Therapeutic Foster Care Redesign
Request For Information (RFI) Forums
04.25.08

The Department of Children and Families has contracted with the University of Connecticut's (UConn) A.J. Pappanikou Center for Excellence in Developmental Disabilities for the convening and facilitation of forums for the purpose of receiving feedback, comments, and recommendations from interested parties regarding how the State's therapeutic level foster care services can be improved. Attendance at these forums is not required, and will have no impact on an entities' ability to apply for services that may be generated through this RFI. Interested parties can, as appropriate, attend the forum(s) and/or submit a written response to the RFI. These forums will be guided discussions and are being held as an additional mechanism in which to allow for broad stakeholder input into the redesign of this service.

PROVIDERS and OTHER KEY STAKEHOLDERS FORUM

(Open to any interested parties)

May 16, 2008, 1:00pm-4:00pm
Lee Auditorium, Merritt Hall
Connecticut Valley Hospital Campus
Eastern Drive
Middletown, CT

It is asked that no more than two persons from the same agency/organization attend the Provider/Key Stakeholder forum due to space considerations. Persons planning to attend this forum must RSVP to the UConn A.J.Pappanikou Center at 860.679.1500, by May 12, 2008.

FOSTER PARENT FORUMS

(Open only to persons who are current or former foster parents.)

In order to better allow foster parents to freely express their thoughts and opinions regarding how to enhance an/or improvement the therapeutic foster care system, providers and other persons who are not foster parents are asked to attend the *PROVIDERS and OTHER KEY STAKEHOLDERS* forum.)
Foster Parents will be provided with gift cards for their participation in the forums below. If child care will be required to aid with a foster parent's attendance at a forum, please contact UConn A.J.Pappanikou Center at 860.679.1500 by May 6, 2008.

May 14, 2008, 9:30am-12:30pm
Waterford Country School Therapeutic Foster Care Program
2 Clinic Drive
Norwich, CT

May 16, 2008, 9:00am-1:00pm
Willow Plaza Community Center
60 Elmwood Street
Waterbury, CT

May 23, 2008, 9:00am-1:00pm
The Village for Families, Trumbull Robinson Center
1680 Albany Avenue
Hartford, CT

May 27, 2008, 9:30am-1:30pm
Children's Community Program
446-A Blake Street
New Haven, CT

May 21, 2008, 9:00am-11:00am
ASPIRA of Connecticut, Inc.
1600 State Avenue
Bridgeport, CT

May 21, 2008, 6:00pm-8:00pm
Black Rock Art Center
2838 Fairfield Avenue
Bridgeport, CT

RFI ADDENDEUM

An addition has been made to the *Performance or Results Based Contracting* section of the RFI. The new language is presented in purple.

Any further addendums to the RFI, if needed, will be posted by May 1, 2008 on the State of Connecticut Department of Administrative Services website.

Therapeutic Foster Care Redesign

REQUEST FOR INFORMATION

April 4, 2008

State of Connecticut
Department of Children and Families
Office of Foster Care Services

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Request For Information (RFI)

I. TITLE

Therapeutic Foster Care Redesign

II. OVERVIEW

The Department of Children and Families (DCF/Department) is seeking input from providers, families, youth, and any interested persons or entities regarding the development of an enhanced, redesigned therapeutic foster care system for children. The information received through this process is expected to support the re-procurement of Connecticut's private provider therapeutic level foster care services.

III. PROCUREMENT SCHEDULE

RFI Published	April 4, 2008
RFI Addendum	On or about April 25
Deadline for Receipt of Information Submissions	May 30, 2008

IV. RFI PURPOSE AND GOALS

The Department's Office of Foster Care Services (OFCS) recognizes the importance of family and strives to support children in their homes and communities. When this is not possible, a family setting such as foster care, which is designed to meet the child's individualized needs, is pursued. Therapeutic Foster Care is defined as a home in which the foster parents have received specialized training to enable them to provide care for a wide variety of children and adolescents, usually those with significant emotional or behavioral problems.[1]

Therapeutic levels of foster care in Connecticut are provided through contracts or on a child specific basis through community-based, private providers. These programs are intended to serve children with complex mental and behavioral health needs who require temporary, out of home care in a family setting. At present, OFCS manages regular and therapeutic levels of foster care services. There are four (4) therapeutic levels of foster care[2] that OFCS funds through private providers. These service levels are as follows:

i. Therapeutic Foster Care
ii. Therapeutic Foster Care-Specialized
iii. Treatment Foster Care
iv. Professional Parent

[1] Adoption.com Glossary

[2] This listing excludes Therapeutic Foster Care-Medically Complex, which serves a child with complex medical needs. This is defined as a child who has: A diagnosable, enduring, life-threatening condition; a medical condition that has resulted in substantial physical impairments; medically caused impediments to the performance of daily, age-appropriate activities at home, school or community, or a need for medically prescribed services as identified on DCF-2101, "Certification of Child's Complex Medical Needs". Multi-Dimensional Treatment Foster Care (MTFC) is also excluded. MTFC serves children ages 10 – 16 who are currently in, or have recently been in, a Connecticut Detention Center or who have been released from Detention and identified by Court Support Services Division (CSSD) or DCF as requiring treatment in a residential level of care.

The DCF Office of Foster Care Services (OFCS) is embarking upon the comprehensive redesign of Connecticut's private provider, therapeutic foster care program for children with complex behavioral health needs. Under a redesigned therapeutic foster care system, DCF seeks to ensure effective, child specific, strengths-based, family centered and culturally competent care that results in sustainable, positive outcomes for children and their families. Structurally, the redesign should assist DCF to clearly state the core aspects of the state's therapeutic foster care programming including, but not limited to, referral and assessment processes, access point, care levels, service elements, training, data submission, quality assurance and performance measurements.

Through this Request For Information (RFI) process, the Department is seeking broad input regarding how to redesign its therapeutic level foster care system and create efficient and effective service delivery options. The Department is interested in receiving creative, concrete suggestions regarding how Connecticut's therapeutic foster care system can be revamped consistent with a comprehensive System of Care and wraparound philosophy, the Department's mission, the Office of Foster Care's guiding principles, current research and knowledge regarding promising and evidence-based approaches to foster care., The content of this RFI is intended to provide any interested respondent with basic information about the Department's current therapeutic level foster care system, as well as some concepts regarding the proposed redesigned system. Therefore, responses are hoped to be received from a broad range of individuals and organizations. Respondents do not have to be currently affiliated with Connecticut's foster care system. Responding to this RFI will not help or hinder participation in future competitive procurements.

V. DISPOSITION OF SUBMISSIONS

The Department expects to use the information received from this process to develop one or more competitive procurements for the delivery and administration of a comprehensive, community-based therapeutic foster care system for children. Any and all submissions obtained by DCF through this request, at the Department's discretion, may be used to inform the development of Connecticut's new therapeutic foster care system. The Department reserves the right to use any portion of the materials submitted. The Department will not return any materials submitted. If after review of the responses, DCF determines that it is in the best interest of the Department, OFCS staff may contact respondents for further information. Otherwise, there will be no acknowledgement by the Department of receipt of any submissions or direct response to questions that submitting parties might pose with regard to the RFI.

In addition, the Department is not liable for any costs incurred by persons/entities related to their submission of information pertaining to this request. DCF will not pay for information provided under this RFI and there is no guarantee that a procurement or subsequent contract will be supported as a result of this RFI. Acceptance of response(s) to this RFI places no obligation of any kind upon the Department.

VI. ELIGIBILITY

All interested parties are encouraged to respond to this RFI. Submissions will be accepted from any agency, person, or entity wishing to comment upon and/or provide input regarding Connecticut's therapeutic foster care redesign. All parties responding to this RFI must identify

themselves and provide a brief explanation of their interest in Connecticut's therapeutic foster care system. See Section XIV.

