Maine’s Next Steps
Family First
September 26, 2019

Dr. Todd A. Landry, Director
Office of Child and Family Services
Welcome

Special Thanks to Casey Family Programs and the John T. Gorman Foundation for their support.
Agenda

Welcome 1:00 – 1:10
Opening Remarks 1:10 – 1:20
OCFS Today 1:20 – 1:30
Family First Prevention Service Act 1:30 – 2:30
What it Means for State Policy Makers and Practitioners
Break 2:30 – 2:45
Q&A Panel 2:45 – 3:15
Maine’s Next Steps and Q&A 3:15 – 3:45
Closing Remarks 3:45 – 4:00
Dr. Jeanne Lambrew
Commissioner
Department of Health and Human Services
Dr. Todd A. Landry
Director
Office of Child and Family Services
Engaged with stakeholders through the system evaluation work being completed within OCFS.

Met with providers, community stakeholders, and collaborated across state agencies.

Visited every OCFS district and met with staff throughout the state.
All Maine children and their families receive the services and supports they need to live safe, healthy, and productive lives in their home, school and community.

**Guiding Principles**

- Broad and Equitable Access
- Early Intervention
- Individualized Services
- Culturally-Sensitive, Trauma-Informed Engagement
- Coordinated and Integrated Services
- Effective Evidence-Informed Practices
- Least Restrictive Service & Setting
- Engaged and Empowered Families
- Quality Assurance and Accountability

**Strategies**

**SHORT TERM (2019 – 2022)**

- Revise the waitlist process
- Improve coordination for transition-aged-youth behavioral health services
- Facilitate access to parent support services
- Explore options to amend current service definition for Section 28
- Hire full-time, on-site OCFS Medical Director
- Clarify CBHS roles, responsibilities, procedures, policies, and practices

**LONG TERM (2019 – 2025)**

- Address shortages in the behavioral health care workforce
- Align residential services to best practices and federal quality standards
- Improve CBHS crisis services
- Expand the use of evidence-based models and evidence-informed interventions
- Enhance skills of early childhood workforce to address challenging behaviors
- Explore a statewide or regional "single point of access"
- Establish one or more Psychiatric Residential Treatment Facilities

**Outcomes**

- Family engagement, empowerment, and well-being
- The right service at the right time for the right duration
- Families and children safely stay together in their homes and communities
Early Childhood Education

Current Efforts

- Federal grant supports early childhood education allowing parents to work or attend school / training.
  - Over 3,000 families and nearly 5,000 children
  - No waiting list for these services.
- Bringing subsidy program and child care licensing into federal compliance.
- Increased reimbursement rates.
- Encouraging high-quality care by providing high reimbursement to providers that obtain quality ratings.
- Streamlining eligibility.
- Support the Maine Roads to Quality Professional Development Network to assist early childhood education staff with their professional growth and development.
- Partnering with those involved with the Children’s Cabinet to develop a comprehensive and accessible early childhood education system.
Maine Office of Child and Family Services
Strategy and Initiative Map | July 2019

47 Total number of initiatives
11% of initiatives are mandated
70% of initiatives are recommended in the PCG evaluation

Anticipated Outcomes
- 31% Process Outcomes
- 68% Child and Family-Level Outcomes

Primary Initiative Focus
- 72% of initiatives are focused on staff

Initiative Time Horizon
Estimated Completion
- 45% 0-6 mos.
- 25% 6-12 mos.
- 15% 12-24 mos.
- 8% 24+ mos.
- 8% Ongoing

Percentage of Initiatives per Practice Model Principles

Initiative Plan Source
- CARE 12
- CFSP/PIP 31
- Other 4

*Colors correspond to principle headings below

Initiatives and Practice Model Principles

I. Child Safety, First and Foremost
   1. CASP Reassessment
   2. Increase Caseworker Skills and Communication with Parents
   3. Tighten Assessment Practice
   4. Home Visitation Education Program
   5. 24-Hour Supervisory Intake Report Review
   6. Intake Process and Staffing Improvements
   7. Judicial Caseworkers Practice Training
   8. Clarify Child and Parent Rights for Staff
   9. Background Check Unit Improvements
   10. Rapid Safety Feedback
   11. SDM Tool Consistency

II. Parents have the Right and Responsibility to Raise Their Own Children
   12. Family Engagement Tools Training
   13. Community Partnership for Protecting Children

