

GUIDE TO F-RATE CRITERIA

In using this guide, the determination of appropriate and fair reimbursement rates for those caring for children with medical problems is based upon the specific medically related activities that the caregiver must perform in caring for the child. As diseases may vary in their intensity from one child to another, the value of assessing the specific care that is required for each individual child allows a more objective measure in the determination of an appropriate rate of reimbursement.

The following information is to be used to supplement the F-Rate Criteria Procedural Guide and the F-Rate Documentation form. It is suggested that the CSW observe the activities that must be delivered by the caregiver. Consultation with the DCFS office PHN is encouraged.

1. ASSISTING WITH DAILY LIVING TASKS BEYOND THE LEVEL EXPECTED FOR CHILD'S AGE DUE TO A SERIOUS MEDICAL PROBLEM

Newborns and infants require caregivers to assist with all tasks that are necessary to sustain and enhance life. The caregiver must assume all responsibility for feeding, bathing, helping with ambulation, and dealing with the process of elimination. As children age and develop, they normally learn how to take over many of the activities of daily living functions a caregiver must perform during their early years. In some cases, a serious medical or developmental problem may impair a child's ability to learn or execute these tasks of daily living. When a child has a serious medical problem and a caregiver must perform activities that assume responsibility for daily living tasks beyond the level expected for the child's age, an F-rate reimbursement should be considered.

A serious medical problem is defined (in this context) as a medical problem which:

- a. Lasts longer than two weeks.
- b. Requires a physician's intervention after diagnosis in order to treat the illness.
- c. Significantly impacts the level of care required to be delivered to the child by the caregiver.

A serious medical problem does not include common childhood illnesses that are acute in nature and limited in duration.

1-A EATING

Often children with medical problems or developmental delays have trouble taking in enough food to sustain life and promote growth. They may have trouble sucking, swallowing, chewing, or taking food to their mouth. Some children must have special diets where the food intake is measured in calories, fats, and proteins such as for a diabetic diet, or they must be monitored to safeguard against eating certain food substances that may cause an allergic or other life-threatening reaction.

Some feeding problems are common and should not be considered to be a problem warranting an F-rate. During feeding, newborns and young infants may become "fussy" after consuming just a few ounces of formula. This occurs because the child swallows air during feeding and needs to be burped. After burping, the child usually quiets down and resumes feeding. Whenever possible, the CSW should observe the feeding process to determine the approximate length of time and relative difficulty encountered. Questions concerning the feeding process and requirement for special techniques should be directed to the office PHN.

EATING - LEVEL 1

FEEDING 30-60 MINUTES: At this level, infants or children who take a longer than "normal" time to feed (30-60 minutes) due to a medical problem are considered. The most common medical problems that can prolong feeding times include prematurity, prenatal drug exposure, esophageal reflux, or neurological defects. Prematurity and prenatal drug exposure can cause the infant to be irritable, have poor sucking reflexes, and be overall "slow feeders." Eating problems associated with prenatal drug exposure and prematurity usually are self-limiting and resolve in a matter of months as the child grows and learns the eating process. Esophageal reflux, a condition where the child requires slow feedings with frequent burping and correct positioning to allow the food to move slowly down the digestive tract and not to be constantly regurgitated (vomited), is common in some diseases.

Some cases of esophageal reflux require surgical correction and some resolve on their own, depending upon the underlying medical problem. Neurological

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deficits such as cerebral palsy, stroke, and head trauma can affect the nerve process involved in sucking and swallowing.

SUPERVISED SELF-FEEDING: Also at this level are children who require supervised self-feeding due to medical problems. These children are at an age that usually requires minimal supervision to feed themselves without difficulty. Children who require caregiver assistance and supervision may have difficulty in eating due to neurological problems such as cerebral palsy or Down syndrome which may cause tongue thrust, poor lip closure, or abnormal gag and swallowing reflexes. The caregiver must monitor the child closely during feeding to prevent or treat choking.

EATING - LEVEL 2

FEEDING MORE THAN 60 MINUTES: At this level, infants or children who require over 60 minutes in order to take in an adequate amount of nutrients are considered. Any of the medical problems noted under 1-A, Level 1 also can result in "extremely" prolonged feeding times that last longer than one hour.

CAREGIVER FEEDING REQUIRED: Level 2 also considers the child who is old enough to self-feed, but is unable to do so because of a medical problem. This may be due to any of the previously mentioned neurological problems.

SPECIAL DIET: Included at Level 2 are those children who must have a special diet requiring special meal preparation and monitoring of their response to the food consumed, e.g. failure to thrive. Most commonly, this involves the diabetic child who must maintain a strict diet and take insulin medication in order to adequately control the level of sugar in the blood. This category also includes those children who must limit their salt (sodium) intake due to heart problems or protein intake due to kidney problems.

FAILURE TO THRIVE: Activities involved at this level include caring for a failure-to-thrive child. A failure-to-thrive child may initially show signs of increased irritability during feedings and it is often difficult for the caregiver to ensure proper nutritional intake. A failure-to-thrive infant may arch his/her back, cry, refuse to suck from a bottle, and may even spit up food or formula

that is placed in the mouth. Feeding difficulties with these children is usually time-limited and should disappear in a matter of months.