VII. RFI SUBMISSION DEADLINE

The contact person noted below must receive one complete copy of a respondent's submission. The copies must be received by 3pm, local time, on May 30, 2008, and directed to the RFI contact person at the following location:

Judith Jordan
Department of Children and Families
505 Hudson Street
Hartford, CT 06106

Electronic versions of parties' response to the RFI will also be accepted. They should be submitted to the attention of brenda.heath@ct.gov with the subject heading of *RFI Submission*.

VIII. RFI FORUMS

Opportunities for foster families, youth, providers and other interested entities to participate in forums in which to provide feedback regarding Connecticut's therapeutic foster system redesign will be occurring. Information about the date, times and locations for these forums will be posted on the Department of Administrative Services (DAS) website as an addendum to this RFI and the DCF OFCS website on or about April 25, 2008.

IX. BACKGROUND

Over the course of the past two years, OFCS has undergone considerable structural and personnel transformation. Under a centralized structure, OFCS oversees and manages both regular and therapeutic levels of foster care services. During State Fiscal Year (SFY) 2007 to present, OFCS has engaged in a variety of activities to help inform the redesign of the private foster care system. These activities included consultation with Children's Rights, Inc. and the Center for the Study of Social Policy (CSSP) to identify national evidence-based models and best practices to support Connecticut's transformation of its foster care system; individual provider meetings and case reviews to better support OFCS' understanding of how each provider's contracted foster care service is operationalized; and receiving feedback from Area Office staff, including Behavioral Health Program Directors, FASU Program Supervisors, and foster care liaisons.

This past fall, OFCS developed a tool, *Therapeutic Foster Families Service System Survey*, to obtain feedback and input from foster families licensed by private providers about Connecticut's therapeutic foster care system. In addition, OFCS held foster parent focus groups as a means to identify the supports, services, and training that foster families find most helpful to themselves and the foster children for whom they provide care. OFCS continues to seek opportunities for diverse stakeholder contribution to the enhancement of Connecticut's therapeutic foster care services.

X. BRIEF OVERVIEW-CURRENT THERAPEUTIC FOSTER CARE SYSTEM:

On any given day, over 3000 children are in Connecticut's foster care system. During State Fiscal Year 2007, 1512 children, with a median age of 11.14 years, were served by private provider operated therapeutic foster care programs.

This type of foster care is intended to be an intensive placement option for children in DCF care. This model of service is to provide a family setting, with an array of core services for children whose complex behavioral health needs preclude them from receiving care in a "regular" foster home. This service is also available for children with challenging behaviors who are stepping down from residential, therapeutic group home, hospital or Psychiatric Residential Treatment Facility (PRTF) care levels. Please see Appendix I, Private Provider Service Overview, for a brief service level description and a listing of attending private provider agencies and Appendix IV to view DCF's current Scope of Service template for "Therapeutic Foster Care."

Through state issued foster care regulations, private providers are licensed as Child Placing Agencies to recruit, train, approve and support families to provide the therapeutic levels of foster care. In seeking to redesign this system, we have identified three major problem areas:

1. The distinctions among the levels of therapeutic Foster Care are unclear in terms of target population, eligibility, and service expectations;

2. No real mechanism exists to definitively guide DCF Area Office staff in making a referral to one level of care versus another. In addition, a uniform assessment tool is not currently in place to aid Area Offices or providers in determining the appropriateness of a referral to a therapeutic foster care program, to adequately assist with match-making, or to evidence clinical improvements of the children served in these levels of care; and

3. The existing system lacks outcome measures to evidence the success of the provided service, as well as any uniform, collective, child/client level data reporting.

Thus, the current design of Connecticut's therapeutic foster care system does not adequately ensure that children with serious mental health needs who require therapeutic foster care are efficiently and quickly connected to the most appropriate service level. Moreover, at present, there is not an effective means by which to monitor and track the efficacy of the treatment received and the outcomes that are produced for children in therapeutic levels of care.

XI. NEW MODEL OVERVIEW

A. Conceptual Basics

The Department wants to ensure that Connecticut's therapeutic levels of foster care offer not only safe and loving family settings for children with complex behavioral and/or mental health needs, but are also intensive clinical treatment options where functional improvements can be achieved. In addition, OFCS seeks to create statewide consistency in the development and application of core therapeutic foster care services.

The concepts envisioned as part of the new model are intended to build upon the existing system and better define and detail key service elements to support needs of children in therapeutic foster

care. A brief overview of the model's concepts is set forth below. The *Model Considerations* section of the RFI will further detail the Department's thinking regarding the following:

1. DCF's therapeutic foster care system will continue to serve children stepping down from higher, restrictive levels of care and prevent children from requiring such placements. These are home settings that will incorporate behavioral, psychological, and psychosocial interventions and supports. These programs are to support children's mastery of the skills necessary to ensure, to the greatest extent possible, their growth into happy, self-sufficient and productive adults.

2. This service type will also prioritize and better enable children's permanency (e.g., reunified with their biological parents, adoption, placed with a relative, or transitioned into independent living.) The Department would like for its therapeutic foster care service to prepare children, as appropriate, for reunification with their family of origin or for adoption.

3. Children served in therapeutic foster care should be placed in homes in their community, allowing them, if possible, to attend their home school and maintain relationships with their social network. Placing children close to their school, social network and family should make it possible for services to be delivered in the child's own environment and involve those significant, familiar persons and entities.

4. These programs are expected to be developed and administered in a manner that ensures that foster children and their foster parents receive the supports and resources necessary to facilitate placement stability. Low caseloads will be expected. Foster families will be viewed as allies in devising and implementing treatment options that reduce disruption and support foster children's improved functioning.

Staff will have the expertise and skills necessary to train, coach and support foster parents in their care-giving role for foster children. Care Management and supervisory staff for these services will also serve as advocates for their children and their programs, and as required and appropriate, for the foster families for whom they have licensed.

5. Children will be cared for in a culturally and linguistically competent manner, supporting, respecting and upholding their cultural identity, religious/spiritual ascription and linguistic needs.

6. Collaboration with other providers, including DCF Area Offices, Community Collaboratives, the Systems of Care, Managed Service Systems and various formal and informal community-based services will be expected. Establishment and use of broad community linkages, including with faith-based organizations, will be expected to accomplish the goals and objectives under a new program model.

7. As clinically appropriate and congruent with protective service requirements, private provider staff and foster families will be expected to collaborate with children's biological and relative families. This is to occur to assist birth families in developing the skills and creating connections to resources needed for them to effectively care for their children.

Providers and foster families will encourage and support foster children in their care to maintain or even establish/re-establish ties with their biological relatives. Children's birth family should be

proactively engaged and supported in their meaningful involvement through contact, communication, information-sharing, and active decision-making about their children's treatment.

Foster parents will serve as role models and coaches to the biological family, or an adoptive family. The therapeutic foster care agency will also be expected to provide a comprehensive aftercare component that includes foster parents in order to facilitate transition to reunification through continuity of supports and services, and transfer of skills and strategies to the biological family as a means to successfully maintain children in their homes. Aftercare services would also be similarly used to support children who are transitioning from therapeutic foster care to an adoptive home.

8. Training will be a key component of the new model. DCF envisions that staff and foster families will attend specialized pre and in-service training to support their duties and to meet the individualized needs of the children receiving and/or requiring care. Both staff and foster parents would need to demonstrate basic competencies to evidence that minimum service expectations can be achieved.

9. Accountability and model fidelity will be key aspects of the therapeutic foster care programming. Data and quality management will be critical to effective care within this new model. Child specific and administrative program data will be required to be submitted at routine intervals. This data will be analyzed and reviewed by both the private provider agency and DCF. Data should also be regularly shared with foster parents to aid with ongoing planning for that family and their foster child. Similarly, data will need to be used to monitor quality and identify for both private providers and DCF any programmatic challenges or barriers, as well as potential best practices. Data will further be used to allow for the creation of a performance based contracting approach for these therapeutic foster care services in order to achieve measurable outcomes and meet program objectives.

