Examining the Foster Care Reimbursement System and the Impact on the Prescribing of Psychotropic Medication

A report from
The Department of Family and Protective Services

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Executive Summary

Senate Bill 6, Section 1.65, passed by the 79th Texas Legislature and signed by Governor Rick Perry, mandated DFPS to study the Level of Care System to determine whether the System creates incentives for prescribing psychotropic medications to children in foster care. DFPS was also required to include proposed changes to the System in response to the findings.

DFPS subject matter experts discussed and reviewed the roles of key stakeholders involved in the Service Level System to determine whether there are any incentives to prescribe psychotropic medication for children in foster care. The key stakeholders involved in the Service Level System include the third-party contractor (Youth For Tomorrow), Residential Childcare Providers, Medical Consenters, and Physicians. Subject matter experts also reviewed the Service Level System policies and procedures to determine whether there is any inherent indication that prescribed psychotropic medication influences the service level determination.

The Texas Service Level System is the process for reviewing and assessing the documentation that determines the authorized service level for children needing more than basic services. There are four service levels – Basic, Moderate, Specialized, or Intense. Each service level has a specific rate of reimbursement, set by the Health and Human Services Commission, for residential childcare providers and is directly linked to the services required to meet each child's needs.

Subject matter experts determined that the Service Level System does not appear to increase the likelihood that psychotropic medications will be prescribed to children in foster care. Service level determinations are based solely on the documentation in each child's clinical records. The documentation must describe the child's current adaptive behaviors/functioning and behavioral/medical services required to meet the child's needs. Documentation regarding specific psychotropic medications does not influence the service level determination because the medication alone does not describe the child's current adaptive behaviors/functioning or services needed.

An unintended consequence of the Service Level System is that inaccurate or unbalanced documentation may influence the perceived service level needs of a child as documentation in the clinical records drives the service level determination. Although uncommon, the activity of unbalanced documentation involves overstated characteristics, behaviors, or conditions of a child that might increase the perceived service level needs of the child. Unbalanced documentation in the clinical records of a child is indicated by discrepancies in documentation of the various members of the child's treatment team. Although unbalanced documentation may occur infrequently, DFPS is formalizing

procedures to address these concerns through regional and state office reviews of specific cases. DFPS will determine whether a random sample of other children's records will be reviewed for the same residential childcare provider. A service level peer review that currently exists within DFPS may be conducted for an unbiased review of the case-specific documentation. The peer review will allow DFPS, YFT, the childcare provider, and the peer review committee to discuss and resolve concerns about the quality of information documented in a child's records.

Subject matter experts determined that other reasons exist for the prescription of psychotropic medication regardless of the Service Level System including the desire to manage very real behavioral difficulties in an effort to stabilize and preserve placements, and improve academic performance of children in foster care. However, these incentives to use psychotropics are ameliorated by legislatively mandated measures and DFPS policy and contracting requirements that increase accountability, scrutiny, and judicial review of medical care for children in foster care, including the use of psychotropic medications. Each child in foster care has a medical consenter who is required to complete training on informed consent and participate in each medical appointment of the child. This requirement will help ensure that individuals making medical decisions for children in foster care are knowledgeable of the child's medical needs and make informed decisions concerning all medical care, including consent to psychotropic medication use. DFPS has also implemented the use of *Psychotropic Medication Utilization Parameters for Foster Children* in DFPS policy and residential childcare contracts. These parameters were developed by a team of experts and provide prescribing guidelines for physicians and criteria indicating the need for further review.

Senate Bill directed HHSC to develop a statewide healthcare delivery model for children in DFPS conservatorship. Each child in foster care will have a medical home and a health passport to help ensure continuous, coordinated medical care. The expected implementation date of this model is September 1, 2007. The healthcare delivery model vendor will be required to implement and follow the *Psychotropic Medication Utilization Parameters for Foster Children* through prior authorization and retrospective review functions. In addition, medical review teams will be established to provide peer consultations regarding appropriate psychotropic medication prescribing practices. Until the healthcare delivery model is implemented, HHSC, DSHS, and DFPS are coordinating to implement interim strategies to assure appropriate prescribing of psychotropic medications to children in foster care.