III. Children are Entitled to Live in a Safe and Nurturing Family
   14. Family Treatment Drug Court
   15. Diligent Search Policy Training
   16. Visitation Policy Training - Contracted Supervisors and Case Aides
   17. Visitation Frequency and Quality Tracking
   18. Transportation Service Utilization Improvements
   19. Emergency Placement Improvements
   20. Online Application and Licensing Improvements
   22. Resource Parent Outreach Strategy
   23. Resource Placement Matching Tool
   24. Family Visitation Pilot

IV. All Children Deserve a Permanent Family
   25. A Family for Me
   26. Infant Gallery
   27. Statewide Adoption Pilot
   28. Wendy’s Wonderful Kids
   29. Adoption Preservation Services
   30. Permanency Reviews
   31. Residential Reviews

V. How We Do Our Work is as Important as the Work We Do
   32. Quality Grids
   33. Staff Practice and Policy Feedback Loops
   34. QA Staff Practice and Policy Feedback Loops
   35. Internal Data Dashboard
   36. CQI Team Development
   37. Supervisory Support Enhancements
   38. Update Caseload Size Standards, and Ratios
   39. Workforce Wellness
   40. Update Workload Analytic Tool
   41. MACWIS Replacement
   42. Motivational Interviewing Training
   43. Training Plan for New Processes and Tools
   44. Case Management Activities Time Analysis
   45. Case Closing Summary Model Development Workgroup
   47. TDM Policy and Practice

Principle I

Principle II

Principle III

Principle IV

Principle V

* Indicates Mandated Initiative
** Includes: Safe Sleep, Period of Purple Crying, and Cradle Me/PRN/Bridging
Child Welfare Visioning

**Mission**
Child and Family Services joins with families and the community to promote long-term safety, well-being and permanent families for children.

**Strategic Framework**
In order to achieve their mission, Child and Family Services uses guiding principles as a foundation to employ strategies that lead to improved outcomes for children and families. The strategies listed below were prioritized by executive leadership and regional staff.

<table>
<thead>
<tr>
<th>Guiding Principles</th>
<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Parents have the Right and Responsibility to Raise their Own Children</td>
<td>Re-assess the Alternative Response Program, Enhance Assessment Processes, Improve Staffing, Develop a Permanency Review Process, Monitor the Family Visit Coaching Pilot to develop best practices, Improve EDM tool consistency, Develop family engagement tools and training, Improve resource parent outreach and support</td>
<td>Improved timeliness to permanency</td>
</tr>
<tr>
<td>3. Children Are Entitled to Live in a Safe and Nurturing Family</td>
<td>Well-being</td>
<td>Enhanced well-being of children through identification of individual needs and engagement with formal and informal supports</td>
</tr>
<tr>
<td>4. All Children Deserve a Permanent Family</td>
<td>Staff Training and Support</td>
<td>Strengthened child welfare practice through improved engagement with families and children</td>
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<tr>
<td>5. How We Do Our Work is as Important as the Work We Do</td>
<td>Update caseload size, standards, and ratios, Procure MACWIS replacement</td>
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</tbody>
</table>

> indicates effort underway
Children and Families Served

- **Children in State Custody**: 2,196
- **Family Foster Homes**: 1,517
- **Children Achieving Permanency**: 206
- **Children Authoring Behavioral Health Services**: 18,305
- **Children Receiving Childcare Subsidy**: 5,013
Federal Family First Prevention Services Act

An unprecedented opportunity to improve the lives of children and families in Maine and across the nation.

Federal dollars available to address the underlying factors that lead children to be placed in foster care by providing prevention services that help children remain safely at home.

Prevention services funded must be evidence-based and include mental health services, substance use disorder treatment, and in-home parenting support.

Also includes components meant to improve the lives of children who cannot remain safely with their parents.
The Family First Prevention Services Act
What it Means for State Policy Makers and Practitioners

Tracey Feild
September 26, 2019
For the Office of Child and Family Services
Maine Department of Health and Human Services

Sponsored by
The John T Gorman Foundation
The Family First Act is the most significant federal child welfare legislation since 1980

- Potential to have enormous impact on children and families
- Substantial changes to federal child welfare financing – new resources available, new restrictions on reimbursement
- Varied implementation timelines with some changes already in effect
- Many new requirements on state child welfare agencies and residential providers will increase administrative costs and may require new expertise
- Reforms may require state legislative and regulatory changes
The Family First Act is the culmination of the 50+ years push for family-based care