While OFCS has identified a basic vision, core concepts, and underlying philosophies that are to guide the provision of Connecticut's therapeutic foster care services, a specific model has not been identified or developed. It is through this RFI that the Department seeks to obtain input regarding possible substantive program elements that can be integrated with the Department's proposed service system values to create an effective therapeutic foster care model.

B. Core Model Tenets and Objectives

OFCS' is seeking to create a therapeutic foster care model that meets several core tenets and objectives, including but not limited to:

i. Improves the quality, efficiency, effectiveness and responsiveness of Connecticut's therapeutic foster care system
ii. Creates a clear therapeutic foster care model that results in greater statewide consistency and continuity of service
iii. Provides an integrated system that coordinates and manages foster children's holistic care
iv. Facilitates positive, sustainable outcomes for children
v. Prioritizes and better enables permanency
vi. Embraces individualized, child and family centered programming

vii. Demonstrates cultural and linguistic competency
viii. Improves training for therapeutic foster care staff and foster families
ix. Principled in a Systems of Care/Wraparound approach
x. Embraces broad community-bases linkages, including non-traditional and faith based organizations
xi. Developed and administered based upon a performance based contracting structure
xii. Constructs a management information system and electronic environment that supports efficient and data informed service delivery, quality assurance and fidelity monitoring

C. Model Element Considerations

OFCS enhanced therapeutic foster care system is envisioned to include, but will not necessarily be limited to, the following model components:

1. Levels of Care

OFCS is considering the creation of three, distinct and clearly delineated therapeutic foster care programming levels. An algorithm, under a standardized eligibility assessment tool, would be developed. That metric would be constructed based upon the substantive criteria of the three levels of care. The proposed therapeutic foster care levels are noted below and would serve children with the following clinical presentations:

a. Moderate Level Therapeutic Foster Care

This level would serve children with a mental, behavioral, or emotional disorder that has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. Such children might present with ongoing problems related to interpersonal relationships, including a history of self-abusive behaviors, and minor episodes of aggression toward others. They would also have ongoing needs for mental health treatment, monitoring of school problems and/or special education needs.

A child whose characteristics include one or more of the following would be referred to the Moderate Level of Therapeutic Foster Care:

i. Is due to be released from a treatment facility or other restrictive level of care;
ii. Displays aggressive, destructive, or disruptive behavior;
iii. Is at risk[3] of being placed in a more restrictive setting;
iv. Is at risk[4] of hospitalization;
v. Is at risk[5] of institutionalization; and/or
vi. Has experienced numerous placement failures due to a serious DSM-IV diagnosis and/or behavioral issues that require treatment.

[3] "At risk" is defined to include, but is not necessarily limited to, a child's diagnosis; disruptive behaviors in home, school and/or community-settings; suicidal or homicidal thoughts; self mutilation; sexual acting out; running away; substance use; and/or challenges with activities of daily living due to behavior. These factors singularly or in combination might support a child being identified as at risk for hospitalization, institutionalization, or other more restrictive setting.
[4] Ibid
[5] Ibid

b. Specialized Level Therapeutic Foster Care

This level of care would serve a child whose characteristics include one or more of the following:

i. Unpredictable, non-violent, anti-social acts;
ii. Frequent or unpredictable physical aggression;
iii. Being markedly withdrawn and isolated;
iv. Major self-injurious actions to include recent suicide attempts; and
v. Difficulties that present a significant risk of harm to self or others.
vi. Severe impairment because of the substance abuse
vii. Exhibit serious maladaptive behavior

c. Intensive Level Therapeutic Foster Care

This would be the highest level of therapeutic foster care. It is expected that this level would be similar in intensity and severe clinical acuity as the current Professional Parent programs. These programs would serve children whose characteristics include one or more of the following:

i. Extreme physical aggression that causes harm;
ii. Recurring major self-injurious actions to include serious suicide attempts;
iii. Inability to maintain control in spite of close supervision;
iv. Poor/no response to mental health treatment
v. Other difficulties that present a critical risk of harm to self or others; and
vi. Severely impaired reality testing, communication skills, cognitive, affect, or personal hygiene.

OFCS is further considering creating some Specialized and/or Intensive Level Therapeutic Foster Care programs that are population specific. For example, there might be a specialized or intensive level program that exclusively serves or has slots dedicated for children who are dually diagnosed with MR/PDD and a serious emotional disturbance, or perhaps a program that targets children with a primary attachment disorder diagnosis or even those that have specialized expertise to meet the care needs of children who are identified as sexually reactive or are current fire setters. The Department is also potentially interested in contracting for therapeutic foster care programming that has specialized expertise to meet the mental health, social and developmental needs of children under age six.

While the current thinking is to structure the therapeutic foster care system based upon three levels, the Department has not determined the total number of programs that it will be seeking. Should a future therapeutic foster care procurement result in any change in provider(s), the Department is committed to ensuring that the children and families served by any impacted agency are well supported and fully aided in a planned transition to another local provider.

2. Eligibility Determination

Determination of eligibility for a therapeutic level of foster care would be based upon a child's score on a standard assessment tool. The intent is to take the subjectivity out of the eligibility determination and create a common referral framework and language.

OFCS will be using the Child and Adolescents Strengths and Needs (CANS) (http://www.buddinpraed.org/cans/) as the instrument by which eligibility into therapeutic foster care is determined. A CANS decision support tool and algorithm, developed specifically for Connecticut's therapeutic service system, will be created as the means by which a child's eligibility for this care level is assessed. The CANS will also serve to guide the goal and treatment development process for each child who is subsequently admitted into this care type.

OFCS is proposing to use an electronic, web-based CANS tool. The CANS would be administered either centrally through OFCS, if resources permit, or by the local DCF Area Offices. While the CANS will serve as the primary means by which eligibility and level determination is made, OFCS recognizes that there will be limited instances in which an "override" will need to occur in order to ensure that a child is placed in the most appropriate care level. A protocol for such process would be constructed.

3. Referrals:

OFCS would like to create a uniform referral process. Referrals would be created using a common, preferably electronic format, containing more expanded information than is currently contained on the DCF 469 Form. The referral, accompanied by the child's completed CANS, would be used to connect children to the appropriate level of care and to better facilitate matching of children with a home that will best support their clinical presentation, individual requirements, cultural and linguistic needs, and strengths.

It is desired to develop a real-time, web-based system that will electronically collect referrals into a centralized repository. Based upon the determined format, the referral elements would be inputted into the web-based system. Similarly, key information about the licensed private provider foster homes that are presently available for referrals (e.g., home location, preferences regarding child can/will accept, years fostering, etc.) would be collected and accessible via this system.

Referring DCF staff would have access to such information in order to have a preliminary idea as to whether there is a current, potential match for the child who they are referring. It is being considered whether referral making to therapeutic foster care should be granted to only select persons in the local DCF Area Offices or through a centralized Department process so that there is greater oversight with respect to prioritizing referrals. (e.g., using priority standards that are based upon the child's current placement setting and age cohort).

OFCS is interested in better ensuring that children have expeditious access to therapeutic level placements. Therefore, the Department would like to institute a time-frame by which a provider must respond to a referral. A time-frame of up to 5 business days is being considered.

The Department also wants to develop a referral mechanism that will support child-specific recruitment as a means to facilitate placement of children who may have more specialized needs or placement requirements. OFCS recognizes that significantly more time than what has been proposed above would be required in order to process referrals pertaining to a targeted recruitment. A response time-frame of 45-60 days for these types of referrals is being considered.

4. Target Population:

Therapeutic levels of foster care would prioritize referrals based upon age cohort. For example, referrals of adolescents (i.e., ages 12 -17)) followed by latency aged children might be prioritized. Moreover, therapeutic foster care agencies would be expected to prioritize referrals of youth and children needing to exit from SAFE and Permanency and Diagnostic homes, STAR homes, hospital/emergency department levels of care, residential treatment, group homes and crisis stabilization beds.