EATING - LEVEL 3

INTERMITTENT G-TUBE: Intermittent G-tube feedings mean that the child is fed a liquid diet through a tube that is surgically inserted directly into the stomach or intestine through the abdomen. Any of the previously mentioned medical problems can interfere with food intake to the point that this method of eating must be used to sustain the child's life. The caregiver must learn how to administer the tube feedings and monitor the child for possible aspiration (choking) that can occur if the fluid goes in too fast and backs up into the child's throat. Wound care around the site of the tube insertion into the stomach is required and it also may be necessary to prepare the child for possible future oral food intake (e.g., training the child to suck and receive oral stimulation by the use of a pacifier during the tube feedings).

SPECIAL FEEDING TECHNIQUES: Special feeding techniques that may be required to facilitate food intake are also considered at this level. Children who have cleft palates may require special feeding techniques (positioning, holding the jaw or cheeks during feeding) or equipment (e.g., special bottles and nipples) which enable them to suck and swallow without aspirating (inhaling) the formula. A cleft palate, or opening in the roof of the mouth that leads into the nasal cavity, makes it difficult to suck and swallow. Special nipples and feeding techniques are often used to feed the infant until surgery can be performed to close the opening. Special feeding techniques are usually taught by hospital nursing personnel, and the caregiver must spend a period of time at the hospital prior to the child's discharge to learn the proper feeding procedure.

SPECIAL DIET: Considered in Level 3 are those caregiver activities that require the preparation of special diets, strict diet planning, and close diet monitoring where errors in food intake could endanger the child's life. Very severe food allergies can result in anaphylaxis (a life-threatening allergic reaction requiring caregiver knowledge of the use of an EPINEPHRINE PEN) and may be difficult for the caregiver to prepare diets that are devoid of these substances. Examples are allergies associated with peanuts, shellfish, artificial

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colorings, and wheat or other grains that may be partial ingredients in many commonly eaten foods.

NOTE: This category does not include “intolerance” problems, such as “milk intolerance.” Often wrongly called a “milk allergy,” this problem is due to the child’s inability to digest lactose (milk sugar) effectively, resulting in gastrointestinal problems such as gas or diarrhea. This problem is not “allergic” in origin, nor is it life-threatening. Milk intolerance problems can easily be avoided with the current market availability of soy-based (milk-free) infant formulas and “lactose free” or “lactose reduced” milk products.

Also considered in this category are those diets that must be planned and monitored to avoid foods that may cause severe intellectual disability in children who have Phenylketonuria (PKU). Children with PKU lack the necessary enzyme needed to break down proteins found in meats, milks and cheeses. It is extremely difficult to prepare diets that supply an adequate amount of protein necessary for growth and development while avoiding animal proteins which the child cannot effectively metabolize.

EATING - LEVEL 4

CONTINUOUS G-TUBE FEEDINGS: Continuous G-tube feedings are considered at this level. G-tube feedings require that the child be fed on an almost continuous basis via an electrically powered pumping device (Kangaroo). As mentioned previously, a G-tube is a tube that is surgically inserted through the abdomen into the child's stomach or intestine. Continuous feedings are often done when the child cannot absorb large amounts of formula during one feeding, and instead must have a slow, continuous drip.

NG TUBE FEEDINGS: NG tube feedings require that the caregiver insert a tube through the child's nose and into the stomach for each feeding. This is required when the child is unable to suck or swallow adequately, but is expected to overcome the problem within a relatively short period of time. This technique requires that the caregiver learn the procedure (usually from hospital nursing personnel), and take great care to closely monitor the child before and

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after feedings. The potential of accidentally putting the tube and instilling the formula into the infant's lungs is always present.

PARENTERAL NUTRITION: Parenteral nutrition (total parenteral nutrition or "TPN") is the instilling of a clear liquid (electrolyte) diet directly into the child's veins. This is done when the child's stomach and intestines are unable to tolerate, absorb, or digest formula feedings. An intravenous (IV) line (sometimes called a central line) is inserted into a major vein (usually inside the child's chest or neck) and a prescription "formula" is slowly infused by a pumping device. The risk of infection that can be life-threatening and dislodgment of the tube is very high in these children.

1-B HYGIENE

Caregivers who must perform activities related to the child's hygiene beyond the level expected for the child's age are included in this section. "Hygiene" refers to the activities that must be done to maintain body cleanliness and promote health. Included in hygiene activities are bathing, brushing teeth, dressing, and maintaining the cleanliness of the child's clothing and bedding.

HYGIENE - LEVEL 1

HYGIENE 4-7 YEARS, INCLUSIVE: This level involves hygiene activities that must be delivered to children between the ages of 4 through 7 years, inclusive. A child of this age should, under normal circumstances, be able to independently perform many of these activities, but is unable to do so due to a medical problem. Medical problems can include neurological deficits, injury or trauma. Casted extremities requiring the assistance of caregiver are to be included in this category.