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
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<tbody>
<tr>
<td>1961</td>
<td>AFDC Foster Care created</td>
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<tr>
<td>1978</td>
<td>Indian Child Welfare Act</td>
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<tr>
<td>1980</td>
<td>Reasonable efforts, Adoption Assistance and Foster Care (lost battle to include prevention funding in Title IV-E)</td>
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<tr>
<td>1994</td>
<td>IV-B Part 2 (FPFS) created – Capped prevention funding</td>
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<tr>
<td>1994</td>
<td>First IV-E Waivers to spur prevention</td>
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<tr>
<td>1996</td>
<td>TANF Block Grant (Emergency Assistance prevention funds rolled in)</td>
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<tr>
<td>1997</td>
<td>ASFA (IV-B language on services for timely reunification that was intended for IV-E)</td>
</tr>
<tr>
<td>2008</td>
<td>Fostering Connections Act (push for family placements with kin, direct IV-E access for Tribes)</td>
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<tr>
<td>2010</td>
<td>ACA (home visiting prevention services)</td>
</tr>
<tr>
<td>2011</td>
<td>Child Welfare Improvement Act (reauthorization of waivers)</td>
</tr>
</tbody>
</table>

Source: Annie E Casey Foundation
The Family First Act was the result of growing belief and evidence that we can do better

- Growing understanding/evidence that children do best in families and that many children are being unnecessarily placed in non-family settings
  - History of success in states in reducing group placements (Maine was one of first)
  - ACF report on children placed in group settings without therapeutic need

- Growing understanding/evidence that many children were not having needs met in residential treatment
  - Reports of abuse in group homes
  - Long lengths of stay in residential settings
  - Poor long-term outcomes of children who exit group care

- Growing evidence that teens were being placed in group facilities as default, not because of clinical need
Key concerns
- Lack of flexibility/prevention $
- Lack of incentives
- Lack of accountability
- Admin cost too high
- Underfunded

Proposed solutions
- Block grants
- Waivers*
- Expand entitlement
- Incentives

- What should/shouldn’t be in the entitlement
- Focus on family-based/kinship care
- Delink Title IV-E from AFDC standards
- Workforce investment
- Prevention primarily through Medicaid and TANF

*Waiver results showed that 80-85 percent of expenditures were for services already allowed without the waiver.
The Family First Act itself was 4+ years in the making

- 2013: I O Youth Act (Hatch)
- 2015: Family Stability and Kinship Care Act (Wyden)
- 2016: Family First Act Passes U.S. House
- 2017: Family First Re-introduced
- 2018: Family First Signed into Law

- Introduced for Unanimous Consent in Senate
- Two holds placed in Senate (TX, WY) objections from others (CA, NY)
- Added to 21st Century Cures Act
- Removed from Cures Act following opposition from NC (Burr)

Source: Annie E Casey Foundation
The primary focus of the Family First Act is funding for services to prevent foster care, and limiting and improving residential care

- Investing in prevention of placement through family-based services provided to the child, the parents or kin caregivers
- Ensuring the necessity of a placement that is not a family-based; creates a family foster home preference
- Ensuring the quality of residential treatment
- Modification to Chafee Foster Care Independence Program
- New state plan, reporting and data collection requirements
Opportunity for open-ended, federal reimbursement for services to prevent entry into foster care for all children at risk of foster care without eligibility requirements.

Opportunity to reduce the use of group placements used inappropriately (group placements solely for lack of foster families won’t be reimbursable, nor will group placements that are non-therapeutic).

Opportunity to beef up kin and foster family resources and improve quality of residential treatment. Offers partial federal reimbursement for kinship navigator programs.
Family First offers partial reimbursement for specialized placements


- Opportunities for reimbursement for victims and youth at risk of sex trafficking.

