STATEGY BRIEF

TRANSFORMING CHILD WELFARE SYSTEMS

How are some child protection agencies attending to **Qualified Residential Treatment Program requirements?**

Youth with lived experience in foster care, research, and data tell us that children in foster care do best when placed with family or in family-like settings.[1] While short-term, clinically indicated behavioral health treatment may need to be provided in group or institutional settings,[2] these settings should never be considered as viable substitutes for care by and connection with family.

In 2019, about 1 in 10 young people in foster care in the United States were living in a group or institutional placement setting, but more than 30% of those ages 13 to 18 were in these kinds of facilities.[3] These percentages are higher for Black children, with one-third (33%) of Black teenagers in foster care placed in group or institutional settings. Supporting families — not facilities — to care for children and youth is the most effective way to ensure their safety, permanency, and well-being.

Enacted in 2018, the Family First Prevention Services Act (Family First) provided new federal child welfare funding for up-front services to safely support permanency and stability for children while still living with their families. Informed by the voices of youth formerly in foster care, Family First also sought to reduce overreliance

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on inappropriate use of non-family-based settings by instituting requirements designed to ensure that group and institutional facilities be used only when clinically necessary. The federal policy also stipulates that those settings be time-limited, trauma-informed, judicially reviewed, and focused on engaging the child's family during and after treatment, with the goal to prepare the child for a swift return to family and community life. In order to receive federal funding, non-family-based settings must adhere to these requirements, designated as Qualified Residential Treatment Programs (QRTP).

This brief reflects conversations with child protection agency administrators from five states[4] (Colorado, Kentucky, Maine, Oklahoma, and Washington) about their approaches to QRTP requirements, including embracing the values of keeping children with families or in family-like settings, and reducing placement of children and youth in group or institutional facilities.

Alignment with core values

Family First provides opportunities for states to examine and improve clinical treatment for children in out-of-home care and reduce non-family-based placements. As Christine Theriault, Family First Prevention Services Program Manager in **Maine's Office of Child and Family Services** (OCFS) stated, "our take has always been that this is about reducing the use of residential treatment, and improving care for the small group of youth that may need residential treatment." That means building on a state's existing efforts to reduce non-family-based placements, and ensure that any continued use of residential placements would be reserved only for young people whose therapeutic needs require intensive, clinically-indicated, short-term residential placement. Adherence to QRTP standards also means increasing the quality of treatment while ensuring children and youth do not linger in residential placements. Agency leadership, along with partners throughout Maine, felt so strongly about QRTP-related improvements for residential treatment that they applied the standards to all youth throughout the state, not just those in foster care. As a result, the agency conducted a rate study with the state Medicaid agency and aligned QRTP requirements with licensing and Medicaid rules.

Administrators in **Kentucky's Cabinet for Health and Family Services** (CHFS) felt the idea of "right-sizing" residential placements only for treatments that can't be met in a family or community-based setting aligned well with existing statewide values. The agency also felt that QRTP represented an opportunity to significantly improve Kentucky's overall residential treatment practices. Similarly, for the past 10 years, **Oklahoma Human Services** (OKDHS) has been working to ensure that stays in residential institutions occur after an initial assessment, are brief and intensive in nature, and are the right treatment for that child. Leadership saw Family First as an extension of the agency's ongoing efforts to shift thinking on group homes from being a placement to being a treatment, and focus its work on family-based settings. Administrators with the **Colorado Department of Human Services** (DHS) viewed the QRTP requirements as part of the spirit and intent of Family First, rather than separate or technical requirements. By developing a service and placement continuum that includes QRTPs, the agency intends to tailor services to the needs of each individual youth and prioritize placing children in small, family-based settings.

Collaborative preparation and planning

Partnership and frequent communication between agencies and providers are foundational to all QRTP planning activities. In the five states, agency staff convened workgroups, listening sessions, in-person and virtual meetings, and held regional forums to listen to and engage caseworkers, providers, judicial partners, families, and youth. Ultimately, preparation efforts focused on the following:

- **Messaging.** Foundational to all planning efforts was the creation of a consistent message about QRTP requirements and their value to children and families. The **Washington State Department of Children, Youth and Families** (DCYF) conducted a thorough review of the entire act and sought clarification from its federal partners to ensure it understood the requirements before moving forward with their community partners. **Maine** OCFS reinforced the message that while meeting the QRTP requirements

is a federal mandate, the efforts were ultimately about improving treatment for children and youth.

