administrative regulations (www.lrc.ky.gov/kar/922/001/360.htm).

Initial LOC information is supplied by the state worker, and by the provider for the LOC reviews. This information is organized around the child's needs and strengths in the areas of supervision, mental health, social, education, and medical, along with specific risk factors and previous placement information. The Achenbach CBCL provides an objective, norm-based description of recent child behaviors. Combined with developmental and clinical knowledge, this information is mapped onto the LOC criteria.

Over 9,000 level of care assignments are made and placements of over 2,800 children are finalized each year. As an assessment instrument the LOC has an inter-rater reliability of over 90%. Validity has been established by high correlations between the LOC and the Achenbach CBCL and the CAFAS, when done independently (concurrent validity). Moreover, the initial LOC is highly predictive of the long-term cost of care and the change in CBCL score during care (predictive validity). Perhaps more gratifying is that providers agree with the assigned level of care more than 90% of the time. Disagreements about the assigned LOC most often arise from incomplete or inaccurate information being submitted for LOC consideration and are quickly resolved through an appeals process.

Outcomes for children appear to have improved during the time that LOCs have been used to determine funding. For example, private placements for cohorts of children admitted during each calendar year were followed for three years. For cohort groups from 1997 through 2001 the proportion of time children spent in residential treatment has decreased and the time in treatment foster care has increased. Often treatment foster care was used as a step-down from residential treatment, when the child's behavior had improved and funding had decreased. Consequently, *on a per child basis*, the cost of out-of-home care has decreased with the use of levels of care. Moreover, with decreased length of stay in residential treatment programs, access to these programs was increased for children who had high intensity needs and previously had been on waiting lists.



A frequent complaint by providers is that decreased funding “causes” placement changes, and that such placement changes are inappropriate for the children’s needs. The data suggest an alternative interpretation. The foster home placements of 914 children in treatment foster care were followed for six months after a LOC review (i.e., until their next LOC review). Children’s LOCs on entering this study were: LOC 1 = 5.5%, LOC 2 = 16.1%, LOC 3 = 26.7%, LOC 4 = 26.7% and LOC 5 = 25.0%. The first LOC review resulted in the LOC being unchanged (57%), raised (19%) or lowered (24%). Compared to children whose LOC was not changed, children whose LOC was raised were more likely to move (55% vs 42%). They were also more likely to move out of the agency to a more restrictive placement, such as a psychiatric hospital (45% vs 34%), and less likely to move to a less restrictive placement, such as an adopted home (43% vs 52%). Children whose LOC was lowered were more likely, than those whose LOC was unchanged, to move out of the agency to a less restrictive placement (66% vs 52%) and less likely to move to a more restrictive placement (23% vs 34%). These placement changes are what one would expect if the LOC were an accurate assessment of children’s current needs.

Additional procedures within the Kentucky LOC system allow some safeguards for providers against financial loss. For example, if a provider submits the materials late for a LOC review, the per diem is not stopped, even though the administrative regulations allow for that to occur. This assures for continuity of funding. However, if the LOC review is done and results in a lower LOC, the Cabinet will recoup overpayments. Also, if a child’s needs suddenly increase, the provider or other interested party can secure an immediate increase in funding with a successful “appeal,” or redetermination, of an LOC. This requires providing evidence of the child’s increased need.

The Kentucky LOC system also allows for performance incentives when a provider’s good work has decreased a child’s level of need. (1) When the child’s needs decrease, the provider’s costs should decrease with less need for supervision, crisis intervention and such. However, the per diem will not decrease until the LOC is lowered at the next review date, which is up to three months (residential) or six months (foster care) later. (2) If the child remains in the same placement, the decreased per diem is not effective until 30 days after the LOC review date. During this time the child’s cost of care should have decreased, allowing a net gain for the provider. (3) If the provider appeals (requests an LOC redetermination) during the 30 days after an LOC has been lowered and is successful, the higher per diem remains in effect. This leaves no gap in funding, even though the LOC review resulted in a lower LOC. (4) A provider can accept a child with a “low” LOC and do a comprehensive assessment of the child within 30 days of admission. If that assessment justifies a higher LOC, the provider can request an LOC redetermination, and, if successful, the increased LOC will be retroactive to the day of admission. (5) If a child transfers from a residential treatment program to a treatment foster care program, the higher residential per diem remains in effect for 30 days. This provides an incentive for residential programs to transfer youth to their own treatment foster care programs, or for treatment foster care programs to take the risk of accepting a youth from a residential program.