Subject matter experts recommend that DFPS increase education and training about the Service Level System for residential childcare providers and CPS staff in order to ensure that thorough and accurate documentation is submitted to YFT so that appropriate services are authorized for children in foster care. In addition, the group recommends that DFPS formalize procedures for handling concerns

about inaccurate or unbalanced documentation in clinical records of children in foster care.

Introduction

In May 2005, the 79th Texas Legislature passed Senate Bill 6 (SB 6) outlining comprehensive reform of DFPS. SB6 required a study of incentives to the prescribing of psychotropic drugs for children in foster care. DFPS was mandated to study the level of care system to determine whether the system creates incentives for prescribing psychotropic medications to children in foster care. DFPS must also include proposed changes to the level of care system in response to the findings.

Children in foster care are at higher risk for physical and behavioral health issues due to their experiences of abuse and neglect, separation from their families, etc. It is common for children in foster care to struggle developmentally, emotionally, behaviorally, socially and academically. Psychotropic medication is one method of health treatment for children in foster care who experience significant behavioral problems. Psychotropic medications are drugs that affect the central nervous system resulting in changes in thinking, behavior or emotion. Psychotropic medication may be prescribed for mood disturbances, anxiety, some impulse control problems and confused thinking.

When a child is placed into foster care, CPS staff consults with the child's caregivers, parents, teachers, and other collateral persons to obtain information about the child's needs. The child's current adaptive behaviors and behavioral/medical needs determine the authorized service level for that child. The Texas Service Level System is the process for reviewing and assessing the documentation that determines the authorization of the appropriate service level for children needing more than basic services.

If CPS staff determines that a child requires more than basic services, specific documentation must be submitted to the third-party contractor, Youth For Tomorrow (YFT), for an assessment of the child's service level needs. YFT is required to review the records of CPS children who require more than basic services and determine whether the child requires a higher service level. There are four possible Service Levels:

- Basic
- Moderate
- Specialized
- Intense

Each service level has a specific rate of reimbursement, set by the Health and Human Services Commission, for residential childcare providers and is directly linked to the services required to meet each child's needs.
For a list of rates for 24-hour residential child-care reimbursements, see Appendix A.
For definitions of the different service levels, see Appendix B.

YFT also reviews the services that residential childcare contractors and CPS foster homes provide to children who require Moderate through Intense services. For Moderate service levels, YFT reviews the current clinical records of children every 12 months. For Specialized and Intense service levels, YFT reviews the current clinical records every 3 months. In fiscal year 2005, YFT completed 4,871 initial service level authorizations, 21,365 service level re-authorizations, and 234 service-system monitoring reviews.
For more information about the history of YFT, see Appendix C.

Study Approach

DFPS subject matter experts comprised of state office level staff members discussed and reviewed the roles of key stakeholders involved in the Service Level System to determine whether there are any incentives to prescribe psychotropic medication for children in foster care. The key stakeholders involved in the Service Level System, either directly or indirectly, include:

- Third-Party Contractor - Youth For Tomorrow (YFT) determines service levels for children requiring more than basic services
- Residential Childcare Providers (foster parents, child-placing agencies, residential treatment centers)
- Medical consenters (parents, foster parents, CPS, etc.)
- Physicians

Stakeholders play an important role in determining the needs and services for children in foster care. Therefore, a review of the roles and responsibilities of each stakeholder, in the context of the Service Level System, was undertaken. Service Level System policies and procedures were also reviewed to determine whether there is any inherent indication that psychotropic medications will influence the service level determination. This approach presented DFPS the opportunity to determine not only whether incentives exist but also to explore any unintended consequences as each stakeholder strives to fulfill its primary purpose.