Referrals of very young children (e.g., ages 3-5) would be limited. As noted in the *Levels of Care* section, OFCS is considering some targeted therapeutic foster care programming for children ages 3-5. Agencies would be required to engage in a competitive process in order to demonstrate the competency, skills and expertise in agreement with the specialized needs of that early childhood population.

The joint placement of siblings, including those who do not require a clinical level of foster care placement will be a point of emphasis. Children who do not meet the criteria for therapeutic foster care, yet are being placed with a sibling who does, will be expected to require minimal support and care management from therapeutic foster providers. Therefore, they would not count towards the contracted therapeutic foster care bed capacity and could only count as one-third of a provider's caseload capacity. The regular DCF foster care rates and a uniform per diem administrative rate will be paid to support these children.

5. Matching

Key to the provision of therapeutic foster care will be the promotion of children's emotional, social, cultural, spiritual, intellectual and physical growth. Recruitment of a diverse pool of foster families will be essential to affecting the best possible matches. The process of matching will also be critical in order to ensure a good fit between the child and their foster parent(s). It will be essential that the foster family has the preparation, ability, strengths and skills congruent with the needs of the children to be placed in their home.

As part of the matching process, it will be important to ensure that pre-placement visits occur. OFCS is envisioning a pre-placement process that includes informal meetings, day visits and at least one overnight stay. Where appropriate and in agreement with permanency goals, children's birth families should be integrated into the pre-placement visitations as a means to establish their meaningful involvement at the inception of placement into the therapeutic foster care programming.

6 Waivers:

Regardless of a therapeutic foster care program's specific level of care designation, the Department expects that they all will be serving children with challenging, complex mental and

behavioral health needs. Therefore, programs would be limited to placing only one child who is identified as requiring a therapeutic level of care into each foster home. The placement of siblings would be an exception to this requirement. DCF wants to make certain that therapeutic foster care programs and foster parents are able to fully focus on achieving each child's comprehensive goals. It is thought that placing more than one child with significant and demanding behavioral health care needs will greatly lessen foster families' ability to take the lead role in directing and attaining the child's treatment objectives.

At present, provider agencies may apply for a waiver to allow for more than one non-related, therapeutic foster care level child to be placed in the same home. Under the redesigned therapeutic foster care system, OFCS envisions the granting of such waivers to be very limited. In addition, OFCS is proposing that a foster home may only be eligible for such a waiver if they have had a requisite number of placements, been licensed for a minimum number of years, demonstrated placement stability production, and/or successfully completed an advanced training requirement.

7. Limited Reject-Eject Rule:

Rather than creating a strict no unilateral reject-eject rule for this model, OFCS is considering a limited version of that expectation. The Department is considering a rule whereby providers would be allowed to reject or eject a limited number of referrals each fiscal year, based upon a pre-determined level (e.g., no more than 5 rejections a year). Under a performance-based contracting rubric, providers would be permitted to reject a certain number of referrals or a pre-set number of disruptions/ejections could occur and still be viewed to be within an acceptable contract compliance level. Providers who stayed within the acceptable level would be accorded some reward, potentially monetarily, for their performance. This might be a graduated, inversely proportional reward structure, where the less rejections or disruptions would result in greater remuneration.

8. Clinical Theoretical Framework:

The Department is considering use of a cognitive behavioral management model of care or a relationally-based, trauma informed model. Use of the Antecedent, Behavior and Consequence (ABC) model is also being considered. ABC is a framework for understanding behavior that is based upon learning and teaching, and serves as a means to promote and reinforce goals behavior. Both private provider direct care staff and therapeutic level foster parents would be trained in this model.

9. Assessment

As noted above, the CANS tool is proposed to be used as the instrument to support eligibility determination for therapeutic levels of foster care. OFCS is also considering the use of the CANS as the ongoing assessment tool, implemented at six month intervals, to evaluate the progress of children in therapeutic foster care programs. Other DCF behavioral health programs (e.g., care coordination) use the Ohio Scales and the Behavioral Emotional Rating Scales (BERS) as their routine assessment tools. The Department is looking into whether the CANS should be the sole assessment tool or whether it should be used in combination with another or other instruments.

10 Staff Constellation, Qualifications and Duties:

Therapeutic foster care agencies would need to ensure that they have a culturally and linguistically diverse staff constellation that is reflective of the community in which and persons for whom they are expected to serve.

For the least intensive therapeutic foster care level, care management staff would be required to be at least bachelors' degree in a human services field prepared individuals. Persons in these positions would be expected to fulfill duties including, but not necessarily limited to:

1. Treatment planning and monitoring
2. Referrals and service linkages
3. Foster family support
4. Consultation
5. Therapeutic engagement and support
6. Alternative care plan development
7. Respite and emergency care planning
8. Advocacy
9. Maintaining relationships between children and their families of origin
10. Arranging and/or transporting children to appointments and activities, as needed.
11. Safety and crisis planning and management
12. Care coordinating and monitoring
13. Obtaining information and maintaining involvement in all service provision, care treatment and outcomes, with an emphasis on continuity of care
14. Home visits
15. Child specific training
16. After care support

The caseload size for the lowest level of therapeutic foster care would be between 10 and 12 children at any given time.

Agencies contracted to provide the next two levels of care would likely be required to utilize master's degreed, clinically prepared, care management staff. While all care management staff will need to be clinically astute, these positions are not to function as clinicians to the children and families on their caseload. It will be preferred that child in therapeutic foster care programs have a separate, community-based clinician. This is desired to allow for continuity of care when children return to their families or transition in an alternative placement setting. For these more intense levels of care, the caseload size would expect to be 8-10 children at any given time.

In addition to the child and family specific services noted above, the care managers will be required to establish and maintain a collaborative relationship with the various service providers that are a part of the child's treatment team. This shall include no less than monthly phone or email contacts to the child's DCF social worker. Such contacts should include information about the observations, interventions, progress, ongoing safety and well being of the children that they mutually serve.

Care managers will need to have regular contact with foster parents. The current therapeutic level foster care contracts require at least bi-weekly contact with the foster children. In addition, at least

one visit to the home must occur during the month. OFCS is likely to retain such requirements, but also add weekly contact with the foster parent(s) by their care manager. Such contact could be via the phone, although at least two face to face meetings must occur monthly with the foster parent(s). This increased contact is meant to allow for enhanced communication and information exchange to better support foster parents and the children in their care.

The care management supervisor(s) must have at least a master's degree in social work or a closely related field (i.e., marriage and family therapy, counseling or psychology). OFCS is further considering requiring that position to be held by a person licensed by the State of Connecticut in a clinical field (e.g., LCSW, LMFT, licensed psychologist). The supervisor position may be expected to oversee the clinical match and engage in more direct outreach and support to the foster families than is currently happening. This may take the form of regular phone contact with the foster families, and increased face to face contact with the foster family, foster child and the child's biological, and participation in care planning meetings. A more treatment-oriented supervisory approach is being considered.

OFCS is also considering funding a recruiter position for each contracted therapeutic foster care program. This position would be filled by an individual with a broad recruitment background, strong knowledge of the local community for which they will be recruiting, direct behavioral health/mental health experience, proven knowledge of case management, family systems, organizing and coordinating meetings, and exceptional clinical, organizational, communication, and problem solving skills. The recruiter would work closely with the designated Area Office staff to gain a full understanding of the social-emotional behavioral needs of the children/adolescents identified. This will be an ongoing process to better inform continuous recruitment efforts and individualized child/adolescent and family matching.

Another possibility would be making funding available to allow agencies to subcontract with diverse community organization to do recruitment, home-finding and retention activities. SFY data indicates that 68.5% of the children who received therapeutic level foster care were African American/Black, Hispanic or Multiracial. Thus, it will be important that recruitment efforts occur in a culturally competent manner, informed by the therapeutic foster care population demographics. Partnering with local, grass root and/or faith-based organizations might be a means by which a diverse pool of foster homes can be recruited and retained.