- Opportunity to improve services for pregnant and parenting foster youth.
Title IV-E reimburses states for a portion of the costs they incur for:

- **Case Planning/Case Management**
  - To oversee and manage family-based cases to prevent foster care;
  - To develop and manage case planning, participate in court hearings, place children into care, and supervise a child’s placement;

- **Placement Costs**
  - For stipends for board and care costs while children are in care;
  - For subsidies to persons who adopt special needs children;
  - For guardianship subsidies to relatives;

- **Placement Resources**
  - To recruit, train and supervise foster parents;
  - To recruit, train and supervise guardians and adoptive parents;

- **Training** for those working in each state’s child welfare program; and

- **Administrative costs** associated with the program.
Title IV-E does not cover all child welfare costs

- IV-E does not reimburse states for the cost of investigating child abuse reports.
- Prior to Family First, IV-E did not reimburse states for the cost of services to prevent placement. Most reimbursements were triggered only when a child was removed from the home and placed into care.
- IV-E does not reimburse states for the cost of services (social or clinical) to children in placement or with their families.
- “Services” are defined differently from case planning, case management, case supervision or oversight.
- IV-E reimburses a portion of the cost for administration, including case management and state staff costs (50%), and for board and care costs, based on each state’s per capita income (~63% in Maine).
Title IV-E, as a federal entitlement program, has limited eligibility

- Not all children are IV-E eligible. Initial eligibility is, in part, linked to the financial/income status of the home a child is removed from. The eligibility standards are based on 20-year old income levels, which have never been adjusted for inflation.

- Nationally less than half of all children in foster care are IV-E eligible. The rate of eligibility is declining over time, and varies from state to state.

- Important to note that new policies relevant to IV-E are likely to impact those not eligible for IV-E as well, in order to keep program consistent.
• Primary prevention is *not* part of Family First legislation. In order to have access to Family First prevention funds, a child must be determined to be a candidate for foster care (tertiary prevention) and have a “prevention plan” developed by the child welfare agency.

• Fed leaders talk of flexibility in approving state plans implementing Family First, but must be within statutory framework.

• Fed discretionary grants and demonstration projects focused on primary prevention are part of the Child Abuse Prevention and Treatment Act (CAPTA, the CBCAP program).

• Feds have brought to the table other federal agencies, families and youth served through the system to discuss collaboration at the service delivery level, particularly around primary prevention—requiring coordination with other agencies.
The goal of Jerry Millner’s “reimagined” child welfare system is to reduce the need for formal interventions by preventing the trauma of maltreatment and removal*

- While not included as part of Family First, feds are **emphasizing youth and family voice** both at the case and system levels related to under-funded primary prevention.
  - Current fund source for primary prevention is CBCAP program, which is a very small discretionary grant program.

- Current requirements are in **Child and Family Services Plans** (and Annual Progress and Services Report), which establish each state’s vision and goals. Plan requires states to engage in **“substantial, ongoing and meaningful consultation and collaboration with families, children and youth.”**

- Also required is the **Child and Family Services Review**, which is the federal process to ensure compliance with Titles IV-B and IV-E, and includes **interviews with families, youth and other stakeholders to understand their perspectives on outcomes and practices.**

- New guidance from feds also allows reimbursement for **independent legal representation of children and parents** to prepare for and participate in child welfare court proceedings.

*See ACYF-CB-IM-19-03*
Family First requires considerable planning and training to ensure quality and consistency.

- How to determine “candidacy” for foster care?
- How to figure out which preventive services are needed?
- How to evaluate the effectiveness of current preventive services to get them reimbursed?
- How to decide which preventive service is the right service for which clients?
- Will you meet QRTP criteria or just forego federal reimbursement?
- How to determine “right” criteria for needing residential level of care?
- How to set up a process for ongoing utilization review of residential services?
• Both criteria and a process for making that determination will have to be developed, approved by the feds and implemented.
• We don’t do a very consistent job of deciding who to investigate vs. provide an alternative response, or who to place now.
• Will we include criteria *in addition to* abuse or neglect? (e.g., alternative response cases, child behavior, child mental health, status offenders, etc.) Or will we keep the criteria narrow? (Just open CPS cases?) How wide do we want to cast the net, recognizing that state or local match will be required at 50%, and federal approval will be needed?
• How will decisions get made? By each worker, by sups, by a specialized unit?
• Any change will require a change in cost allocation process, which will require a revision to state procedures, including a new time study for state agency staff.

Who is a candidate for foster care? --At imminent risk of placement?
“Candidate” for foster care has been defined*

• **Definition:** A candidate for foster care is a child who is at *serious risk of removal from home as evidenced by the State agency either pursuing his/her removal from the home or making reasonable efforts to prevent such removal.* [HHS considers the terms "serious risk of removal" and "imminent risk of removal" to be synonymous and States may also use alternate descriptions that are equivalent to "imminent" or "serious risk of removal." ]

• A child **cannot** be considered a candidate for foster care when the State agency has no formal involvement with the child or simply because s/he has been described as "at risk" due to circumstances such as social/interpersonal problems or a dysfunctional home environment.