Discussion

What follows is a discussion about the functions of each stakeholder within the Service Level System:

Third-Party Contractor - Youth For Tomorrow (YFT)
In determining a child's service level, YFT focuses on the child's adaptive behaviors/functioning, current behavioral/medical health needs, and services required to meet the child's needs. YFT does not rely on the diagnoses or types and numbers of prescribed medications when determining a child's service level.

Some children who require the use of psychotropic medication may also need additional medical and behavioral health services and increased supervision. YFT takes into consideration the ongoing services required to meet the medical and behavioral health needs of children in foster care. The increased provision of services, in some cases, will result in higher authorized service levels. However, the use of such medications may modify the child's behavior sufficiently so that fewer services and less supervison is required; thus, allowing the service level to be lowered.

If a residential childcare provider disagrees with YFT's service level determination for a child, they may appeal the decision to YFT. If the provider disagrees with the results of YFT's administrative review, the provider may request a review by the CPS Service Level Peer Review Committee to examine the documentation presented to YFT. The purpose of the Peer Review process is to review YFT's findings regarding compliance with the Service System indicators and the results of service level reviews. This review process assists DFPS in a final resolution of problems related to the Service Level System.

YFT is required to regularly review the clinical records and services provided to children in foster care who require Moderate, Specialized, or Intense levels of service. In doing so, YFT has an opportunity to identify and report to DFPS concerns about the types of services provided to children in foster care. One such concern includes the possibility of inaccurate or unbalanced documentation in a child's clinical records. In response to concerns about the services provided to children, DFPS programs including Child Protective Services, Residential Childcare Licensing, and Contract staff may research and review the concerns to determine whether any corrective action is required.

In an effort to ensure consistency in authorizing service levels, YFT has a quality assurance (QA) program that is an essential component of the administration of their services. The QA plan seeks to identify performance trends or patterns, including personal biases or beliefs, that are inconsistent with YFT policies and procedures or the Service System. The major goals of the QA program are to ensure the highest level of accuracy and consistency in providing contract services, to identify areas needing improvement, to initiate policy and procedure revisions and develop staff training to support revised policies and procedures.

In conclusion, YFT does not make service level determinations based on the numbers or types of psychotropic medications prescribed for a child. YFT has a comprehensive QA program that works to ensure consistency and the highest quality of services to children in foster care. YFT identifies and reports to DFPS concerns regarding the quality of services provided to CPS children in residential settings.

Residential Childcare Providers (Contractors and CPS foster parents)

Residential childcare providers have a responsibility to provide safe and secure environments for children in their care. They are also required to provide the appropriate level of supervision and services required for each child. In doing so, they must also maintain current and detailed documentation in each child's clinical records.

Residential childcare providers and medical consenters may request or suggest that physicians prescribe medication for some CPS children in an effort to relieve the very real behavioral health needs and symptoms of those children. YFT authorizes service levels based on the clinical documentation regarding a child's adaptive behaviors/functioning and the services required to meet the child's needs. If a child taking psychotropic medication requires increased monitoring or medical testing, the service level may rise; however, the use of this medication may actually reduce the service level if the resultant child behaviors require fewer services or if the medication controls behaviors resulting in the need for fewer services.

It is possible that inaccurate or unbalanced documentation in a child's records occurs as a result of personal biases or lack of understanding normal versus abnormal child behavior. Because service levels are authorized based on the information documented in children's records, unbalanced documentation might influence service level determinations. DFPS must also consider the possibility that despite improved provider documentation, a provider may document in such a way to influence service level determinations. Unbalanced documentation in the clinical records of a child is indicated by discrepancies in documentation of the various members of the child's treatment team. Although unbalanced documentation may occur infrequently, DFPS is formalizing procedures to address these concerns through regional and state office reviews of specific cases. DFPS will determine whether a random sample of other children's records will be reviewed for the same residential childcare provider. A service level peer review may be conducted for an unbiased review of the case-specific documentation. A service level peer review may be conducted for an unbiased review of the case-specific documentation. The peer review will allow CPS, YFT, the childcare provider, and the peer review committee to discuss and resolve concerns about the quality of information documented in a child's records.