Next, some current provider programs include therapeutic behavioral aide positions as part of their staffing team. The Department is considering whether such positions would be appropriate to be funded, particularly for programs that would be designated to serve children identified as needing a high level of therapeutic foster care (e.g., Specialized or Intensive). These would be master's level positions that would provide consultation, guidance, support and direction regarding the creation and implementation of an individualized behavioral modification plan for the children served. They would work with a child as a means to improve, maintain or restore their behavioral functioning and skills. The therapeutic behavioral aide would be expected to work in the home and community with the foster child, foster family and biological family, and serve as a core member of the treatment team.

Finally, within the Systems of Care approach, the pairing of care management staff with a family advocate is a longstanding and valuable tradition. Family advocates typically are expected to ensure that families are provided with the information, training, direct advocacy, empathetic listening, guidance, encouragement, and support necessary to fully participate in the planning of their child's behavioral health treatment. OFCS is considering a model configuration that would include such a teaming, as an additional support for foster parents licensed under private providers. It is thought that such positions would be hired through and supervised by local family support or advocacy agencies.

11. Staff Training

More uniform training of the staff providing therapeutic levels of foster care is desired. OFCS would like to ensure that all care management staff and their supervisors are conversant in trauma based treatment. As such, the Department is considering the implementation of a trauma treatment training model such as Dialectical Behavioral Treatment across providers. The Department would expect to contract for and fund that training for its private providers.

Some of the pre-service training topics, in addition to DBT and the ABC model, that OFCS is considering to require under the redesigned system include, but may not necessarily be limited to, the following:

1. Cultural and linguistic competence and culturally responsive care
2. Dynamic assessment and evaluation
3. Crisis prevention and intervention
4. Philosophy and characteristics of a Systems of Care/Wraparound Approach
5. Grief, loss and separation issues for children in foster care
6. Significance and value of birth families to children placed and supporting their inclusion
7. Staff's role in minimizing multiple placements
8. Significance of relationship building and connections
9. Family Systems Approach

12. Foster Parent Training

DCF wants to ensure that foster parents receive intensive preparation and training in order to meet the specialized and complex needs of the children to be served in their home. . The Department is considering reducing the number of PRIDE curriculum hours required for pre-service in favor of increasing the amount of clinical training provided. OFCS is interested in supporting foster parents so that they are in effect the primary source of treatment (i.e., change agents) for the child(ren) placed in their home.

Similarly, OFCS is considering requiring that a set number of post-licensing training hours are dedicated to clinical knowledge enhancement. OFCS is further considering that the actual number of required clinically related training hours is tied to the level of therapeutic foster care for which an agency is credentialed, and in turn the level for which the foster parent will be expected to provide. Thus, the highest therapeutic foster care designation would require a greater number of clinical training hours than a lower level.

Related, instituting some standard training topics that may include the following are being considered:

i. Special needs of children in therapeutic foster care (sexual abuse issues, understanding emotional disturbance, medication management, educational and vocational needs)
ii. Attachment issues
iii. Problem solving
iv. The family's role in the treatment team
v. Separation and loss issues
vi. Philosophy and characteristics of a Systems of Care/Wraparound Approach
vii. Childhood and adolescent development
viii. Crisis prevention and intervention
ix. Unconditional care
x. Behavioral management

Training specific to the clinical presentation and/or diagnosis of the child in the home would also need to be provided to foster parents by their therapeutic foster care agency. Some of the above topics would seem appropriate as part of foster family's pre-service training, yet feedback regarding the feasibility of including them at that time is needed.

13. Training Provision:

Presently, each private provider of therapeutic foster care service is responsible for the development (excluding the PRIDE curriculum) and provision of training for their program staff and the foster families that they license. The Department is considering the option of separately contracting for a single entity that would be responsible for the development, scheduling, coordination, administration and/or provision of all or some required training for therapeutic foster care staff and foster parents. As has been noted, the Department is seeking to standardize some of the training requirements, including the types of topics that must be provided. The proposed training entity would be charged with developing or arranging for needed trainings in conformance with standards that would be established under the re-design. Child specific training for individual foster families, however, would remain the responsibility of each private provider agency.

14. Foster Parent Expectations

Foster parents are to be the primary persons through whom effective care and treatment implementation for a child in therapeutic foster care will happen. They will have central input into treatment planning based upon their knowledge and observations of the child in their natural settings. Therapeutic foster parents will be expected to implement in-home treatment strategies that support children's increased behavior management, interpersonal skill development, problem solving and acquisition of independent living skills.

In addition, therapeutic foster parents would be integral to assisting to meet the child's permanency goals. As it occurs presently, foster parents would under the redesigned system, continue to ensure that foster children are served in a loving, family setting. Children will be helped to develop social support networks and build healthy, meaningful relationships with caring individuals. Foster parents will provide children with a normative experience, embracing their daily care needs in a

manner identical to that of any other child who is a member of their family. In support of this, the following would be expected of all therapeutic level foster families:

1. Appropriate care, nurturing, and affection
2. Establish trusting relationships
3. Model and teach pro-social behavior and healthy daily living, self care skills
4. Model family roles and decision making
5. Celebrate and acknowledge the child's achievements
6. Support opportunities for the child to pursue his or her talents, hobbies, or interests
7. Advocate on behalf of the child(ren) in their care
8. Arranging and attending medical, mental health, dental appointments and other necessary appointments
9. Ensure the child's access to age and developmentally appropriate social, recreational and summer camp opportunities, including systemically setting aside money from the per diem to ensure funds are available
10. Participate in therapeutic foster care treatment team meetings and other meetings related to the child's care provision (e.g., education, mental health, etc.)
11. Reinforce the child's progress
12. Participate in school functions and recreational activities related to the child
13. Become involved with a child's family of origin, serving as role models and support system.
14. Provide necessary transportation
15. Cultivate healthy relationships between the child and their birth family or other significant tie.
16. Daily documentation of child's behavior, progress and areas of challenge

15. Care Domains

Connecticut's therapeutic foster care system is intended to be comprehensive, individualized, cultural competent, family centered and strength based. It will be guided by a System of Care approach and wrap around philosophy. Furthermore, care will be informed by the following proposed core domains:

1. Mental/Behavioral health
2. Social-Emotional
3. Health
4. Recreational and Spiritual
5. Educational/Vocational/Career
6. Life Skills/Daily Living

Clear treatment planning and supportive resources would be expected to address all of these components in a strength-based, outcome oriented manner, congruent with the child's age, development level, cultural and gender needs and other individual factors. Input from the foster children, and birth family as appropriate, would be expected to be sought to ensure their desires and wishes are considered in the treatment plan development and delivery.

Care provision would also need to be delivered in a manner consonant with the child's routine and expected needs. Moreover, goals, activities, services, implementation steps, outcome

measurements, time-frames and responsible person(s) would need to be attached to each domain as a means to guide holistic and integrated care for children served in these therapeutic foster care programs. A robust service array for each child would also need to be created within the construct of the domains. It would be expected that all children receive a broad range of community-based programming that aids in their increased positive skill development and improved functioning.

16. Discharge Planning and Aftercare

Discharge planning will be expected to begin at the time of placement, in concert with the child's treatment team in order to ensure a coordinated and successful transition following their care in therapeutic foster care. Consonant with the Foster Family-based Treatment Association standards, the Department would expect the discharge plans to address the following[6]:

a. expected duration of treatment
b. major treatment recommendations that are likely to facilitate a successful discharge
c. most viable and beneficial post-treatment placement for the child

These plans would need to be reviewed on a regular basis, but no less than every quarter.