HYGIENE - LEVEL 2

HYGIENE 8 YEARS OR OLDER: This level involves children age 8 or older who are unable to adequately perform hygiene activities on their own. The problems may be identical to those listed in Level 1, but due to the increased

body size of the older child, the workload and activities of the caregiver are expected to be greater.

1-C ELIMINATION

Considered in this category are children with medical or developmental problems that are manifested by an inability to control bladder or bowel functions, or reliance on appliances to facilitate elimination.

ELIMINATION - LEVEL 1

4 YEARS OR OLDER AND NEEDS ASSISTANCE: Children 4 or older who need caregiver assistance with toileting due to medical problems are considered at this level. This *also* includes children who are nighttime bed-wetters (nocturnal enuresis) or who soil their beds with fecal matter (nocturnal encopresis). Nighttime bedwetting may be associated with neurological disorders, specific diseases, or a genetic tendency that runs in families.

ELIMINATION - LEVEL 2

4 YEARS OR OLDER WITH ENURESIS OR ENCOPRESIS: Children 4 or older who have no bladder and/or bowel control day and night due to a medical problem are considered at this level. Most likely, children who require this level of activity are those with severe neurological disorders.

ELIMINATION - LEVEL 3

INTERMITTENT CATHETERIZATION, COLOSTOMY, URETEROSTOMY: Children who require the use of appliances to facilitate the elimination of body wastes require this level of caregiver activity. The term "Appliances" refer to the tubes and bags that are used to collect wastes external to the body. The term "appliances" includes the use of catheters (tubes) that must be inserted by a caregiver into the bladder periodically to drain urine e.g. indwelling catheter; ureterostomy and ureteroileostomy appliances which are surgically implanted tubes that drain urine contents into a collection bag worn by the child; and, colostomy and ileostomy appliances, which are also surgically implanted tubes

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that drain to bags worn by the child to collect fecal matter. Surgically implanted tubes and their collection bags must be monitored closely for signs of internal infection, skin breakdown or erosion, and/or impaction or blockage. Wound care around the site of insertion must be done frequently, and the appliance must be changed when full or soiled.

ELIMINATION - LEVEL 4

DIALYSIS: Peritoneal or hemodialysis. Many children who have kidney disorders must receive dialysis to internally regulate the elimination of wastes from their body fluids. The child must be connected to a filtering (dialysis) machine via an intravenous (IV) route (i.e., "shunt") which is surgically implanted. Treatments are done daily or less frequently (every other day, every three days, etc.) in medical treatment centers, depending upon the severity of the child's medical condition. Some children may have devices that can be used at home during their sleeping hours. Children who require this level of care are usually candidates for kidney transplants. They are very prone to infection and must have their diet closely regulated. If a home dialysis device is to be used, the caregiver must receive intensive instruction in the use of this equipment.

1-D AMBULATION

The child who is over two years of age and whose ability to ambulate on his/her own is impaired due to medical problem is considered in this category.

AMBULATION - LEVEL 1

Age 2 years or over that require prescribed orthopedic corrective devices (e.g. A.F.O.'s - ankle, foot orthotics) that are time limited.

AMBULATION - LEVEL 4

NON-AMBULATORY: Care for any child age two or over who is non-ambulatory (unable to walk unassisted) is considered at Level 4. Children who are dependent upon a wheelchair, gurney, braces or walker for mobility.

Any age with extensive casting.

Note: A child who is unable to leave a burning building without assistance is considered non-ambulatory.

1-E VISION/HEARING

VISION HEARING LEVEL 1

Eye Prosthesis: Child has an eye prosthesis following an enucleation (removal of the eye) for any reason.

VISION/HEARING - LEVEL 2

Legally blind or hearing impaired requiring the use of assistive devices to hear: Children who are legally blind or children who are hearing impaired, but able to hear with the use of assistive devices are considered at this level.

Children who are legally blind may have some eyesight, but usually this is very limited. The legally blind child may require special glasses in order to discern shapes, or need to learn Braille in order to read.

The child who is hearing impaired but able to hear with the use of assistive devices will need the caregiver's supervision to be sure the assistive device is working properly and being worn.

VISION/HEARING - LEVEL 4

Totally blind or profoundly deaf and unable to hear with assistive devices.

Children who are totally blind are considered at this level.

Also considered at this level are the children who are profoundly deaf and are unable to hear even with the use of assistive devices. The caregiver is to communicate using American Sign Language (ASL).

2. ADMINISTERING MEDICAL OR DEVELOPMENTAL REGIMENS

This category includes performing medically related activities that are prescribed by a physician for the caregiver to perform. Caregivers who must deliver medical treatments and therapy in the home usually are instructed in the correct procedures by the hospital of discharge or by visiting home nurses. **It is required that the physician clearly indicate in writing the medical services to be delivered by the caregiver.**

2-A SURGICAL/WOUND CARE

Caregiver activities may be required (usually on a time-limited basis) to care for children who have undergone a trauma and/or surgery that requires extensive wound care. In most cases, the caregiver must be trained by hospital medical staff in the proper wound care procedures to be followed.