DFPS relies on the community of residential childcare providers to provide the highest quality of care and services for children in foster care. These residential providers are reimbursed for their services based on the authorized service level for each child. This review of the residential childcare provider role in the use of psychotropic medications indicates that DFPS may need to provide additional information and training about the Service Level System policies and procedures and the need for accurate and detailed documentation. This increased understanding and improvement in the accuracy of documentation should further

the ability of YFT to determine the most appropriate service levels for children in foster care.

Medical Consenters

Texas Family Code §266.004 requires the court to authorize an individual or DFPS to consent for medical care for a child in DFPS conservatorship. If DFPS is authorized then DFPS must designate an individual to consent to medical care and notify the court. DFPS designates:

- A professional employee of an emergency shelter when the child resides in an emergency shelter;
- The child's live-in caregiver when the child resides in a family-like setting, such as a foster home or kinship placement; or
- DPFS staff when the child resides in a staffed residential facility, unless the child has an involved relative or fictive kin willing to serve as medical consenter.

Medical consenters are required to complete a DFPS-approved training on informed consent and participate in each medical appointment of the child. These medical appointments include reviews by the healthcare provider of the progress of children prescribed psychotropic medications as required every one to three months by DFPS policy, Service Level Indicators, Licensing Minimum Standards for Child-Placing Agencies and Residential Child Care Contract Standards. Medical consenters who are not DFPS employees are required to keep DFPS updated about the medical care provided to the child and to notify DFPS by the next business day of a prescription of a psychotropic medication or Schedule II-V drug (controlled substance).

Medical consenters face many challenges when making medical decisions in the best interests of children in DFPS conservatorship who, often, are struggling developmentally, socially, emotionally, behaviorally and academically. They may view the use of psychotropic medications as a means for managing real behavioral difficulties, preserving placements, and improving academic performance. DFPS will continue to explore education and/or training opportunities for medical consenters to enhance their abilities to make informed medical decisions for children.

Physicians

Physicians providing care for children in foster care face a number of obstacles:

- Frequent lack of a complete and accurate physical, behavioral, and social history of the child necessary to do a comprehensive evaluation
- Presentation of the child for treatment when in crisis and needing immediate decision-making without information described above
- Lack of knowledge or understanding of the foster care system
- Lack of knowledge of or access to other behavioral health services to refer these children to for ancillary or supporting services

- Lack of compensation for the ancillary services necessary to do a thorough assessment

The above factors operate independently of the current design of the Service Level System. Unfortunately, these obstacles may result in reluctance of physicians to treat this population.

Current Initiatives

There are a number of new requirements that hold stakeholders accountable for the roles they have in providing services to children in foster care. Although System stakeholders may have different reasons to suggest the use of psychotropic medications, there are now measures that create additional protections for children. These include:

- The structure of the Service Level System and YFT's quality assurance efforts to ensure consistency in authorized service level determinations. YFT has no incentive to base service level determinations on the types or numbers of psychotropic medications;
- Judicial review of medical care as required by Texas Family Code (TFC) §266.007. TFC requires DFPS to include a summary of medical care in court reports that DFPS submits for hearings required under TFC §263 or more frequently if ordered by the court.
- The requirement for medical consenters who are not DFPS employees to notify DFPS within one business day after the prescribing of psychotropic medications or Schedule II-V drugs (controlled substances);
- The implementation of the *Psychotropic Medication Utilization Parameters for Foster Children* in February 2005. The *Parameters* have since been implemented in policy and residential childcare contracts and will be incorporated into the new child care licensing minimum standards; and
- Efforts by the Health and Human Services Commission (HHSC), the Department of State Health Services (DSHS) and DFPS to assess the use of psychotropic medications by children in foster care and to assist healthcare providers in using psychotropic medications more appropriately. DFPS efforts include the hiring of nurses and developmental disability specialists in each region who are available for case consultations.

