

# MICHIGAN MEDICALLY FRAGILE FOSTER CARE

This report provides an overview of the Medically Fragile Foster Care Analysis & Planning project facilitated by Arbor Circle child welfare services.

# ACKNOWLEDGEMENTS

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The **Medically Fragile Foster Care Analysis & Planning** project was funded by a grant awarded by the Michigan Health Endowment Fund. The project has been data-driven and focuses on five groups of individuals tasked with the safety of medically fragile children involved with the Michigan child welfare system: courts, medical providers, child welfare staff/agencies, biological parents/family, and foster/adoptive/relative caregivers.

A group of individuals with lived experience and professionals from the child welfare, court, and medical systems worked together on this project from 2019 - 2022. In addition to workgroup and subcommittee members, over the course of these years, numerous professionals and community members engaged in this project through sharing data and personal stories, vetting documents, organizing trainings, providing feedback, and more. Their contributions have been integral to the process and have ensured that individuals from diverse backgrounds and various Michigan community-types had their perspectives and experiences interwoven throughout this project. Additional thanks to the Michigan Department of Health and Human Services for providing data, allowing staff participation, and giving feedback throughout this project.

This report was written and edited by Amy Bailey, LMSW, Child Welfare Director at Arbor Circle. The contents of this report were created through participation and contributions from the individuals identified on page 9 of this report.

# OVERVIEW OF THE PROBLEM

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The term “medically fragile children” refers to children who experience prolonged dependency on medical care to sustain health and at times, prevent fatality. There is a wide range of medical conditions which are included in this category such as, but not limited to, children who (a) are dependent upon medical equipment such as tracheostomies, heart monitors, feeding tubes, ventilators, etc. (b) have chronic health conditions such as brain or spinal cord injuries, AIDS, genetic disorders, etc., and (c) may have dually diagnosed developmental disabilities such as cerebral palsy, spina bifida, autism, seizure disorders, etc.

Medically fragile children involved with the child welfare system are often viewed as the most vulnerable of an already vulnerable population (foster care) and some research suggests they experience the highest levels of Maltreatment in Care. These children can be difficult to place in family settings and require highly skilled resource (relative/foster/adoptive) parents. Case management and permanency planning for these children can be difficult for child welfare staff, attorneys, and judges who are not trained in medical treatment and may lack a full understanding or access to information related to all of the child’s diagnoses and how these impact the child’s well-being. Medical providers serving these children may not understand the nuances of the child welfare and court systems, and therefore may not provide medical information in a way that allows those entities to make safe recommendations and decisions for the child.

Within the state of Michigan, the foster parents of medically fragile foster children are eligible for an increased daily rate through their foster care payments which helps offset some of the costs of caring for the children. These rates are referred to as Determinations of Care (DOC’s) and within this funding bracket, there are four levels with Level I being the children with lowest needs/caregiver intervention and Level IV being the children who have the highest risk of fatality and hospitalization and require the highest level of care to maintain health stability and sustain life.

# CREATING THE SOLUTIONS

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## Creating a Common Goal

To address the multi-layered barriers noted on page 3, this workgroup developed the following goal: *Create integrated services for a medically fragile child's care within the multi-layered systems of child welfare, healthcare and the court to improve outcomes related to health, safety, permanence, & well-being*



## Implementing Change

To reach this goal, the workgroup completed the following objectives:

- Gather & analyze available data on medically fragile children in foster care who are identified as having a Level 3 or Level 4 Medically Fragile Determination of Care (DOC).
- Create trainings, tools, and resources for the five primary stakeholder groups (child welfare staff, courts, medical providers, biological parents/family, and foster/adoptive/relative providers).
- Increase availability of resources through creation of a website. This website can be found at <https://mimffc.org/>
- Provide recommendations to MDHHS for consideration of a statewide Medically Fragile Treatment Foster Care model.

## Overview

The data gathered and reviewed during this project was specific to approximately 300 medically fragile children in foster care between 2017-2021, with Level 3 and 4 Medically Fragile DOCs. The following data is relevant to this project and final recommendations:

- Of the data sample, 83% are ages 0-5
- Racial data for the data sample was identified as 52% white, 47% Black/African American, and 1% Native American/American Indian
- Median length of stay for Black/African American children is longer in almost every discharge category with discharge to adoption being the largest disparity
- Permanency/exit data: 58% adoption with a median length of stay of 780 days; 16% reunification; 16% had not yet achieved permanency; the remainder of the data sample exited the system through guardianship, death, or emancipation
- 57% were placed in non-metro communities
- Primarily served by Private Agency Foster Care (PAFC) providers
- The higher the DOC, the more likely the child is to be placed in a licensed unrelated foster home
- Median number of placements is 5 (includes hospitalizations over 14 days)
- 47% have at least 2 hospitalizations of 14 days or more; hospitalization median number of days per stay is 42 days

## Data Gaps

Through this process it was found that robust data is not readily available on medically fragile children involved with CPS only. Additionally, data regarding children who have only resided in a hospital setting following removal is limited within the context of this project. Lastly, data for children who have only been placed with a non-respondent parent and/or fictive kin placement is not available. These data gaps are due to the focus being connected to children with Level 3 and Level 4 DOCs which can only be determined once a child is in a family setting.