SURGICAL/WOUND CARE - LEVEL 2

ESTABLISHED CEREBRAL SHUNT CARE: At this level, children with cerebral (brain) shunts are considered. An established cerebral shunt is one that has been in place for more than six months. Cerebral shunts are tubes that are inserted into brain cavities (ventricles) to drain excess levels of fluid that accumulate. The tubes usually drain into the abdomen or major blood vessels internal to the child. Cerebral shunts are used in children who are termed hydrocephalic (“water on the brain”). Hydrocephalus can be congenital (present at birth) or caused by disease, meningitis (infection in the lining of the brain), trauma or stroke. The caregiver must be knowledgeable concerning the signs of an increased intracranial pressure (irritability, high-pitched crying, seizures, etc.) which could indicate a tube blockage or infection.

ESTABLISHED PROSTHETIC FOR MISSING APPENDAGE: Caring for the child who has prosthetic devices (artificial limbs) to replace a missing appendage also falls under this level of care activities. The caregiver usually must work with the child in both physical and occupational therapy in addition to dealing with the psychological issues involved.

SURGICAL/WOUND CARE - LEVEL 3

NEW OR REVISED CEREBRAL SHUNT CARE: First Six Months After Insertion or Revision). At this level are those caregiver activities necessary to care for a child with a newly inserted (first 6 months) cerebral shunt. As mentioned under Level 2, a cerebral shunt drains excess fluid from the brain. During the post-operative period immediately following the shunt placement and for approximately the first six months, the caregiver must closely observe the child for signs of internal infection or tube blockage. The caregiver must be knowledgeable concerning the signs of an increased intracranial pressure (irritability, high-pitched crying, seizures, etc.) which could indicate a tube blockage. Cerebral shunts have to be replaced periodically as the child grows, and the risk of blockage, infection, and malfunction is higher during the post-operative period.

DAILY/FREQUENT DRESSING CHANGES: Utilizing Sterile Technique (e.g. burns, large wounds). Also considered at this level are the caregiver activities that involve daily or frequent (2-3 times/week) wound dressing changes utilizing sterile techniques. Commonly, this type of care involves children who have been burned, have large open wounds. These conditions are usually time-limited, and the child would be expected to recover in a matter of months. Sterile techniques involve the use of sterilized bandages, sterile gloves, germicidal soap washes, and topical antibiotic ointments to avoid infection at the wound site.

NEW PROSTHETIC FOR MISSING APPENDAGE (First Six Months After Surgery): Caring for a child who has a new prosthetic device (first six months after surgery) to replace a missing appendage is considered at this level. In addition to working with the child in both physical and occupational therapy and dealing with the psychological issues involved, the caregiver must provide wound care for the stump.

SURGICAL / WOUND CARE LEVEL 4

POST-MULTISTAGE SURGICAL CARE (e.g. Burn Reconstruction, *skin grafting*): Considered at Level 4—are similar wound care activities outlined above at Level 3—At this level, more extensive wound care is required to be performed by the caregiver. This type of wound care is often required for extensive burn reconstruction.

2-B RESPIRATORY CARE

Care requirements for children who have respiratory disease vary considerably according to the child’s diagnosis and the severity of the illness. Some children with respiratory problems that manifest early in their lives, such as bronchopulmonary dysplasia (BPD), may have few or no symptoms once they grow in body and lung size, and their lungs mature. Other children may have respiratory illnesses such as asthma that exacerbate (get worse) during certain seasons of the year but remain trouble-free for most of the year. The CSW must work closely with the caregiver and the physician to ascertain the respiratory care needs of the child in relation to his/her illness.

It is important that children with asthma live in smoke free homes.

ASTHMA / RESPIRATORY DISEASE - LEVEL 1

Administration of as needed medications: Treatment for mild, intermittent asthma /respiratory disease.

Caregiver activities listed at this level include the administration of medications to children with asthma/respiratory disease (*RAD, BPD, PHTN*) on an as needed (PRN) basis. These medications may be administered by:

- a. Aerosol treatments that involve the delivery of sterilized water, normal saline (salt water) or medications by an electrically powered (or compressed-air/oxygen cylinder).
- b. The use of metered dose inhalers (MDI) which are hand held medication devices, or

- c. The use of oral bronchodilators on an as needed basis. The caregiver must be knowledgeable concerning when the child would benefit from this type of medication.

ASTHMA / RESPIRATORY DISEASE- LEVEL 2

Administration of daily medications for: Treatment of mild, persistent, moderate persistent and severe persistent asthma / respiratory disease.

The medications may be administered by nebulizer, metered dose inhaler, or by inhaler with spacer/holding chamber and face mask. Short acting bronchodilators may also be prescribed for use on an as needed basis for quick relief of symptoms. Additional activities for the caregiver will include the monitoring of daily peak flows, household allergen control measures, and the keeping of a symptom diary.