ISSUES TO CONSIDER IN AN LOC SYSTEM

The following considerations reflect our experience and values as LOC providers in Kentucky and may be considered as new LOC systems are being constructed:

- 1) The provider of levels of care, like the Children's Review Program, should function within a collaborative partnership between itself and the funding agency and the service providers. Initially this may be represented by an Advisory Committee, which functions during the formative stages of LOC system development. Later this function may be achieved by focused, time-limited workgroups, where all parties participate in improving the LOC system.
- 2) The levels of care funding system should be applicable to all providers who provide the same services, so that a child receives the same funding regardless of which agency provides the services within a type of placement, e.g. treatment foster care.
- 3) Levels of care should be determined by the child's needs and strengths and be connected to level of funding. LOC should not determine type of placement. For example, recent research on in-home services and treatment foster care indicate that children with severe needs can be appropriately treated with effective supportive services.
- 4) The per diem associated with each LOC should be determined by a cost finding process that is based on the actual costs of providing the services necessary to meet children's needs at each level and should be periodically updated. Kentucky's cost-finding process is detailed in administrative regulations and open for review (www.lrc.ky.gov/kar/922/001/360.htm).
- 5) Levels of care determinations should not be influenced by the bottom line. Persons who assign LOCs, whether state employees or private contractors, should not have those decisions influenced by financial considerations. At the end of the budget year, the likelihood of receiving a high LOC should be the same as at the beginning of the budget year. Nor should the persons who assign LOCs be penalized by granting too many high LOCs.
- 6) The persons making LOC decisions should be professionally competent. They should have the training, experience and supervision needed to accurately assess children's needs and strengths. At the Children's Review Program we require a masters degree in psychology, social work or related field, and three years experience with youth who have severe emotional disabilities, preferably in an out-of-home care setting. The program director has a Ph.D. and is licensed for independent practice. A child and adolescent psychiatrist is available as a consultant.
- 7) The LOC is an assessment, even if by proxy. Therefore, the LOC should be able to have demonstrated reliability and validity. Different LOC reviewers should arrive at the same LOC, and the



LOC should be correlated to other instruments that are intended to measure the same constructs. Moreover, the LOC should be able to predict future resource utilization and costs. The LOC should also be based on multiple sources of information. Our data on initial LOCs indicate that the objectively scored, norm-based Achenbach Child Behavior Checklist supplements the state worker's narrative report and improves the reliability and validity of our LOCs. The state worker's report summarizes information from multiple sources, often including the family, court, school and previous treatment providers.

- 8) The LOC determination should be completed in a timely manner to meet the children's needs for continuity in placement and service planning. There should be specific expectations about how long it should take to do an initial LOC, an LOC review, and an appeal (LOC redetermination). Timeliness of each is important, as they influence the children's access to needed services and ultimately permanency.
- 9) If the child's needs increase, e.g. as a result of a new trauma, it should be possible to increase funding through an appeal by requesting a redetermination of the LOC at any time during placement. This should be able to be initiated by any interested party, such as the service provider, state worker, advocate, youth or parent, supplying evidence of the increased need.
- 10) If the result of an appeal is not satisfactory to the requestor, there should be a process for a higher level appeal outside the LOC provider, perhaps with the LOC funding agency.
- 11) The criteria and process of determining LOCs should be transparent and open to public review. The LOC reviewer should be able to state the rationale for each LOC in such a way that an outsider can determine whether or not the evidence supports that LOC.
- 12) The LOC provider should be publicly accountable. For example, there should be a mechanism for a provider organization to ask for a review of the pattern of LOCs given or otherwise question LOC decisions.

SELF-DEFEATING BEHAVIORS TO AVOID

Our experience and discussions with providers have indicated that there are some things that some providers do which are self-defeating, including to their own budget. The following are offered for consideration:

- 1) **Hiding.** Be part of the solution by participating in discussions while the LOC system is in its formative stage. Encourage a collaborative partnership. Be an advocate for your program and your children to insure that the rules are unambiguous and fair and that there are safeguards against



sudden financial changes for your program. Work with the LOC funding agency to insure that the cost-finding methodology is also unambiguous and fair. Continue to participate in all available workgroups to stay informed and advocate for your interests.