## SPECIAL CONSIDERATIONS

The following items were given special consideration during this project:

- Impact of racial bias within medical, court and child welfare systems
- Complexities for families whose primary language is not English and/or individuals who are undocumented
- Barriers for secondary caregivers, particularly fathers and same-sex couples

## LIMITATIONS

The following subsets fell outside the scope of this project and need further assessment and consideration:

- Medically fragile youth who are aging out of foster care and have unique transitional needs
- Medically fragile children that have co-occurring behavioral and/or emotional needs in conjunction with medical complexity



# RECOMMENDATIONS

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Through the work of this project, it is recommended that Michigan Department of Health and Human Services implement a Medically Fragile Treatment Foster Care (MF-TFC) model in Michigan that is comprised of the following team members and programming with correlating policy requirements:

- A foster care worker that possesses a Master's Degree in Social Work or other comparable field. Additional face to face contacts should be required as well as participation with all of the child's medical appointments. To accommodate these expectations, the worker should have a lowered case-load of 6 cases.
- A pediatric registered nurse that assists with implementing the permanency plan through (1) completing monthly home visits to child's home, (2) supervising parenting times and providing medical care if needed during this time, (3) providing trainings related to the child's specific medical needs to biological parents or other placements such as relative caregivers or adoptive parents, and (4) assistance that supports a successful transition of medical care back to the biological family or other permanent placement.
- A care-coordinator or "way-finder" that (1) maintains weekly contact with the placement provider, (2) acts as an insurance mediator, (3) assists with referrals to specialized services, (4) assists with proper equipment needs such as Durable Medical Equipment, dedicated circuits, etc, and (5) coordinates the child's care with other providers such as Community Mental Health, schools, etc.
- A specialized recruitment staff or team to increase the pool of resources and assist with building a respite provider system.
- Increased per diem administrative rates to support providers with covering higher service costs.
- Respite care available for the medically fragile child as well as other children in the home when the medically fragile child is in need of increased care due to hospitalizations, destabilized health, etc.
- Peer support programming and monthly support groups for biological parents and for foster/relative/adoptive caregivers
- Performance Improvement staff who conduct ongoing, intensive evaluation and reporting of program implementation and outcomes.
- On-call availability of MF-TFC staff 24 hours a day, 7 days a week.

# RECOMMENDATIONS CONTINUED

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In addition to a formal MF-TFC model, the following recommendations should also be considered by MDHHS:

- Statewide roll-out of CPS Investigation and Ongoing Checklists to support best practice. These tools can be found at <https://mimffc.org/downloadable-tools/>
- Until a model can be implemented, increase case involvement of the Health Liaison Officer (HLO) specific to serving Level 3 and Level 4 DOC medically fragile children involved with the child welfare system (ex: attendance at all Family Team Meetings, attendance and testimony at court hearings, maintaining direct contact with placement providers through a minimum of monthly contact, etc).
- Coordination with State Court Administrative Office (SCAO) to implement statewide use of Judicial and Lawyer Guardian Ad Litem (LGAL) "Best Practice Guide for Medically Fragile Children in Child Protective Proceedings." These tools can be found at <https://mimffc.org/downloadable-tools-2/>
- Request assignment of Court Appointed Special Advocates (CASA) to all children who qualify for a Level 3 or Level 4 medically fragile DOC.
- Utilization of secondary level questions for all Centralized Intake allegations involving medically fragile children and/or medical neglect.
- Additional data tracking and analysis specific to data gaps and limitations noted within this report.
- Utilization of the project website <https://mimffc.org/> statewide

# MEDICALLY FRAGILE FOSTER CARE WORKGROUP & SUBCOMMITTEE MEMBERS

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For additional information on this project and to review and utilize tools connected to serving medically fragile children involved with the child welfare system, please see the project website found at <https://mimffc.org/>

Requests for training may be submitted to [abaileylmsw@gmail.com](mailto:abaileylmsw@gmail.com)