• **Documentation:** A State must document that it has determined that a child is a candidate for foster care pursuant to one of three acceptable methods:
  – A case plan that identifies foster care as the goal absent preventative services;
  – An eligibility form used to document the child's eligibility for title IV-E; or
  – Evidence of court proceedings related to the child's removal from the home.

*Social Security Act - section 471 (a)(15); Departmental Appeals Board Decision No. 1428*
• **Aftercare**: A child who is reunified, adopted/placed with legal guardian or transferred to a relative may be considered a candidate if the services or supports provided to the family can be considered the *State agency's reasonable efforts to prevent the child's removal from the home and re-entry into foster care.*

• **Length of candidacy**: HHS does not prescribe the maximum length of time a child may be considered a candidate; however, a State must document its justification for retaining a child in candidate status for longer than six months.

• **Prevention services episodes**: Each prevention services episode cannot last longer than 12 months, but additional episodes are allowed with new documentation of candidacy.
The state must submit a 5-year prevention plan to gain access to prevention services reimbursement

The state plan must define services and programs to be provided, including:

- **The Services**: How services were chosen and the target population for each service, and the evidence level each service has received;

- **Service Fidelity**: How implementation will be undertaken and continuously monitored for fidelity, and how service effectiveness will be measured, the outcomes achieved, and how continuous quality improvement will be done.

- **Caseworker Supports**: How caseworkers will be trained and supported to access the services and determine the continuing appropriateness of the service, how caseload size and type will be determined, managed and overseen, and how state will ensure the workforce is competent and skilled to deliver trauma-informed and evidence-based services

- **Service Coordination**: How other state agencies and community providers were involved in order to ensure a continuum of services for children and their parents or kin caregivers, and how services to individual families will be coordinated across agencies and providers.
For each child, the plan must include:

- A description of the foster care prevention strategy that will allow the child to remain at home or temporarily or permanently with a kin caregiver and the services to be provided, specified in advance of service provision.

For a pregnant or parenting foster youth, the prevention plan must:

- Be included in the child’s case plan,
- List the services to be provided to ensure the youth is prepared or able to be a parent, and
- Describe the prevention strategy for any child born to the youth.
There are 5 categories of programs and services eligible for prevention funding through Family First

**Types of services**

1. Mental health services
2. Substance abuse prevention and treatment
3. In-home parent skill-based programs
4. Kinship Navigator programs
5. Residential parent-child substance abuse treatment programs

**Additional requirements or limitations**

- No more than 12 months (per candidate episode)
- Must meet certain evidence-based requirements
- Must be trauma-informed
- Services must be provided by a qualified clinician
• Feds have specified that programs and services eligible for reimbursement must be categorized as **promising, supported, or well-supported programs**.
• At least 50% of expenditures to be reimbursed must be for **well-supported programs** (the highest standard of evidence).
• “Judging” of the evidence has been contracted to ABT Associates, who is running the Title IV-E Prevention Services Clearinghouse to assess and categorize all the candidate services and programs for prevention funds.
• Currently few services/programs meet the standards.
• *But how do we even know what we need?*
• Systems are weak in assessing needs of service population in order to determine what services to buy. Families and children get what’s available, which may or may not be what’s needed.
States are required to undertake certain activities to obtain federal reimbursement for prevention services

- Importantly, no Title IV-E income eligibility requirement for services or related training and administrative expenses
- Funds available beginning October 1, 2020, at 50% FFP until FFY2026, then at FMAP.
- State Plans must describe how states are undertaking:
  - Periodic risk assessment
  - Continuous quality improvement
  - Caseworker training
- Maintenance of Effort (MOE) based on FFY2014 expenditures
- Evaluation of evidence-based prevention programs is required
- Performance measures and data collection required for each child receiving prevention services:
  - Services provided and costs
  - Per child spending
  - Duration of services
  - Child’s placement status after 12 months and 2 years
12 services have been reviewed by the Title IV-E Prevention Services Clearinghouse *(Remember 50% of expenditures must be for well-supported programs)*

