

## **RESEARCH ABSTRACT**

**Foster Family-based Treatment Association's  
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### **Levels of Care and Treatment Foster Care: Kentucky's Five Years of Experience and How Providers Make the Best of It**

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#### **Introduction**

The Children's Review Program is a program within the Bluegrass Regional MH/MR Board, Inc. (a community mental health center) and is under contract with the Kentucky Cabinet for Health and Family Services' Department for Community-Based Services. Since 1996, the Children's Review Program (CRP) has assigned levels of care (LOC) to children in the custody of the Cabinet who are entering private residential treatment programs. Since 1999, CRP has also assigned LOCs to children entering private treatment foster care programs, as well as public foster care. A child's LOC defines the funding for private residential or foster care treatment and is reviewed periodically to insure that the LOC reflects the child's current level of need.

The Children's Review Program is designed around the Cycle for Performance Improvement and has the mission of improving children's lives by supporting state workers and providers with the data and information needed for performance improvement. Consequently, children's LOCs are integrated with placement decisions, outcomes and standards of care measurement, and case, program, and state level consultation. The LOC has proven to be a reliable and valid assessment tool, even though the LOC is based on documents and not face-to-face contact.

The present studies reflect on the CRP's experience with LOC since its implementation in Kentucky. We examine the impact of LOC on placement stability in treatment foster care, outcomes, access, resource utilization, and costs. This presentation was made by a representative of CRP and a veteran TFC provider. The attendees engaged both presenters in a lively discussion on the merits of LOC and how to survive and thrive with LOC funding.

#### **Issues Studied**

1. In TFC, how do Level of Care (LOC) reviews influence placement changes?
2. Has LOC contributed to changes in outcomes over the years?
3. Has LOC increased access to residential treatment facilities?
4. Has LOC helped change the use of residential vs. foster care treatment?
5. Has LOC helped reduce the per-child-cost of out-of-home care?

## Population Studied

The studies reviewed in this presentation focused on children and youth who were committed to Kentucky's Cabinet for Health and Family Services and placed in private residential or foster care treatment programs between 1996 and 2004.

## Research Results

- 1. LOC changes and placement stability** was studied with 911 children in private treatment foster care programs who had LOC reviews completed between January 2004 and June 2004. The LOC review could produce an increase or decrease in LOC (experimental group) or the same LOC (control group). Of the 911 LOC reviews, 57% produced no change in LOC, with 19% producing an increased LOC, and 24% producing a lower LOC. Overall, within six months after the LOC review approximately 44% of the children moved, regardless of LOC change. Whether the LOC was lowered or raised, out-of-agency placements appeared to be appropriate to the increased or decreased level of need indicated by the LOC. With LOC lowered, most children went to less restrictive placements, such as a home, and regardless of placement restrictiveness, were at least as likely to stay there as if the LOC were unchanged.

With LOC increased, most children went to more restrictive placements if the original LOC was 4 or 3, indicating higher treatment needs. With the original LOC being 2 or 1, indicating low level treatment needs, children with increased LOC were more likely to go to less restrictive placements, such as home. The success of these placements is difficult to judge due to low numbers of children. Overall, it appears that within six months of a LOC change only slightly more children moved, and those moves appear to have been appropriate to the level of need indicated by the LOC.

- 2. LOC and outcomes** were studied for residential treatment discharges from 1999 to 2004 and treatment foster care from 2000 to 2004. Data for "planned discharge rate" and "in less restrictive placement four months after discharge" showed no meaningful increase or decrease over the years studied, suggesting that LOC had no impact on outcomes at this gross level of analysis.
- 3. LOC and access to residential treatment facilities** was studied between 1997 and 2004. While the number of admissions more than doubled, the average length of stay decreased only slightly (median = 25 days; mean = 90 days). This suggests that LOC alone can account for part of the increase of admissions, through the mechanism of lower LOCs encouraging a discharge to less restrictive (and less costly) placements.
- 4. LOC and RTF vs. TFC utilization** was studied by following children in placement for three years after they began a private residential or foster care treatment program, beginning with admissions during 1997. The percentage of time during the three years that was spent in residential programs decreased dramatically, as opposed to the dramatic increase in the percentage of time spent in treatment foster care. This suggests that decreasing the LOC (and subsequently the per diem) encourages utilization of less costly foster care placements.
- 5. LOC and cost of care** was studied with the same children as #4 mentioned above, with time in each placement multiplied by the appropriate per diem for the LOC in 2001 dollars. Since 1997, the cost per child for three years of residential care has decreased, as opposed to

treatment foster care, which has increased. Combined costs for three years of private residential and foster care decreased over the years; this represented an overall cost reduction of over three million dollars per year, comparing admissions in 1997 to 2001.

### **Implications for Practice**

Although LOC funding programs appear to present an additional administrative burden to TFC providers, as well as an intrusion into their independence, these data show that LOC does not force providers to make inappropriate placement changes. By contrast, it appears that LOC funding programs encourage more referrals to foster care, as opposed to residential treatment programs, indicating a source of growth for the foster care industry.

The study also detailed the advantages of using a LOC system, such as funding following the child and the LOC being an assessment to inform placement decision making. Overall, in Kentucky, it has been our experience that LOC has helped residential and foster care providers transition from a model of long-term custodial care to a model of focused treatment with shorter-term care and increased movement toward permanency.

In addition, the presenters discussed financial safeguards (e.g., a successful LOC appeal within 30 days is retroactive to the date the LOC change was made) and performance incentives (e.g., even if the costs of children's care decreases due to improved behavior, the LOC will not change until the next LOC review date, which is up to six months away). TFC providers should encourage these safeguards and incentives in developing LOC programs.

A survey of Kentucky TFC providers gave numerous suggestions on how to survive and even thrive with LOC funding. Some suggestions were to become actively engaged in developing the LOC system, become well-informed on LOC procedures, hold staff accountable for meeting due dates for LOC reviews and supervising those progress reports, and encouraging staff to have positive attitudes toward LOC.

Much of the above is presented in greater detail in "Levels of Care and Treatment Foster Care" by Paul Stratton, Ph.D. (2005) and is available from the Foster Family-based Treatment Association at [http://www.ffa.org/publicpolicy\\_advocacy/locpaper.pdf](http://www.ffa.org/publicpolicy_advocacy/locpaper.pdf).

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