Texas Family Code, Chapter 266.003 directs HHSC to design a comprehensive healthcare delivery system for children in foster care. The expected implementation date of this new system is September 1, 2007. The new healthcare delivery system will implement and follow the *Psychotropic Medication Utilization Parameters for Foster Children* through prior authorization and retrospective review functions. In addition, medical review teams will provide

peer consultations regarding appropriate psychotropic medication prescribing practices.

Prior to the implementation of the healthcare delivery model, HHSC, DSHS and DFPS are coordinating to assess the use of psychotropic medications by children in foster care and to implement short-term strategies to encourage appropriate prescribing of these medications. In June 2006, HHSC released a report on the *Use of Psychoactive Medication in Texas Foster Children in FY '05,* based on an analysis of Medicaid claims and medical prescription data. Short-term strategies to encourage appropriate prescribing of psychotropic medication include:

- Distribution of newsletters to physicians;
- Development of future reports on psychotropic medication use by children in foster care;
- Establishment of goals to lower percentages of children whose psychotropic medication regimens fall outside the parameters; and
- Establishment of focus groups with top physician prescribers.

Significant procedures and protocols are either already in place or in preparation to ensure there are effective protections for children and appropriate supports for those providing or securing services, including psychotropic medications, for children in foster care.

Conclusion

As a result of this review to determine if Service Level System incentives exist for the use of psychotropic medication, the following conclusions were identified:

- The process of determining a child's service level is dependent on the clinical documentation about the child's adaptive behaviors and functioning, and the services required to meet the child's needs.
- If documentation is inaccurate or unbalanced, a child may be authorized for an incorrect service level.
- A child's prescribed psychotropic medications do not alone influence service level determinations.
- Psychotropic medications that might require increased supervision or medical testing may influence the service level determination if the prescribed services are documented in the child's clinical records.
- DFPS and YFT policies and procedures do not create incentives within the Service Level System for the use of psychotropic medications.
- The passage of SB6 resulted in increased protections for children in foster care, as there is more accountability, scrutiny, and judicial oversight of the decisions to prescribe psychotropic medications for children in foster care.

- The Texas Legislature, HHSC, DSHS, and DFPS have taken appropriate and critical steps to ensure the appropriate and safe use of psychotropic medications for children in foster care.
- Texas Family Code §266.004 requires the court to authorize an individual or DFPS to consent for medical care for a child in DFPS conservatorship. Medical consenters are required to complete a DFPS-approved training on informed consent and participate in each medical appointment of the child.
- DFPS has also implemented the use of *Psychotropic Medication Utilization Parameters for Foster Children* in DFPS policy and residential childcare contracts. These parameters were developed by a team of experts and provide prescribing guidelines for physicians and criteria indicating the need for further review.
- Senate Bill directed HHSC to develop a statewide healthcare delivery model for children in DFPS conservatorship. Each child in foster care will have a medical home and a health passport to help ensure continuous, coordinated medical care.

Recommendations

1. DFPS should develop and implement education and training about the Service Level System for residential childcare providers and CPS staff in order to ensure that thorough and accurate documentation is submitted to YFT so that appropriate services are authorized for children in foster care.

2. DFPS should formalize procedures for reviewing concerns about the services provided to children in foster care including concerns about inaccurate or unbalanced documentation in the records of children in foster care. As such case-specific concerns are identified, regional and state office reviews will be conducted. A service level peer review may also be conducted for an unbiased review of the case-specific documentation. CPS will determine whether a random sample of other children's records will be reviewed for the same residential childcare provider.

3. Once implemented, HHSC and DFPS should collaborate with the new healthcare model for children in foster care to assess the availability and utilization of integrated behavioral and physical health services.