- **Consistent and frequent communication.** Statewide operationalization of QRTP standards requires coordinated communication. **Washington** DCYF realized that managing such a large effort required a dedicated position and hired a project manager to oversee QRTP planning. Early communication efforts with providers began with large webinars and meetings to review requirements and outline the importance of improved treatment services for children and families. To effectively and transparently communicate QRTP requirements, **Colorado** DHS developed a dedicated website. As planning progressed, large-scale communications still occurred, but the focus shifted to smaller affinity-based groups for collaborative learning conversations. **Maine** OCFS engaged youth and family in development and planning conversations and has continued to engage its youth leadership advisory team following establishment of QRTP requirements across the state.
- **Collaborative learning conversations.** In partnership with the states, providers came together to discuss how their current practices aligned with the requirements and to identify areas for improvement. **Oklahoma** OKDHS was invested in ensuring a collaborative effort and never held a meeting without including providers. The monthly gatherings allowed for a team approach to meeting the requirements and, while providers were hesitant at first, the process allowed for transparency and accountability. **Kentucky** CHFS convened regional forums as well as individual conversations with the partners most impacted by QRTP requirements, such as residential providers and judicial leaders, to hear their specific concerns and clearly communicate how QRTP requirements lead to improved outcomes for children and families. Conversations were an opportunity to hear feedback, share relevant data, learn from each other, and work together to meet the requirements.
- **Readiness.** Key to any systems improvement effort is understanding when it is time to move forward. **Washington** DCYF created a QRTP readiness checklist for its providers. The agency and providers worked together through each item on the checklist to understand which were currently being met. For those items not being met, they developed a plan to meet the requirement. **Colorado** DHS held multiple provider webinars with executive leadership to create a dialogue about providers' needs. The agency used these conversations to create a list of ways to support providers as they made the transition to a QRTP.
- **Engaging Medicaid.** The Departments of Medicaid in **Kentucky** and **Colorado** were instrumental in advancing QRTP requirements. In Kentucky, Medicaid helped create a code for the QRTP assessment, effectively offsetting a portion of the cost. It also helped create a code for aftercare, allowing the child protection agency to bill Early and Periodic Screening, Diagnostic and Treatment services after receiving prior authorization. In its efforts to ensure that its QRTPs were small and did not meet the definition of an Institute for Mental Disease, **Colorado** DHS built a strong partnership with its Medicaid office and implemented a weekly check-in to answer questions and address challenges.
- **Leveraging the** Family First Transition Act**.** In addition to helping providers with accreditation, jurisdictions reported using portions of the funds they received through the Family First Transition Act to support increased provider per diem rates and fingerprinting efforts. In **Colorado**, the state passed legislation allowing 15% of Transition Act funds to be applied toward helping providers transition their business model.

Addressing QRTP provisions

After partnerships were established and initial planning occurred, agency staff and leadership worked with providers and interested stakeholders to ensure each of the QRTP provisions were met.

Provider accreditation

Accreditation was already a requirement for many providers with child welfare service contracts. In other

states where accreditation had not been a requirement, supporting a gradual transition to accreditation was key. **Washington** DCYF reached out to accreditation entities and consultants in order to help connect providers with these groups and help them navigate the process, including determining what accreditation model to seek. Facilitating these connections for providers helped decrease provider anxiety and resistance. In addition, the department elected not to cancel contracts if accreditation requirements were not fully met by the October 1, 2019, deadline, instead offering providers that were working toward accreditation a readiness rate during this transition phase, with the full rate provided following accreditation.

Other states used a portion of their Family First Transition Act dollars to fund accreditation. Maine OCFS developed an application process and allowed those already accredited to apply for funds to cover their renewal fees. To further assist providers in becoming accredited, **Maine** OCFS administered a periodic readiness assessment to address any barriers to accreditation.