OTHER CHRONIC RESPIRATORY CONDITION – LEVEL 2

POSTURAL DRAINAGE AND PERCUSSION UP TO THREE TIMES PER

DAY: Conditions that require postural drainage and percussion (PD & P) three or fewer times a day are in this category. Postural drainage and percussion is a therapy maneuver that helps the child cough up lung secretions. The child is positioned in various head-down positions (postural drainage) and often thumped or patted on the back (percussion) to further assist with secretion removal. The procedure usually takes 20-30 minutes. This procedure is commonly used with children who have the diagnosis of cystic fibrosis or bronchiectasis, but may also be used with any child with respiratory problems which interfere with the removal of lung secretions. The caregiver must receive special training in order to learn how to perform this procedure safely and effectively.

APNEA/HEART MONITOR: Children who must be monitored by an apnea (“lack-of-breathing”) or heart monitor also are considered at this level. The use of this equipment requires special training which is often given by both the hospital of discharge and the equipment rental company. The caregiver must be trained in how to deliver cardiopulmonary resuscitation (CPR) and must

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have a telephone in the home to call for emergency services in case the child stops breathing. The apnea/heart monitor is usually on the child continuously, but may be prescribed only for the hours the child is sleeping. All apnea/heart monitors frequently sound “false” alarms due to various problems (slipped monitoring band or electrodes, baseline alarm setting not calibrated to child’s condition, etc.), and are very stressful for the caregiver.

OTHER CHRONIC RESPIRATORY CONDITIONS - LEVEL 3

POSTURAL DRAINAGE AND PERCUSSION 4 + TIMES PER DAY: Children who require postural drainage and percussion (PD & P) four or more times a day are considered at this level. As previously detailed, PD & P is a therapy maneuver that helps the child cough up lung secretions. The child is positioned in various head-down positions (postural drainage) and often thumped or patted on the back (percussion) to further assist with secretion removal. The procedure usually takes 20-30 minutes.

INTERMITTENT USE OF OXYGEN: Included at this level are the activities required to care for children who require intermittent oxygen use. These children may require supplemental oxygen only during certain times of the day. Some children require oxygen during their hours of sleep, during feeding, or during stressful times such as bathing or dressing. Some children require oxygen during exertion only (play/work), and some children require oxygen only during times of respiratory distress (shortness of breath, wheezing, coughing, etc.). The caregiver must be alert to the needs of the child, and the oxygen equipment and supply of oxygen must be maintained in a ready state. Oxygen equipment is rented and the rental agency is responsible for periodically filling and servicing the equipment. The caregiver must alert the company when refills of the oxygen or repair of the equipment is needed.

OTHER CHRONIC RESPIRATORY CONDITIONS - LEVEL 4

CONTINUOUS OXYGEN: Activities at this level include caring for the child who requires continuous oxygen or mechanical ventilation. As mentioned under Level 3, the use of oxygen requires the caregiver to interact closely with

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the equipment rental agency, monitor the oxygen levels in the cylinders, and assure that an adequate supply of oxygen is available at all times.

VENTILATOR DEPENDENT: A child is ventilator dependent when he/she is unable to breathe effectively on his/her own, and requires the assistance of an electrically-powered machine to perform this function. The child must have a tracheostomy tube in order to receive this therapy on a continuous basis. Children who are ventilator dependent are often very critically ill, or so neurologically impaired that mechanical ventilation is usually considered a lifelong therapy.

TRACHEOSTOMY: Children who have tracheostomy tubes (tubes inserted through the neck into the windpipe) who require caregivers to suction periodically are considered at this level. Suctioning is done by using a suction catheter (tube) which is connected to an electrically-powered device. The catheter is inserted down the tube into the main airways of the lungs to suction out secretions that the child is unable to cough out on his/her own. Suctioning is a skill which requires that the caregiver be taught the proper procedure by hospital nursing personnel or visiting home nursing services. Risks due to airway damage (trauma during suctioning), infection, and airway blockage are always present during this procedure. The caregiver also must be trained to reinsert the tracheostomy tube should it become dislodged or accidentally removed.

2-C MEDICAL AND DEVELOPMENTAL TREATMENT

Depending upon the child's medical diagnosis, different therapies or medical treatments are prescribed by the physician and must be delivered by the caregiver. The delivery of medications and the performance of therapy procedures require that the caregiver be educated to the specific needs of the child.

MEDICAL TREATMENT – LEVEL 1

CONTROLLED SEIZURE DISORDERS WITH MEDICATION(S):

Caregivers who must care for children with controlled seizure disorders must be trained to administer first-aid and possible cardiopulmonary resuscitation

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(CPR). Seizures in children can be due to high fevers (usually disappearing around the ages of 3-4), neurological problems such as epilepsy or cerebral palsy, or past head trauma. The caregiver must make sure that the environment is made safe for the child should a seizure occur (e.g., padded bedrails or posts, carpeted bedrooms, protective headgear, etc.).

ADMINISTRATION OF TOPICAL MEDICATIONS FOR CHRONIC SEVERE

SKIN CONDITIONS: The administration of topical medications (creams, lotions, ointments) on a daily basis for severe chronic (long term) skin conditions (e.g. severe, chronic eczema) is considered at this level. This category does not include treatments for diaper rash or other short term skin conditions that can be alleviated by normal hygiene and appropriate skin care.