- 2) **Believing that levels of care will go away or that they do not apply to your program.** Learn as much as you can about LOC, and establish a “liaison” staff person who has the responsibility of staying informed about LOC issues and updating staff.
- 3) **Regarding LOC as “just more paperwork.”** Your program’s survival and growth, in part, depends upon meeting financial goals, and the LOC is about securing adequate funding for the costs of meeting children’s needs. The new paperwork is about requesting LOC funding. Funding may not be adequate if the materials for LOC reviews are submitted late or lack sufficient detail or specificity for a reviewer to determine the children’s needs. The materials to request LOC funding should be an extension of your staff’s ongoing assessment of the children’s needs and consistent with service planning. It should all be the same information, just in a different format.
- 4) **Letting requests for LOC funding go unsupervised.** Create a system for tracking due dates and staff compliance. Require that the materials be prepared prior to the due date and have a supervisor who knows the case review and sign off on the requests for LOC funding. This should facilitate the on-time submission of thorough and accurate reports. It is just as bad to have requests for LOC funding that under-represent children’s needs as it is to over-state those needs.
- 5) **Being shy about requesting an LOC appeal.** The LOC provider expects there to be appeals, and not doing so denies your program the funds needed to meet children’s needs. Appeals are part of the dialog which is necessary for the partnership to work. Sometimes LOC providers make mistakes in interpreting information or data entry, and sometimes program staff are not sufficiently thorough in their reports. Know the LOC criteria and how the information on your staff’s report match those criteria. Between LOC reviews children’s needs may vary dramatically, perhaps due to a new trauma, and a successful appeal can make the needed adjustment in funding.
- 6) **Failing to plan.** Since your program does help children, at some point the children’s needs will decrease and funding will decrease. This has implications for your program’s budget. If children are to remain in the program, the budget should accommodate the full range of funding for children while in the program. Similarly, if foster parents are reimbursed proportional to the LOCs of their foster children, they need to plan their family budget on the “average” LOC, rather than on always having the same LOC as when the children first join their family.
- 7) **Cultivating bad attitudes about LOC.** Cognitive behavior therapy has taught us that self-defeating emotions and behaviors most often originate with self-defeating attitudes and beliefs. Agency leadership should be proactive by setting the stage for positive attitudes about LOC.



For example, it is not helpful to believe that reduced LOC is a “punishment” for success. To the contrary, it is like your family doctor who helps you through an illness, and, as a consequence, you are not scheduled for another appointment. This is an expected outcome of good medical care. Similarly, a reduced LOC is a positive outcome which reflects good work. What is new is that now funding is proportional to the cost of meeting children’s needs. The good news is that, when successful treatment leads to improved behavior, the reduction in per diem will be delayed until the next LOC review, which most likely is months away.

CONCLUSION

In response to limited resources more states are looking to managed care methods and specifically to levels of care to authorize and periodically review and reauthorize funding for out-of-home care. This evolution has taken place in behavioral health care over the past 20 years. Successful providers of behavioral health have learned how to work with the managed care system and now are optimistic about positive systemic results. Treatment foster care may experience a similar evolutionary process. At first denial, anger and resistance may be expected from some. Those who survive and grow past this point may then engage in negotiation and acceptance. Many of the providers who have not survived in Kentucky have been those who were caught up in their denial, anger and resistance and have engaged in some of the self-defeating behaviors outlined above.

Our experience in Kentucky has shown that children are not harmed by levels of care and most will benefit from less restrictive placements. Moreover, the state benefits from some cost savings. The providers benefit from a rational, transparent cost-finding process and a funding process that is uniformly applied to all providers. Our experience has led us to believe that a fair and equitable LOC system can be constructed and implemented. The success of that system will, in part, be due to the ability of the state or county and providers to establish a collaborative partnership in pursuit of their common goal, moving children toward permanency.

Author’s Notes: Paul Stratton, Ph.D. is the Director of the Children’s Review Program. This is a program within the Bluegrass Regional MH/MR Board, Inc., a community mental health center in central Kentucky (www.bluegrass.org), and is funded by the Kentucky Cabinet for Health and Family Services. The content of this report was originally presented to the 3/8/2005 FFTA Policy Institute, Washington, D.C. and is available on the FFTA website.



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