<table>
<thead>
<tr>
<th>Program/Service</th>
<th>Category</th>
<th>Rating</th>
</tr>
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<tbody>
<tr>
<td>Functional Family Therapy</td>
<td>Mental Health</td>
<td>Well Supported</td>
</tr>
<tr>
<td>Multisystemic Therapy</td>
<td>Mental Health</td>
<td>Well Supported</td>
</tr>
<tr>
<td>Parent Child Interaction Therapy</td>
<td>Mental Health</td>
<td>Well Supported</td>
</tr>
<tr>
<td>Healthy Families America</td>
<td>In-Home Parent Skill-Based</td>
<td>Well Supported</td>
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<tr>
<td>Nurse-Family Partnership</td>
<td>In-Home Parent Skill-Based</td>
<td>Well Supported</td>
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<td>Parents as Teachers</td>
<td>In-Home Parent Skill-Based</td>
<td>Well Supported</td>
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<td>Families Facing the Future</td>
<td>In-Home Parent Skill-Based</td>
<td>Supported</td>
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<td>Trauma-focused Cognitive Behavioral Therapy</td>
<td>In-Home Parent Skill-Based</td>
<td>Promising</td>
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<tr>
<td>Methadone Maintenance Therapy</td>
<td>Substance Abuse</td>
<td>Promising</td>
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<tr>
<td>Children’s Home Society of New Jersey Kinship Navigator Model</td>
<td>Kinship Navigator</td>
<td>Does not currently meet criteria</td>
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<tr>
<td>Kinship Interdisciplinary Navigation Technologically-Advanced Model</td>
<td>Kinship Navigator</td>
<td>Does not currently meet criteria</td>
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<tr>
<td>Multisystemic Therapy for Child Abuse and Neglect</td>
<td>Mental Health</td>
<td>Does not currently meet criteria</td>
</tr>
</tbody>
</table>
**Mental Health**
1. Attachment and Bio-Behavioral Catch-up*
2. Brief Strategic Family Therapy*
3. Child Parent Psychotherapy
4. Incredible Years
5. Interpersonal Psychotherapy
6. Multidimensional Family Therapy*
7. Triple P – Positive Parenting Program

**Substance Abuse**
8. Brief Strategic Family Therapy*
9. Family Behavior Therapy
10. Multidimensional Family Therapy*
11. Seeking Safety
12. The Seven Challenges

**In-Home Parent Skill-Based**
13. Attachment and Bio-Behavioral Catch-up*
14. Brief Strategic Family Therapy*
15. Homebuilders
16. Multidimensional Family Therapy*
17. Nurturing Parenting
18. SafeCare
19. Solution Based Casework

**Kinship Navigator**
20. Ohio’s Kinship Support Intervention/ Protect Ohio
21. YMCA Kinship Support Services, YMCA Youth and Family Services of San Diego County

*Included in more than one category.*
How do agencies evaluate the effectiveness of current preventive services to get them reimbursed?

- Requirements for well supported and promising programs are stiff.
- New handbook on standards and procedures is daunting.*
- Lots of new opportunities for evaluators.
- Systems will have to develop skills in developing RFP’s and securing funding for evaluations.
- There is an opportunity for states to submit evidence for programs not on the list, but documentation of evidence is substantial. If another states submits evidence, that can be used until Clearinghouse makes an independent judgment about the program or service.

How do agencies decide which preventive service is the right service for which clients?

- Tendency toward more is better or to under-refer!
- Must develop a process for determining which service is the right service, especially if there is an array of clinical services.
- Will services be provided in-house? Or contracted? If it’s a clinical assessment, will all clients need clinical services?
- With evaluation of impact of services on preventing placement after 2 years, field has lots of learning to do on what works to keep children safe in their families.
- If several services are provided to a single family, analysis will be needed to figure out what’s making the difference.
Will agencies meet QRTP criteria or just forego federal reimbursement?

- Reimbursement limited to 14 days unless QRTP requirements are met.
- Criteria for Qualified Residential Treatment Programs (QRTPs) are meant to ensure quality residential treatment, and end the practice of using non-therapeutic group settings, or using residential as default for teens. All programs must be accredited.
- Need for gatekeeping and ongoing utilization management will require new processes and lots of attention and oversight.
- States with Psychiatric Residential Treatment Facilities (PRTFs) through Medicaid may wish to eliminate facilities that are not PRTFs to simplify their oversight requirements.
- States with primarily teens in residential settings, with low FMAP* (Maine’s is ~63%) and low IV-E eligibility (Maine’s is about 55%) may decide not to claim any residential care and continue current practices.