MEDICAL TREATMENT – LEVEL 2

Children with early onset of Type II Diabetes and their caregivers must be educated on the diabetic disease, treatment and the complications of uncontrolled diabetes. Diet, Oral Hypoglycemic Medication administration, urine and blood sugars must be monitored closely.

Administration of injectable medications for chronic conditions, i.e. Lovenox, Growth Stimulating Hormone.

MEDICAL TREATMENT - LEVEL 3

CAREGIVER ADMINISTRATION AND/OR SUPERVISION OF INSULIN REGIMEN INCLUDING BLOOD SUGAR TESTING AND DIET

MANAGEMENT: A child who needs a caregiver to administer insulin or supervise a child who self-administers insulin is considered at this level. Children with Juvenile Diabetes - Type I Diabetes - must have their diets monitored and insulin medication administered based upon the in home testing of blood sugar levels. Caregivers must be educated in this process by medical personnel, and are required always to be alert to possible signs and symptoms of sudden hypoglycemia (low blood sugar), which can be life threatening. Children with juvenile diabetes should be taught as early as possible how to monitor their own diets and mix, calculate, and administer their own insulin. Caregivers must monitor that the child is self-administering the medication as

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ordered, and must also be knowledgeable concerning the diabetic disease and treatment. Problems can occur with older children who may use self-administration of insulin and diet control as a means to rebel against authority, requiring frequent hospitalizations for hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar).

CAREGIVER ADMINISTRATION AND/OR SUPERVISION OF

ADMINISTRATION OF FACTOR 8: Also considered at this level are children who require caregiver activities to supervise the administration of and/or administer the Factor 8 medication used by hemophiliacs to stop excessive bleeding from minor or major wounds. Caregivers must be vigilant to assure that the child receives the medication when needed, even after minor falls with possible bruising. The caregiver must make sure that a first-aid kit and adequate supplies are available at all times.

MEDICAL TREATMENT – LEVEL 4

NEWLY DIAGNOSED DIABETIC (DIAGNOSED WITHIN THE PAST SIX

MONTHS): Considered at this level are children with newly diagnosed diabetes. These children and their caregivers must rapidly learn how to cope with a chronic illness that requires diet control, frequent blood sugar testing, and the administration of oral and/or injectable medication several times a day. The child's blood sugar must be kept within a range prescribed by the physician to prevent hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) which can be a life threatening condition.

IV/CENTRAL VENOUS LINE: Children who require caregiver activities to administer medications through an intravenous (IV)/central venous line directly into the child's circulatory system are considered at this level. Children who have medication delivered in this manner are usually very ill and require close monitoring and supervision. Cancer and leukemia chemotherapy are usually administered in this manner. In many cases, visiting home nurses are responsible for the direct administration of medications through the IV line, but the caregiver must make sure that the line is kept patent (open) by periodically injecting an anticoagulant (anti-clotting) medication into the tubing. The child

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must be monitored closely for signs of possible infection, which could be quickly life-threatening if not treated promptly.

SEIZURE DISORDER NOT CONTROLLED BY MEDICATION: The child who takes anti-seizure medication, but continues to have seizures on a regular basis is considered at this level. The caregiver must be constantly vigilant for the child's safety, and must be sure that the child's environment is as safe as possible when seizures occur. The caregiver must be trained in first aid for seizures and in cardiopulmonary resuscitation (CPR).

Children who require the activities required by the caregiver to protect a child who has an uncontrolled seizure disorder are also considered at this level. These children have frequent (more than 1 time per day, or 4 per month) seizures, with at least one seizure each month that lasts greater than 5 minutes. Caregivers must be trained to administer first-aid and possible cardiopulmonary resuscitation (CPR), for all children who have seizure disorders, but who are more likely to use this procedure with the child who has seizures lasting greater than five minutes. Uncontrollable seizures in children are usually due to neurological problems such as epilepsy, cerebral palsy, or past head trauma, and are not fully controlled by preventive medications. The caregiver must assure that the environment is made safe for the child should a seizure occur (e.g., padded bedrails or posts, carpeted bedroom floors, etc.) and in many cases, the child must be made to wear protective headgear at all times.

DEVELOPMENTAL TREATMENT - LEVEL I

PRESCRIBED DEVELOPMENTAL TREATMENTS PROVIDED BY THE CAREGIVER: Activities prescribed by the physician or a Regional Center to be performed by the caregiver on a daily basis are considered at this level. Infant stimulation procedures, and physical, occupational and speech therapies are all applicable at this level. These therapies may be ordered for the infant/child who was born severely premature (28-32 weeks), or for the child who was born prenatally drug-exposed. Infant stimulation may be required for the premature or developmentally delayed infant who has slowed reflexes and needs stimulation in order to facilitate movement and normal muscle

development. Speech, occupational, and physical therapy may be prescribed by the physician or Regional Center. The caregiver may be asked to perform such ordered therapies specifically designed for the child to help him/her develop skills required for optimum development.