Appendix A

The following rates were effective September 1, 2005 through August 31, 2006.

Rate Structure	FY 2006 Foster Care Daily Rates*
Basic CPA	$37.00
Basic Foster Family	$20.56
Basic Facility	$37.00
Moderate CPA	$67.32
Moderate Foster Family	$35.97
Moderate Facility	$82.22
Specialized CPA	$89.68
Specialized Foster Family	$46.25
Specialized Facility	$118.20
Intense Child Placing Agency	$164.45
Intense Foster Family	$82.22
Intense Facility	$207.62
Emergency Shelter	$96.61

The amounts below are the minimum amounts that a child-placing agency must reimburse its foster families for clients receiving services under a contract with DFPS.

Service Level	Minimum Daily Amount to be Reimbursed to a Foster Family
Basic	$20.56
Moderate	$35.97
Specialized	$46.25
Intense	$82.22

Appendix B

Service Level System Characteristics and Definitions

Basic Service Level

The Basic Service Level consists of a supportive setting, preferably in a family, that is designed to maintain or improve the child's functioning, including:

- routine guidance and supervision to ensure the child's safety and sense of security;
- affection, reassurance, and involvement in activities appropriate to the child's age and development to promote the child's well-being;
- contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
- access to therapeutic, habilitative, and medical intervention and guidance from professionals or paraprofessionals, on an as-needed basis, to help the child maintain functioning appropriate to the child's age and development.

Children who need Basic Services

A child needing basic services is capable of responding to limit setting or other interventions. The children needing basic services may include one or more of the following characteristics:

- transient difficulties and occasional misbehavior;
- acting out in response to stress, but episodes of acting out are brief; and
- behavior that is minimally disturbing to others, but the behavior is considered typical for the child’s age and can be corrected.

- Developmental delays or mental retardation whose characteristics include minor to moderate difficulties with conceptual, social, and practical adaptive skills.

Moderate Service Level

The Moderate Service Level consists of a structured supportive setting, preferably in a family, in which most activities are designed to improve the child's functioning including:

- more than routine guidance and supervision to ensure the child's safety and sense of security;
- affection, reassurance, and involvement in structured activities appropriate to the child's age and development to promote the child's well-being;
- contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and

- access to therapeutic, habilitative, and medical intervention and guidance from professionals or paraprofessionals to help the child attain or maintain functioning appropriate to the child's age and development.

In addition to the description above, a child with primary medical or habilitative needs may require intermittent interventions from a skilled caregiver who has demonstrated competence.

Children who need Moderate Services
A child needing moderate services has problems in one or more areas of functioning. The children needing moderate services may include:

- One or more of the following characteristics:
  - frequent non-violent, anti-social acts;
  - occasional physical aggression;
  - minor self-injurious actions; and
  - difficulties that present a moderate risk of harm to self or others.

- Abuses alcohol, drugs, or other conscious-altering substances and:
  - substance abuse to the extent or frequency that the child is at-risk of substantial problems; and
  - a historical diagnosis of substance abuse or dependency with a need for regular community support through groups or similar interventions.

- Developmental delays or mental retardation marked by:
  - moderate to substantial difficulties with conceptual, social, and practical adaptive skills to include daily living and self-care; and
  - moderate impairment in communication, cognition, or expressions of affect.

- Primary medical or habilitative needs including assistance with:
  - occasional exacerbations or intermittent interventions in relation to the diagnosed medical condition;
  - limited daily living and self-care skills;
  - ambulatory with assistance; and
  - daily access to on-call, skilled caregivers with demonstrated competency.

Specialized Service Level
The Specialized Service Level consists of a treatment setting, preferably in a family, in which caregivers have specialized training to provide therapeutic, habilitative, and medical support and interventions including:

- 24-hour supervision to ensure the child's safety and sense of security, which includes close monitoring and increased limit setting;

- affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being;
- contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
- therapeutic, habilitative, and medical intervention and guidance that is regularly scheduled and professionally designed and supervised to help the child attain functioning appropriate to the child's age and development.