Requirements for QRTPs could be difficult to meet for some programs

• Must have a trauma-informed treatment model and capacity to meet clinical needs of children;
• Must have licensed clinical and nursing staff on site during business hours and available 24/7.
• Must facilitate family participation in treatment and document how they are integrated into treatment process;
• Must facilitate outreach to family members, including siblings and maintain family contact information;
• Must provide discharge planning and family-based aftercare for at least 6 months; and
• Must be accredited.
Some residential settings are excluded from QRTP requirements

- A setting where a child has been placed with a parent in a licensed residential family-based treatment facility for substance abuse. (12-month limitation)
- A setting specializing in providing prenatal, post-partum or parenting supports for youth.
- Supervised independent living settings in states that have extended foster care coverage past age 18.
- A setting providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming sex trafficking victims.
How do agencies determine “right” criteria for needing residential level of care?

• Must be completed within 30 days of QRTP placement.
• Assessment by qualified individual, a trained professional or licensed clinician who is not a state employee or affiliated with any placement setting (may be waived).
• Tool must be age appropriate, evidence-based, validated, functional assessment (HHS to release guidance).
• Assessment must be conducted in conjunction with the family and a permanency team meeting.
• If QRTP is determined necessary, professional must document why child’s needs cannot be met in a family.
• If assessment does not support QRTP placement, states have 30 days to move child to an eligible placement or risk losing federal reimbursement.
For all children not in foster family home, for each placement setting:

- Numbers of children served
- Ages, gender, race/ethnicity of children
- Special needs, diagnosed mental or physical conditions
- Permanency goal
- Length of placement
- Whether placement was first placement, or number of previous placements
- Extent of specialized education, treatment, counseling provided in the setting
- Number and ages of children with APPLA goals
How do agencies set up a process for ongoing utilization review of residential services?

- Court review within 60 days of QRTP placement.
- At every status and permanency hearing, state must submit evidence
  - Ongoing assessment confirms need for QRTP placement
  - Specific treatment needs that will be met
  - Length of time child is expected to need additional treatment
  - Efforts made to prepare child to transition to a family
- Child welfare director approval for children in QRTP placement for 12 consecutive/18 cumulative months (or for 6 months for children under 13).
- Protocol to prevent inappropriate diagnoses.
- Criminal background checks for adults working in QRTPs and other group settings.
- States will have to certify that efforts to meet federal funding limits on non-family settings will not increase juvenile justice population.
Foster family home requirements have been updated

- States must adopt federally-defined, model licensing standards for foster family homes.
- Additionally, foster family homes have been defined as:
  - The home of an individual or family;
  - The caregiver resides with the child;
  - The caregiver must adhere to reasonable and prudent parent standards;
  - The caregiver provides 24-hour care; and
  - The caregiver provides care for no more than 6 children, with some exceptions (i.e., parenting youth, siblings, established relationships, special training).
Other opportunities and restrictions are included

- Reimbursement for evidence-based, kinship navigator programs is available without regard to eligibility for foster care.
- Grant funding for Regional Partnerships, which are collaborative agreements among public and private agencies to improve outcomes for children and families affected by substance use disorders, is available.
- States must develop a plan to document, track and prevent child maltreatment deaths.
- No policies enacted by a state can significantly increase the population in the state’s JJ system.
• Services begin at age 14 and extension of care up to age 23, education and training vouchers to age 26, with overall 5-year limitation.

• Focus on:
  – preparing youth with training and opportunities to practice daily living skills,
  – helping youth achieve meaningful, permanent connections with a caring adult,
  – helping youth engage in age or developmentally appropriate activities, positive youth development, and experiential learning that reflects what their peers in intact families experience.

• Training on youth development.

• States must analyze services compared to outcomes.
• BUT, states will have to embrace these new opportunities, not just comply with a myriad of new regulations.
• Lots of policy decisions need to be made about how to implement new law.
• Lots of new policies and procedures will have to be developed.
• New training to implement these changes will be extensive to get caseworkers and supervisors and providers up to speed.
“The creation of the title IV-E prevention program is an unprecedented step in recognizing the importance of working with children and families to prevent the need for foster care placement and the trauma of unnecessary parent-child separation. The Title IV-E prevention program is part of a much broader vision of strengthening families by preventing child maltreatment, unnecessary removal of children from their families, and homelessness among youth. It provides an opportunity for states to re-think dramatically how they serve children and families and creates an impetus to focus attention on prevention and strengthening families as our primary goals rather than placing children in foster care as our main intervention. The Children’s Bureau strongly encourages all title IV-E agencies to take this opportunity to not only use the title IV-E prevention program to fund these very important services, but also to envision and advance a vastly improved way of serving children and families, one that focuses on strengthening their protective and nurturing capacities instead of separating them.”
Recent Congressional plan to propose Family First Transition bill with 3 goals could be helpful (as of 9/17)