In order to qualify for F-rate reimbursement, these therapies must be prescribed by a physician or Regional Center, and the caregiver must complete special training in order to perform these in-home services.

3. MONITORING HEALTH STATUS OF THE CHILD

Once an infant/child is documented to be un-infected, the specialized care rate no longer applies.

Considered in this category is the specialized care required for children with or at risk of life-threatening illness/disease that may be communicable or non-communicable. These illnesses include but are not limited to HIV/Aids, Hepatitis B, Hepatitis C, sickle cell disease (not trait), tuberculosis, cancer, organ transplant, etc.

3-A POTENTIALLY LIFE-THREATENING NON- COMMUNICABLE DISEASE/ILLNESS

ADMINISTRATION AND/OR SUPERVISION OF SPECIFIC MEDICATIONS FOR POTENTIALLY LIFE THREATENING CONDITIONS - LEVEL 3

Children with cardiac problems or other serious conditions where the administration of medication requires specific monitoring skills. These skills may include taking pulse or blood pressure, or other observations as directed by a physician. The caregiver keeps a written record and consults with the physician according to a written protocol.

SERIOUS ILLNESS IN REMISSION: Also considered at this level are the caregiver activities required for a child whose serious condition is in documented remission, but where the caregiver must continue vigilant monitoring of the child's health status due to high risk of relapse.

DAILY MONITORING - LEVEL 4

Caregiver activities include closely monitoring the child's vital signs (respiratory rate, heart rate, blood pressure, level of consciousness), watching for signs of organ rejection, or dealing with multiple, life threatening problems are

considered at this level. Included are the care of children who have leukemia or other diseases such as sickle cell disease, aplastic anemia, or immune deficiency disorders that require an intense level of care. The caregiver must be knowledgeable concerning the child's disease and educated to the monitoring processes necessary to assure that the child receives prompt medical care for any potential problem.

REVERSE PRECAUTIONS: Also included at this level are caregiver activities which may be required to prevent the spread of infection to a child who may have a weakened immune system due to disease states (immune disorders, bone marrow transplants, chemotherapy, etc.) Precautions such as limiting visitation from friends and other children, prohibiting visits to the mall or supermarket with the child, and frequent hand washing for all family members are often required and may significantly impact family functioning.

3-B POTENTIALLY LIFE-THREATENING COMMUNICABLE ILLNESS/DISEASE

Normal caregiver activities such as frequent hand washing, not sharing razors or toothbrushes, and proper cleaning of toilet facilities, etc. are often all that is necessary to prevent the spread of most infectious diseases. Some illness, such as chickenpox, measles, or tuberculosis, which are spread by airborne droplets after coughing, sneezing and talking, can cause an infection if inhaled. Most of these airborne illnesses (e.g., chickenpox, measles) are time limited and vaccine preventable. Other (e.g. tuberculosis) are rendered non-communicable (not contagious) rapidly with proper treatment. Normal caregiver activities which are expected for all children are not considered specialized care activities.

POTENTIALLY LIFE-THREATENING COMMUNICABLE ILLNESS/DISEASE LEVEL 1

Considered at this level are specialized care activities for children who are prescribed medication that must be administered for a six month period of time or longer to prevent communicable disease, such as M. Tuberculosis prophylaxis. Caregiver activities are expected to include some form of monitoring as well as follow up medical visits.

UNIVERSAL PRECAUTIONS ESSENTIAL - LEVEL 3

Considered at level 3 are those caregiver activities necessary to practice strict universal precautions to protect themselves and others from life-threatening illness. Caring for children with chronic Hepatitis B and/or Hepatitis C is included in this level. Another communicable disease that may cause severe infections is the newborn and pose a risk to some family members is cytomegalovirus (CMV) infection.

DRUG RESISTANT INFECTIONS: Included at this level are caregiver activities related to the child with a drug resistant infection, where the caregiver must insure strict adherence to a prolonged medical regimen. Drug resistant illness, ie. MRSA, ORSA.

POTENTIALLY LIFE-THREATENING COMMUNICABLE ILLNESS/DISEASE LEVEL 4

Included at this level are caregiver activities required for the infant or child with an HIV positive blood test. These include strict universal precautions, frequent medical appointment, complex medication regimens, “reverse precautions”, etc. (reverse precautions are those activities which may be required to prevent the spread of infections to a child who may have a weakened immune system due to illness states [immune disorders, bone marrow transplants, chemotherapy, etc.] Precautions such as limiting visitation from friends and other children, prohibiting visits to the mall or supermarket with the child, and protecting the child from common illnesses such as colds and flu, are often required and may significantly impact family functioning.)

4. CARING FOR INFANT PRENATALLY-EXPOSED TO DRUGS/ALCOHOL

Prenatal drug exposure may be diagnosed early in a child by a positive drug-screen in either the infant or the mother, or by symptoms of prenatal drug-exposure manifested by the infant at birth. Infants who are prenatally drug-exposed may show early symptoms which require specific caregiver interventions.