Assessment by a qualified individual

Approaches have varied among states to meet the requirement that children and youth are assessed by a qualified individual. While **Kentucky** CHFS had an existing contract with a provider responsible for assessments, recommendations, and referrals, the agency also worked with the developer of the Child and Adolescent Needs and Strengths (CANS) tool to create an algorithm based on a subset of the CANS questions. After administering the CANS, and in conjunction with other information such as treatment summaries, past discharge summaries, and interviews with the parent/caregiver and child, the algorithm guides the clinician in the assessment process to determine level of placement.

Oklahoma OKDHS and **Maine** OCFS convened workgroups to identify an assessment tool and develop guidelines for the assessment process. Maine OCFS built on an already existing relationship with a provider involved in its residential system approvals. The state chose to use the Child and Adolescent Symptom Inventory (CASI) checklist and created a provider guide and flowchart to familiarize caseworkers and providers

with the new requirements. The Oklahoma OKDHS workgroup chose the CANS and consulted with other states to learn how they were using it, with what population, and how it was administered. The agency piloted the process with a subset of children and providers in a QRTP setting to determine feasibility.

After convening a workgroup, **Colorado** DHS decided to partner with its Office of Behavioral Health to utilize existing administrative service organizations, which already were familiar with the state and its existing resources. This allowed Colorado DHS to meet the requirement that assessments be done by a qualified, independent individual and partner with an organization already providing a similar service.

Court reviews within 60 days

Efforts to ensure court reviews occur within 60 days also varied by state, however all five jurisdictions relied heavily on early engagement and communication with their judicial partners to meet this requirement. **Colorado** DHS created a webpage specifically for its judicial partners to engage and inform them from the beginning. **Kentucky** CHFS used existing judicial engagement meetings to educate judges about Family First and QRTPs. Together they developed a web-based training for family court judges detailing the connection between QRTP requirements and improved outcomes for children and families. **Kentucky** CHFS continues to educate caseworkers and judicial partners about the need to plan ahead to avoid schedule delays.

Ensuring that court reviews happen within 60 days in **Maine** and **Washington** required a legislative change, and was accompanied by outreach efforts and online webinars that messaged the importance of abiding by the timeframe to promote improved treatment for youth. **Maine** OCFS concentrated on a language shift, reminding caseworkers and judges that a stay in a residential facility is intended to be treatment, not placement. Both jurisdictions oversaw the development of new forms and processes for courts and caseworkers. **Washington** DCYF developed an online overview to educate its judicial partners about these changes.

Since **Oklahoma** has 27 judicial districts that each operate slightly differently, OKDHS encountered challenges with operationalizing the court requirement consistently across the state. OKDHS identified QRTP experts in each district responsible for becoming knowledgeable about the requirements and partnering with local judicial staff to develop an implementation plan. Plans will be reviewed at the state level for gaps and then state and local staff will work together to address any gaps identified.

Trauma-informed treatment model

Many jurisdictions already required providers to have a trauma-informed treatment model prior to Family First. Through work with a QRTP subcommittee, **Maine** OCFS developed a list of evidence-based trauma models from which providers could choose, followed by a trauma-informed assessment. Similarly, **Washington** DCYF gave providers an outline of the federal requirements and a list of models, allowing them to choose the one that best fits the needs of their agency and the children they serve. Regardless of whether they already offered a trauma-informed model, many providers reported that they did not view the requirement as cumbersome and that it helped some of the smaller entities become more therapeutic.

Oklahoma OKDHS and **Kentucky** CHFS focused instead on the use of basic trauma-informed principles, as opposed to a specific model. OKDHS defined what each of these principles means in practice and required that they be evident in all provider policies, clinical records, and trainings. Through contract monitoring, Oklahoma DHS determines provider adherence to its trauma-informed principles and definitions. Agency staff worked closely with and provided detailed guidance to those providers that did not meet initial requirements. While the shift to trauma-informed treatment remains a work in progress in **Kentucky**, CHFS felt it has allowed children to receive a higher quality of care that is more treatment focused.