In addition to the description above, a child with primary medical or habilitative needs may require regular interventions from a caregiver who has demonstrated competence.

Children who need Specialized Services
A child needing specialized services has severe problems in one or more areas of functioning. The children needing specialized services may include:

- One or more of the following characteristics:
  - unpredictable non-violent, anti-social acts;
  - frequent or unpredictable physical aggression;
  - being markedly withdrawn and isolated;
  - major self-injurious actions to include recent suicide attempts; and
  - difficulties that present a significant risk of harm to self or others.

- Abuse of alcohol, drugs, or other conscious-altering substances that results in:
  - severe impairment because of the substance abuse; and
  - a primary diagnosis of substance abuse or dependency.

- Developmental delays or mental retardation marked by:
  - severely impaired conceptual, social, and practical adaptive skills to include daily living and self-care;
  - severe impairment in communication, cognition, or expressions of affect;
  - lack of motivation or the inability to complete self-care activities or participate in social activities;
  - inability to respond appropriately to an emergency; and
  - multiple physical disabilities including sensory impairments.

- Primary medical or habilitative needs that require assistance with:
  - regular or frequent exacerbations or interventions in relation to the diagnosed medical condition;
  - severely limited daily living and self-care skills;
  - non-ambulatory or confined to a bed; and

- constant access to on-site, medically skilled caregivers with demonstrated competencies in the interventions needed by children in their care.

Intense Service Level

The Intense Service Level consists of a high degree of structure, preferably in a family, to limit the child's access to environments as necessary to protect the child. The caregivers have specialized training to provide intense therapeutic and habilitative supports and interventions with limited outside access, including:

- 24-hour supervision to ensure the child's safety and sense of security, which includes frequent one-to-one monitoring with the ability to provide immediate on-site response.
- affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being;
- contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child, to maintain a sense of identity and culture;
- therapeutic, habilitative, and medical intervention and guidance that is frequently scheduled and professionally designed and supervised to help the child attain functioning more appropriate to the child's age and development; and
- consistent and frequent attention, direction, and assistance to help the child attain stabilization and connect appropriately with the child's environment.

In addition to the description above, a child with developmental delays or mental retardation needs professionally directed, designed and monitored interventions to enhance mobility, communication, sensory, motor, and cognitive development, and self-help skills.

A child with primary medical or habilitative needs requires frequent and consistent interventions. The child may be dependent on people or technology for accommodation and require interventions designed, monitored, or approved by an appropriately constituted interdisciplinary team.

Children who need Intense Services

A child needing intense services has severe problems in one or more areas of functioning that present an imminent and critical danger of harm to self or others. The children needing intense services may include:

- Characteristics include one or more of the following:
  - extreme physical aggression that causes harm;
  - recurring major self-injurious actions to include serious suicide attempts;
  - other difficulties that present a critical risk of harm to self or others; and

    - severely impaired reality testing, communication skills, cognition, expressions of affect, or personal hygiene.

- Abuse of alcohol, drugs, or other conscious-altering substances that includes a primary diagnosis of substance dependency in addition to being extremely aggressive or self-destructive to the point of causing harm;

- Developmental delays or mental retardation marked by:
    - impairments so severe in conceptual, social, and practical adaptive skills that the child's ability to actively participate in the program is limited and requires constant one-to-one supervision for the safety of self or others; and
    - a consistent inability to cooperate in self-care while requiring, constant one-to-one supervision for the safety of self or others.

- Primary medical or habilitative needs that present an imminent and critical medical risk and characteristics include one or more of the following:
    - frequent acute exacerbations and chronic, intensive interventions in relation to the diagnosed medical condition;
    - inability to perform daily living or self-care skills; and
    - medical supervision, 24-hour on-site, to sustain life support.