4-A COPING WITH PRENATALLY DRUG-EXPOSED INFANT BEHAVIORS

Infants/children (0-2 years old) who were prenatally exposed to drugs may, or may not, show symptoms of this exposure. Early (newborn/infant) symptoms that could be caused by prenatal drug-exposure include irritability, arching of the back, rigidity (stiffness) or flaccid muscles, poor sucking reflex, or refusal to make eye contact. The older drug-exposed child may also exhibit these same symptoms, usually to a lesser degree, and may also show signs of slow speech development and other developmental delays. Probably the most difficult symptom for the caregiver to cope with is the extreme irritability that may be seen in some of these infants/children. For that reason, this symptom is used to guide the assessment of the appropriate F-rate level for the caregiver.

PRENATALLY-EXPOSED TO DRUGS/ALCOHOL - LEVEL 1

CRYING UP TO 6 HOURS/DAY: Infants/children who require caregiver activities involved in calming an infant/child with inconsolable crying and high-pitched screaming which lasts up to six hours a day are considered at this level. Caring for an infant/child who cries to this degree is stressful for the caregiver and the family system.

PRENATALLY-EXPOSED TO DRUGS/ALCOHOL - LEVEL 2

CRYING 6 TO 12 HOURS/DAY: Children who require caregiver activities involved in calming an infant/child with inconsolable crying and high-pitched screaming which lasts up to 12 hours a day are considered at this level. Caring for a infant/child who cries to this degree is very stressful for the caregiver and the family system.

PRENATALLY-EXPOSED TO DRUGS/ALCOHOL - LEVEL 3

CRYING MORE THAN 12 HOURS/DAY: Children who require caregiver activities involved in calming an infant/child with inconsolable crying and high-pitched screaming which lasts more than 12 hours a day are considered at this level. Caring for an infant/child who cries to this degree is extremely stressful for the caregiver and the family system.

5. CARING FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES

This category is for those children who have received a diagnosis of a developmental disability from a Regional Center. These children will receive the appropriate dual agency rate if receiving Regional Center services unless child is eligible for a higher F-rate (i. e. child is 0 – 3 years old, receiving Early Start services but not yet determined to have a qualifying developmental disability and has an additional medical/physical condition that warrants an F-2, F-3 or F-4 rate; or for those children receiving AAP, they may receive the higher F-1 rate in lieu of the Early Start rate).

5-A DISABILITIES

Children who have been diagnosed by or are receiving services from Regional Centers for developmental disabilities are considered in this category. If the child was diagnosed by a private provider or agency, a confirming diagnosis must be obtained by a Regional Center. The following levels are based upon diagnoses as given by the Regional Centers but does not determine the F-rate as the Regional Center rates have already been set. For the current dual agency rate(s).

refer to:

[Procedural Guide 0900-511.10](#), AFDC-FC/GRI-FC Rates

[Procedural Guide 0900-511.12](#), Regional Center Rates for Dual Agency Children

Note: Regional Center identifies children, with an intellectual disability and under age three as “developmentally delayed” until more thorough testing can be performed.

DEVELOPMENTAL DISABILITIES - LEVEL 1

Children who have the following Regional Center diagnoses are considered at this level:

- Developmentally Delayed (under age 3)
- Mild Intellectual Disability (age 3 or older)
- Epilepsy/Seizure Disorder
- Mild/Moderate Cerebral Palsy

DEVELOPMENTAL DISABILITIES - LEVEL 2

Children who have the following Regional Center diagnoses are considered at this level:

- Moderate Intellectual Disability
- Autism - mild

DEVELOPMENTAL DISABILITIES - LEVEL 3

Children who have the following Regional Center diagnoses are considered at this level:

- Severe Intellectual Disability
- Autism - moderate
- Severe Cerebral Palsy (significantly impairs activity)

Note: In level 3 and 4, if there is no other diagnosis except the autism or Intellectual Disability, the case is not eligible for transfer to Medical Placement Unit.

DEVELOPMENTAL DISABILITIES - LEVEL 4

Children who have the following Regional Center diagnoses are considered at this level:

- Profound Intellectual Disability
- Severe Cerebral Palsy (significantly impairs activity)
- Autism - full syndrome

6A WORKING WITH A CHILD’S BEHAVIOR PROBLEMS IN CONJUNCTION WITH MEDICAL PROBLEMS

Caring for an infant or child with a medical problem is especially difficult when the child also has an emotional or behavioral problem which interferes with rendering prescribed medical care. To be considered in this category, the child must be age 3 or older, have a documented emotional/behavioral problem, and be enrolled in and attending a treatment program designed to address the emotional/behavioral problem diagnosed. This category was added to recognize the many challenges associated in caring for the medically-needy child with emotional/behavioral problems, and increases the F-rate by one level beyond the highest medically-related activity required to be delivered by the caregiver.

6B WHEN A CHILD HAS MULTIPLE MEDICAL PROBLEMS: that require the caregiver to attend multiple appointments, administer multiple treatments, or visit multiple specialists, consideration may be given to increase the rate one level above the highest medically related caregiver activity - up to level four. Specific caregiver tasks need to be documented by the healthcare provider(s).