Availability of registered/licensed nurses and licensed clinicians

Agencies admitted initial confusion regarding what the Family First legislation meant by the term “available,”

but upon talking with and gathering information from their providers, they found many were either already meeting or close to meeting this requirement. For example, providers in **Washington** already employed clinical staff and only required a shift to include on-call clinical staff. The state already had a nursing hotline available, so Washington DCYF coordinated with providers to call the hotline when in need of a nursing consultation. **Maine** OCFS connected multiple small rural providers together to utilize one licensed staff provider for their network. This solution was a direct result of the continuous communication and engagement between providers and the state.

Family and youth engagement

Ongoing and meaningful engagement of children and families with lived experience should be part of every child welfare system, and many agencies report that they already are doing this. In **Washington**, ensuring that children and families have a voice in their treatment plan was included in the state's practice model years ago, in part by implementing child and family team meetings. Leveraging the expertise of its youth leadership advisory team, **Maine** OCFS developed guidance on family and youth engagement best practices and integrated it into their provider guide.

Hearing directly from parents and youth impacted by the child welfare system appears to have been transformative for lawmakers in **Kentucky**, who gained a firsthand understanding of how their policies and legislation directly impact agencies, children, and families. Leadership with Kentucky CHFS reports that recent legislation reflects a philosophy that is more family-friendly than what had been proposed and enacted in the past.

To engage families early and often and to support ongoing communication regarding a youth's possible placement in a QRTP, **Colorado** DHS created a toolkit for caseworkers that includes YouTube videos for youth and families. The goal is to engage families from the beginning, discuss the process, and keep them involved. QRTPs in **Colorado** have outlined explicitly what they will do in both policy and practice to make sure the youth and family are involved in the youth's treatment plan and will continue to be.

Aftercare

Providing aftercare services to families and youth leaving a QRTP is an essential support to the family as the youth transitions home. Agency staff believed in the need for and the importance of aftercare but initially struggled to integrate it in a meaningful way. In **Kentucky**, some providers already were providing aftercare that aligned with Family First, so Kentucky CHFS was able to learn from and apply these efforts to QRTP. Similarly, the provision of aftercare in **Washington** already was part of provider contracts and required only slight modifications.

Maine OCFS convened an aftercare workgroup composed of youth, stakeholders, and parents to learn what families would want as part of their aftercare support. The workgroup developed a comprehensive plan for all providers, not just residential treatment providers. Providers will bill the aftercare rate separately after a child is discharged instead of embedding the cost into the treatment rate. Families embraced the opportunity to outline a plan for aftercare support that reflected their experiences and needs.

> We felt that the spirit and intent of the Family First Act really clearly aligned with best practices and what our values needed to be.
>
> **— CHRISTA BELL,**
> EXECUTIVE ADVISOR, DEPARTMENT FOR COMMUNITY BASED SERVICES, KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES

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To learn more, visit Questions from the field at Casey.org.

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2 Group and institutional placements refer to placements that house young people in large, medium, or small facilities, including emergency shelters, group homes, institutions, campuses, cottages, and residential treatment centers with 24-hour shift care or house parents.

3 Data derived from the Adoption and Foster Care Analysis and Reporting System (AFCARS) data as of September 30, 2019 and made available by the National Data Archive on Child Abuse and Neglect (NDACAN) data at Cornell University.

4 Information in this brief was obtained through phone interviews with: Angelina Callis, Colorado Department of Human Services, Family First Project Manager, on Oct. 22, 2021; Christa Bell, Executive Advisor, Department for Community Based Services, Kentucky Cabinet for Health and Family Services, on Sept. 16, 2021; Christine Theriault, Family First Prevention Services Program Manager, Maine Office of Child and Family Services, on Sept. 24, 2021; Keitha Wilson, Family First Prevention Services Administrator, and Maegan Wiss, Program Administrator, Continuum of Care Programs, Oklahoma Human Services-Child Welfare Services, on Sept. 16, 2021; and Doug Allison, Administrator, Rachel Mercer, Family First Prevention Services Manager, and Steve Grilli, Director of Child Welfare Programs, Washington State Department of Children, Youth & Families, on Sept. 23, 2021.

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