Appendix C

History of Youth for Tomorrow

Youth for Tomorrow, originally known as Paul Anderson Youth Home, was established as a non-profit, residential program in 1960 to serve homeless children and was located in Lewisville, Texas. The program was reorganized in 1985 and renamed Youth for Tomorrow (YFT). In 1988, the YFT Board of Directors closed the program, which remained a legal but dormant organization until November 1990.

In November 1990, the Board of Directors responded to a Request for Proposals to provide LOC support services to the Texas Department of Family & Protective Services (DFPS). DFPS awarded the contract to YFT effective January 1, 1991. YFT is a private, non-profit organization. Each year, YFT competes through a competitive process for a contract with the Texas Department of Family and Protective Services.

In 1997, the Texas Legislature mandated the Level of Care (LOC) Service System beginning September 1998. Prior to implementation, the State of Texas reimbursed residential providers based on license type. The LOC Service System was developed as a method of directly relating reimbursement to the needs of individual children and to promoting the development of multiple levels of care within facilities in order to minimize the movement of children as their care needs change.

Since 1998, there have been many changes and enhancements to the System. During FY 03, DFPS substantially revised the LOC System. A major change converted the six (6) levels of care to four (4) service levels. The new services are referred to as Basic, Moderate, Specialized and Intense. Each service level has a different rate of reimbursement for residential providers. The new Service Level System went into effect on September 1, 2003.

Service Level System

In terms of the Service Level System, YFT provides the following services:

1. Authorizes initial services at the Moderate, Specialized, or Intense levels;
2. Conducts Utilization Reviews to re-authorize services;
3. Conducts annual Service System Implementation Monitoring of residential contractors and DFPS regional child placing agencies;
4. Conducts Service Level System Implementation Reviews for respondents to the residential request for proposals.

Initial Service Levels

CPS caseworkers and supervisors are required to submit the following documentation to YFT in order to request initial service levels (Moderate, Specialized, Intense):

- Service Level Authorization Request Form
- Common Application
- Psychological or psychiatric evaluation completed within 14 months, or
- Physician's evaluation describing medical conditions or disabilities, etc.

YFT uses this documentation to develop an understanding of each child's behaviors, social history, needs, and current risk indicators.

Residential providers may accept foster children who are new to conservatorship at a Basic service level, except in residential treatment centers. If the residential provider determines within the first 45 days of substitute care that the child needs more than Basic services, then the provider may submit the required documentation to YFT for an initial service level.

Utilization Reviews (UR) for Re-Authorization of Services

YFT conducts utilization reviews to re-authorize services for children at the Moderate, Specialized, and Intense levels. Children needing Moderate services are re-authorized every 12 months and children needing Specialized or Intense services are re-authorized every 3 months. YFT does not conduct scheduled utilization reviews for children placed in emergency shelters, juvenile detention, hospitals, and placements with families or relatives. YFT completes the utilization reviews by reviewing the clinical records for the previous 30 days, which are submitted by the residential provider and/or CPS.

Typically, a clinical record includes a current service or treatment plan, individual and group therapy reports, daily caregiver reports, school records, medical reports, any recent special evaluations, serious incident reports and any other documentation that describes the child's current needs.

When residential providers believe that a CPS child needs a higher service level, DFPS requires that providers contact the child's CPS caseworker to review the matter. If the CPS caseworker agrees that the child's service needs should be reviewed, the CPS caseworker requests a copy of the clinical record for the previous 30-days, attaches an Authorization Request Form, and forwards this information to YFT for a non-scheduled review.

Service System Monitoring Reviews of DFPS Residential Contracts

YFT conducts annual quality assurance reviews of the Service System indicators implemented by residential programs contracting with DFPS. This monitoring of residential caretakers is a way to review the types and quality of services provided to children in their care and to determine whether services provided meet the needs of children requiring Moderate, Specialized, or Intense levels of service.