In addition, OFCS wants the new model to include a strong and proactive aftercare function. The Department hopes that therapeutic foster care services will be a critical resource in allowing children to be, as appropriate, reunified with their birth family or facilitate their adoption. The new model of therapeutic foster care will prioritize a comprehensive after-care component based upon the child's age and permanency goal(s).

The aftercare service would support transition into and stabilization within the biological or an adoptive home. After a child returns to their birth family or becomes part of their adoptive family, the therapeutic foster care agency would provide after-care services (e.g., care management, referrals, service linkages, behavioral management strategies, crisis support, etc.) to the family for a minimum period of time. (e.g., up to 3 or 6 months) The child's foster parent would also be compensated to be part of the after-care support team as a means to assist with continuity of care. In the aftercare phase, therapeutic foster parents would continue to serve as a coach and model to encourage, empower and support the birth or adoptive family. They may also serve as a respite resource to the biological or adoptive family. Aftercare services would also be extended to youth who transition into an independent living situation.

17. Cultural Competency:

Therapeutic foster care programming will need to occur in a manner that is culturally and linguistically competent. The new model will emphasis care that is individualized and supports children's development of a healthy racial, cultural and self identity. Providers will need to ensure that their staff and therapeutic foster parents have strong cross culturally competent skills and are actively supporting and inserting the children's cultural orientation into their individual care.

OFCS broadly defines the concept of culture. Therefore, culturally competent and responsive programming with Connecticut's therapeutic foster care system will need to be cognizant of the

[6] Programs and Standards for Treatment Foster Care, Foster Family-based Treatment Association (1995)

child's/youth's race, religion, spiritual needs, heritage, gender and sexual orientation. Program staff and therapeutic foster care families will need to possess the skills and receptivity needed to comfortably and effectively serve and achieve positive outcomes for children across the cultural continuum.

Related, the Department thinks that the provision of routine hair and skin care reflective of the cultural and racial needs of children in foster care is critical. OFCS knows that some hair care processes, including regular maintenance and upkeep, can be more expensive for children of color. The Department does not want there to be knowledge and/or monetary barriers that prevent children from receiving needed hair care services. Therefore, OFCS is considering a couple of options to better support children's hair care needs. For example, OFCS is considering identifying a pool of beauticians and barbers across the state who would bill the Department for services rendered to foster children based upon a set fee schedule. Another possibility would be providing the therapeutic foster programs an annual lump sum amount for each child that would be reserved to cover costs associated with their hair and skin care needs.

18. Community Linkages

As has been stated, the new therapeutic foster care model will be predicated upon a Systems of Care approach. (See Appendix VII) Consonant with the Systems of Care, partnership with a breadth of community services is a central feature. The Department is interested in a therapeutic foster care model that seamlessly integrates a broad array of community based services, including faith-based and non-traditional supports, which can be wrapped around the child and their family. This linkage is desired to ensure that children in therapeutic level of foster care have expeditious access to a variety of needed and appropriate services (e.g., outpatient/child guidance clinics, enhanced care clinics, extended day treatment, mentoring, recreation, medication management, education, etc.). In addition, because a wraparound philosophy recognizes that a child and their families care needs are dynamic, the establishment of broad collaborations and partnerships is viewed to be critical to the effectiveness of the therapeutic foster care system.

DCF wants the selected therapeutic foster care agencies to have solid clinical expertise and knowledge, but the children should be connected to local behavioral health, rehabilitative, social, recreational and educational services. This includes ensuring that children are connected to a community-based clinician. Since reunification or adoption are goals of therapeutic foster care, linking children to local programs is viewed to be best if they return to their own or a new community.

19. Fiscal

DCF is committed to both ensuring that the needs of children and families served within Connecticut's therapeutic foster care system are well met, as well as being prudent stewards of public funds. The Department is currently reviewing the rates that will likely be required to compensate foster families and pay provider agencies to meet the rigorous expectations that will come under a newly designed therapeutic foster care model. DCF is interested in developing rates that are fair and result in cost effective community-based programming. In particular, the Department wishes to standardize the rates for its therapeutic foster care services. Presently, there are some therapeutic foster care services that are provided outside of a DCF purchase of

services (POS) contract. As such, the rates for such programs vary from child to child. Instead, OFCS desires to move to standard rates for each level of care.

In addition, the Department wants to incentivize key outcomes for children. OFCS wants to lessen the financial impact that might thwart children's permanency goals (e.g., provider revenue loss if therapeutic foster parents adopt the children in their care). Therefore, the Department is exploring payment methods that reward achievement of outcomes.

Next, the Department hopes to maximize revenue for the therapeutic foster care program. In furtherance of that goal, the Department is exploring Medicaid billing options for some or all components of the therapeutic foster care system. While the Department does not expect that the new model of therapeutic foster will be immediately implemented with Medicaid billing requirements, it is envisioned that these programs would eventually move to some payment structure that includes Medicaid reimbursement. Contracts will be constructed to include language that requires providers to bill for any service components that may be reimbursable under the state's Medicaid, behavioral health carve out, the Connecticut Behavioral Health Partnership (CTBHP).

20. Performance or Results Based Contracting

OFCS is seeking to develop the new model of therapeutic foster care under a contracting approach that holds all parties accountable for achieving results. Whether it is the Performance -Based Contracting Model Contracting (PBC) approach or Results Based Accountability (RBA) system, it will be based upon defining service requirements in terms of outcomes. These systems typically incorporate some or all of the following[7]:

- Emphasizes results related to output, quality, and outcomes
- Has an outcome orientation and clearly defined objectives and timeframes,
- Uses measurable performance standards and quality assurance plans, and
- Provides performance incentives and ties payment to outcomes.

It is hoped that this mechanism will provide incentives to improve provider performance, tie some portion of providers' compensation to achievement, reward good performance, and result in better outcomes for children and their families.[8]

The Department recognizes that the establishment of sound baselines, implementation integrity and the development of solid monitoring structures, including assuring the receipt of accurate data, is key to cultivating a realistic and fair accountability environment. As informed by an anticipated evaluation of the new therapeutic foster care system, OFCS would likely be phasing in an outcome based contracting and payment structure within 2 years of the model's start.

As indicated in the *Fiscal* section, the Department would like to implement a model that includes incentives as recognition and reward for achieving or exceeding contract expectations. The type(s) of positive incentives that the Department is considering include enhanced rates and/or graduated bonuses. Such incentives would be extended to provider agencies based upon their

[7] *Best Practices And Trends In Performance Based Contracting, Office of Financial Management, FCS Group (2005)*
[8] Ibid.

attainment or exceeding of core outcomes, as well as for therapeutic foster parents who demonstrate effective care and meet minimum standards. For example, therapeutic foster parents might receive an increased per diem rate upon the successful completion of certain training requirements, a lump sum amount for achievement of placement stability or permanency, or perhaps garner a bonus for receipt of a positive independent evaluation.

Penalties for contract non-compliance and under-achievement of outcomes by therapeutic foster care agencies may also be part of the Department's performance based structure. DCF is not considering instituting penalties for foster parents.

The nature and types of provider penalties, both monetary and non-monetary, are under review. OFCS is considering possible funding options, whereby a portion of funding may be prospective with additional funding based upon the accomplishment of milestones (progress payments). The Department is interested is receiving feedback regarding the following concepts:

a. What activities within the provision of therapeutic level foster care might the Department consider in instituting incentives?

b. What activities within the provision of therapeutic level foster care might the Department consider in instituting penalties?

c. What should be the structure of the incentives?

d. What should be the structure of the penalties?

e. How large of an incentive would be needed to make a difference in outcomes?

f. How large of a penalty would be needed to make a difference in outcomes?