- **One time implementation funds**: Would provide states with a total of $500 million in one-time, flexible funding to support implementation of FFPSA and reduce any adverse fiscal effects due to startup costs, waiver transition, and improving foster care safety and quality. Distributed like IV-B, Part 1 funds, with 3% set aside for tribes.

- **50% of prevention reimbursement requirement for “well-supported” programs**: Proposal to delay this requirement for two years (through FY 2021), and then allow spending on both “supported” and “well supported” programs to count toward that 50% requirement in FYs 2022 and 2023. In FY 2024, the requirement that 50% of claims be for well supported programs would resume.

- **IV-E losses due to waiver wind down**: Would provide temporary grants to states or jurisdictions with expiring waivers if they face a significant loss of funds as they transition away from child welfare waivers. 90% of loss in FY20, 75% of loss in FY21.
Questions?

Thank you

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Family First Panel Discussion

Dr. Todd A. Landry
Director, Office of Child and Family Services

Mr. Daniel Despard
Senior Director, Casey Family Programs

Ms. Tracey Feild
Independent Consultant, recently retired Director of the Child Welfare Strategy Group of the Annie E. Casey Foundation
Maine’s Next Steps

All Maine Children & Families
SAFE, STABLE, HAPPY, HEALTHY

Dr. Todd Landry
Director
Office of Child and Family Services
Children in DHHS State Custody

The goal of the child welfare system is to keep children safe from abuse and neglect. When a child cannot be kept safely in their own home, the court may order them into state custody. This map shows the number of children in State custody based on the county they were removed from. Data is as of a point in time based on the date selected.

**Total Number of Children in State Custody**

2,195
Placements (September 2019)

- Residential: 41%
- Regular Foster Care: 33%
- Therapeutic Foster Care: 9%
- Other: 4%
- Residential: 4%
- Adoption: 2%
- Unlicensed: 2%
- Trial Home: 5%

Residential: 86
Residential Accredited: 52
Children In Foster Care By Placement Type: Group Home or Institution (Percent) – 2017

National KIDS COUNT
KIDS COUNT Data Center, datacenter.kidscount.org
A project of the Annie E. Casey Foundation
Children In Foster Care By Placement Type: Group Home or Institution (Percent) - 2017

United States: 12%
Connecticut: 10%
Maine: 5%
Massachusetts: 16%
New Hampshire: 22%
Rhode Island: 18%

National KIDS COUNT
KIDS COUNT Data Center, datacenter.kidscount.org
A project of the Annie E. Casey Foundation

Maine Department of Health and Human Services
Family First Act Next Steps

**TEAMS**

**Evidence Based Practices**
Gather and present data to inform target populations, contribute to and review 5-year Prevention Plan.

**QRTP**
Create the QRTP requirements guide for providers and develop report and QRTP assessment process.

**Workforce/Training Supports**
Contribute to 5-year Prevention Plan and the Standards of Practice and training requirements.

**Candidacy**
Define the requirements of candidate for prevention services in the 5-year Prevention Plan.

5-year Prevention Plan
What is your role in the implementation of Family First in Maine?

Now is the time to begin understanding Family First and talking about how it will improve outcomes for kids and families in Maine. Here are some things you can do in your community during the Family First implementation to keep kids safe and strengthen families:

- Learn more about Family First and share information on implementation and other resources with local leaders and community members who care about kids
- Promote positive messages around Family First implementation in Maine on social media
- Help connect parents, especially those struggling with addiction, to prevention and treatment resources in your community
- Offer a helping hand or shoulder to lean on for parents going through tough times
- Become or recruit foster parents
- Support relative and fictive kin families
- Help OCFS build the state plan for Maine
We Need You!

• Consider volunteering for one of our Family First Planning Teams
  - Evidence-based Practice
  - QRTP
  - Workforce / Training Supports
  - Candidacy

• Conference survey to follow the event today
  - Final question will solicit your desire to support one of these groups
Thank You!

Special Thanks to Casey Family Programs and the John T. Gorman Foundation for their support.