21. Outcome Measures

A variety of outcome measures, process goals, and performance indicators will be developed related to the new therapeutic foster care model and its core expectations. While the Department will likely select only a few meaningful outcome measures that will be directly tied to payment, OFCS is considering a floating system. Under such system, the mix of out measures that are tied to performance may be changed at given intervals to reflect changing needs. Some of the performance measures that are being considered for program monitoring, and/or evaluation are as follows:

A. Child Related Indicators

- Increased stability of placement (disruption reduction)
- Child's Functional Improvement:
  - ◊ Reduced emergency department contact
  - ◊ Reduced hospitalizations
  - ◊ Improved school attendance
  - ◊ Improved school performance

- ◊ Reduced juvenile justice involvement
- ◊ Progress on standard assessment instrument(s)
- ◊ Increased well-being

- Attainment of a requisite level or number of linkages to community services and enrichments as set forth in the child's treatment plan
- Achievement of service plan goals
- DCF participation in treatment planning
- Permanency achievement
- Step down to a lower level of care (e.g., reunification, adoption, relative placement, special study, regular foster care)
- Reduction of children's emotional and behavior crises that result in hospital use or police calls
- Reduction of running away
- The continuity of family relationships and connections is preserved or established
- Development of sustainable family and/or significant relationships
- Increased number of children placed with at least one sibling
- Children's satisfaction with their foster care placement and care management services

B. Foster Family Related Indicators

- Foster Family Post Licensing Training Completion
- Investigations (substantiated and unsubstantiated)
- Foster Family Satisfaction

C. Contract Related Indicators

- Regular attendance at DCF Administrative Case Reviews and Treatment Planning Conferences
- Number of waiver requests submitted
- Number of children placed within their local community or within 30 minutes of it.
- Number of referrals rejected
- Time from referral to placement (waitlist)
- Visitation/contact attainment
- Increased recruitment and licensing of foster families
- Increased retention of licensed foster families
- Achievement of contract capacity
- Timely and accurate data submission
- Achievement of annual recruitment and retention goals

22. Electronic environment

Increased used of technology will be a point of emphasis under the new therapeutic foster care model. As noted above, the Department is seeking to use an electronic eligibility assessment process and a web-based referral system. OFCS is also interested in making some key, child specific materials that therapeutic foster care providers generate accessible to select DCF staff (e.g., Area Office Behavioral Health Program Directors, DCF Areas Office Resource Group, OFCS management). The items that might be developed by therapeutic foster care providers within or batched into a central web-based repository could include a children's therapeutic foster care

service plan(s); case notes, logs, and progress reports. If a remotely accessible, web-based repository is deemed feasible for development, the Department would seek to construct it such that information that therapeutic foster parents may need to maintain (e.g., daily logs, behavioral charts, etc.) can also be inputted by them directly into the system.

23. Data Reporting

At present, therapeutic foster care providers submit monthly administrative data through a web-based application. This data provides aggregated program data regarding some aspects of the therapeutic foster care program (e.g., number of licensed homes, number of homes on hold, number of recruitment events, etc.) Under the new model, expanded program data would be expected. The processes and practices that are defined under the new model will be monitored via the data collection system. The required data would be congruent with the outcome measurement variables created to support accurate performance Based Contracting.

In addition, clinical level data would be required for submission at standard intervals. Child specific data would need to be provided at the time of the child's placement into the program, update data submissions at a set interval (e.g., every 6 months), and at the point of discharge. The Department expects to develop a web-based reporting system that will allow therapeutic foster care providers to directly enter client level data or send such data through a batch submission process.

24. Quality Assurance and Program Evaluation

The Department is committed to the success of Connecticut's therapeutic foster care system. Expanded data collection and reporting requirements will be a part of the therapeutic foster care redesign. The Department and provider programs will be expected to routinely use the data that is collected in order to monitor model fidelity, ensure quality and support outcome achievement.

In addition, therapeutic foster care providers would be required to create annual quality assurance plans. These plans would detail how the agency will monitor the efficacy of their service, congruent with the process goals and outcome measures that are created under the new model. Such plans would need to be submitted to and approved by the Department before implementation. Related, provider agencies would be expected to create annual recruitment and retention plans in order to articulate the means by which they will ensure the availability of a highly qualified, diverse pool of therapeutic foster homes.

As part of ensuring the provision of an effective and quality service, OFCS is interested in engaging in an accompanying independent evaluation of the new therapeutic foster care during its first year to two years. This is viewed to allow the Department to better identify and correct any potential challenges at the onset of the new model. It is envisioned that the evaluation will also result in the creation of model fidelity monitoring criteria and tools. In addition, the evaluation would support the assessment, and if necessarily, re-development of solid and realistic attainment levels for each performance indicator and measure. DCF would seek to contract with an entity for the provision of such evaluation.

XII. RFI SUBMISSION QUESTIONS AND TOPICS OF INTEREST

Please respond to the questions of interest below. Respondents may choose to respond to all or to a limited number of questions, based on their interest or knowledge. Response to this RFI will be used to inform planning and program development; they will not be evaluated for quality or completeness. These questions should serve as a guide, however, respondents are encouraged to provide feedback regarding any other aspects of the redesign and care model. Again, responses to this RFI will not help or hinder the respondent's success in achieving future awards from the Department.

It is asked that submitted responses consider the Department's goals and model concepts. Respondents should set forth any benefits and challenges that they identify regarding the model's structure, processes and expectations. Any assumptions that respondents are making with respect to their comments or recommendation should be included. It is also hoped that clear, innovative, and concrete ideas are provided. Respondents are also welcome to submit any feedback that might inform cost and rate development. In such instances, it is requested that respondents include a detailed methodology that readily outlines how any financial recommendations were derived (e.g., staffing levels/Full Time Equivalents, units of service, service episodes/frequency, etc).

A. General Areas for Response:

1. What tenets and goals should be addressed through the re-design of Connecticut's therapeutic foster care system, in addition to those set forth in the RFI?

2. How might the Department increase resources and create flexibility to better serve children and families served through therapeutic foster care?

3. What supports and resources are needed to support placement stability?

4. What supports and resources are needed to enhance permanency options, including reunification with children's family of origin or adoption?

5. How best can children's birth families be integrated into the therapeutic foster care placement?

B. New Model Responses:

1. What level of care structure might be developed to effectively address the distinct needs of children with varying clinical presentations?

2. How might the Department create a therapeutic foster care system that includes care levels that will best meet the needs of special populations? (e.g., children with mental retardation, pervasive developmental or autism spectrum disorders, sexually reactive children, fire-setting children, children with reactive attachment disorder, etc.)

3. What assessment tools and processes might the Department consider to ensure that children are appropriately identified for and meet the criteria for therapeutic foster care?

4. What type of information is recommended to be included in the referral material for therapeutic foster care? Consider the type of information that is needed to determine whether the agency can effectively meet the needs of the child and the type of information necessary to successfully match a foster home to a referred child.

5. What mechanism(s) might the Department use to support a uniform referral process and ensure that children, based upon an identified prioritization framework, are expeditiously admitted into the appropriate level of therapeutic foster care?

6. How might the Department support targeted recruitment for children who have specialized or highly complex needs

7. What clinical models might the Department consider to create positive outcomes for children in therapeutic foster care? Are there any existing curricula that DCF might consider for this service? If so, set forth whether the models are proprietary and whether there is any associated cost or use fee.

8. What instruments might the Department use to measure and assess the progress and achievement of children receiving therapeutic foster care services? Please set forth whether the tool(s) that are recommended are proprietary. If so, please include any possible costs associated with their purchase and implementation.

9. Would the use of contracts with local grass-root agencies be helpful to assisting with the recruitment and retention of a diverse pool of foster homes? Please detail the potential benefits and/or challenges that might be presented by such an arrangement.

10. What staff constellation is recommended to best support the goals and objectives of Connecticut's proposed therapeutic foster care system? What qualifications should be required for any positions identified or recommended? Detail the responsibilities that should be accorded to each position, including any quantifiable expectations (e.g., units of service, frequency of care provision, etc.)

11. Would the inclusion of family advocate positions be of benefit to therapeutic level foster families? Please detail the potential benefits of including these positions or set forth why they might not provide added support to therapeutic foster families.

12. Would the inclusion of therapeutic behavioral aide positions be of benefit to the children that may be served in the two highest levels of therapeutic foster care? Please detail the potential benefits of including these positions or set forth why they might not provide added support to the children in care.

13. What type of trauma informed training should the Department consider? If the training and its curriculum are proprietary, please include any possible costs.

14. What types of pre-service and in-service training should be required for therapeutic foster care agency's direct service staff? What is the recommended total number of hours of in-

service training and per-service training for program staff? Please include why you are recommending the specific type(s) of training and the number of training hours.

15. What types of pre-service and in-service training should be required for therapeutic foster care parents? What is the recommended total number of hours of in-service training and per-service training for foster families? Please include why you are recommending the specific type(s) of training and the number of training hours.

16. What mechanism for training delivery will best ensure that program staff and foster parents receive high quality training and support greater consistency across programs? If training is to continue to occur wholly or in major part through individual therapeutic foster care provider agencies, how can the Department ensure the quality and integrity of the training?

17. What resource and support would be needed to assist foster parents in meeting the comprehensive expectations that would be required under the redesigned system? What are the barriers and challenges that might thwart foster parents from being able to successfully achieve all the outlined expectations?

18. What barriers or challenges are likely to prevent the successful implementation of the identified care domains? What recommendations are proposed to allow children to attain expected goals under those domains?

19. What are the barriers and challenges that the proposed aftercare component presents? What alternative aftercare program structure is recommended? Please be sure to detail the staffing and other supports that would be part of that aftercare service and the proposed length of time for which a child and their birth family might receive aftercare services.

20. What innovations might the Department consider to better support the provision of culturally competent care? Please be sure to think about care that is gender specific, and responsive to children's racial, linguistic, spiritual, and sexual orientation identification.

21. How might DCF meet the hair and skin care needs of culturally diverse children who are served in therapeutic levels of foster care?

22. Based upon the Department's proposed model concepts and its attending expectations, what provider and foster family rates ranges should be considered. Please be sure to fully detail how you have arrived at such rate(s) (i.e., constructed metric/methodology), including any assumptions that have been used. It will be helpful to set forth what staffing, qualifications, training, stipends, service elements, and supports, etc. have been included in constructing the rate(s).

23. What barriers or challenges are envisioned that may negatively impact providers being able to bill for some services through the CTBHP?

24. What type of performance based contracting structure might the Department consider? How can such structure be implemented to ensure fairness and reasonable risks for

providers, as well as support DCF's desire for accountability, reward exemplary service, and ensure quality care?

25. What outcome measures might the Department consider to support effective therapeutic foster care services for children and foster families?

26. What type of managed information system and electronic environment will be needed to successfully implement therapeutic foster care in Connecticut?

27. How might the Department partner with provider agencies, foster parents, and foster children in ensuring the effectiveness and quality of therapeutic foster care services?

C. Other Suggestions

1. Respondents are welcome to include any other recommendations that they think will be helpful to informing the redesign of Connecticut's therapeutic foster care system.

XIII. RFI SUBMISSION INSTRUCTIONS:

RFI submissions are to use the format set forth in Section XIV: RFI RESPONSE FORMAT. Submissions must also conform to the requirements stated below.

Page Limit	15
Submission Format	Submit clipped copies (no binders) or electronically
Font Size	12 pt
Font Type	Times New Roman
Margins	1 inch all sides
Line Spacing	Double

Please ensure all pages of the RFI submission are numbered

XIV: RFI RESPONSE FORMAT

Responses to this RFI must be submitted using the format below. Respondents may submit comments with respect to any or all of the questions that the Department has posed. Responses should be organized under the three broad headings below. Submissions are not to exceed 15 double spaced pages, using 12 point, Times New Roman font. No other materials may be included with the submission (e.g., brochures, manuals, flyers, reports, etc.). Please number all pages of the submission.

Name of Respondent:	
Affiliation (check one): ☐Foster Parent ☐Youth ☐ Service Provider ☐ Provider Association ☐Other (specify):	
Agency Name:	Address:
Phone:	Email:
Respondents interest in Connecticut's Therapeutic Foster Care system:	

A. General Areas for Response:

B. Model Specific Responses:

C. Other Suggestions:

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APPENDIX I: PRIVATE PROVIDER SERVICE OVERVIEW

Service Type	Contractors	Description	Target Population
Therapeutic Foster Care	▪ Boys and Girls Village, Inc. ▪ Children's Center Community Programs, Inc. ▪ Community Residences, Inc. ▪ Family and Children's Agency, Inc. ▪ Jewish Family Services of New Haven, Inc. ▪ Klingberg Comprehensive Family Services, Inc. ▪ New Opportunities ▪ Village for Families and Children, Inc. ▪ Waterford Country School, Inc. ▪ Wheeler Clinic, Inc.	Recruitment, training and approval of families to provide care for children and/or youth who require substitute care due to abuse, neglect or other risk factors and due to the behavioral emotional challenges they present.	DCF active children ages 3 – 17 who, at the time of intake, need clinical interventions in order to address the trauma of their past as well as current thought and behavior issues. These children have not been successful in "regular" foster care, have a history of challenging behaviors and/or a current high clinical need that preclude that basic level of care. These are children who may be at risk for hospitalization or for residential treatment or who are "stepping down" from those placements.
Treatment Foster Care	▪ Boys and Girls Village, Inc. ▪ Catholic Charities Inc Archdiocese of Hartford ▪ Community Health Resources, Inc. ▪ Family & Children's Aid, Inc. ▪ United Community and Family Services, Inc. ▪ Wheeler Clinic, Inc. ▪ Yale University	Individualized treatment for children, youth and their families within the context of a treatment foster family. Foster parents, trained, supervised and supported by qualified program staff implement key elements of the treatment plan.	Children and adolescents at imminent risk of entering or returning from residential treatment or those discharged from hospitals, who meet the criteria for a DSM-IV Axis I diagnosis and who have a complex behavioral health disorder that substantially interferes with or limits their performance of developmentally appropriate activities at home, in school or in the community.
Therapeutic - Specialized Foster Care	▪ NAFI Connecticut, Inc. ▪ DARE	NAFI: Recruitment, training and approval of families to provide care for children and/or youth who require substitute care due to abuse, neglect or other risk factors and due to the behavioral emotional challenges they present. This is a family-based service delivery approach providing individualized treatment for children, youth and their families. Treatment focus is on emotional/behavioral issues preventing the child/youth from fully participating in family and community life. The program recognizes the therapeutic effectiveness of providing youth and children with an environment as normalized as possible. Treatment is delivered through an integrated constellation of services with a primary focus on key interventions and supports provided by specialized foster parents who are trained, supervised and supported by qualified Contractor staff.	NAFI: DCF active children ages birth – 18 who, at the time of intake, need clinical interventions in order to address the trauma of their past as well as current thought and behavior issues. Children from the DCF Voluntary Services Program and Juvenile Parole Services (Delinquent or Dually Committed) may also be referred, as may individuals over the age of 18 who are still receiving services from DCF. These children have not been successful in "regular" foster care, have a history of challenging behaviors and/or a current high clinical need that preclude that basic level of care. These are children who may be at risk for hospitalization or for residential treatment or who are "stepping down" from those placements. A teen mother and child, as well as a pregnant teen, are appropriate

		DARE: Recruitment, training and approval of families (where at least one parent will be identified as a "Mentor") to provide care for children and/or youth who require substitute care due to abuse, neglect or other risk factors and due to the behavioral emotional challenges they present.	referrals for placement if the teen has the clinical needs described. DARE: primarily includes adolescent and latency age children with an open case in DCF, who are "stepping down" from more restrictive placements (i.e., residential treatment facilities, group homes, shelters, hospitals and sub-acute units). These are children who are not a danger to themselves or others when in a community setting and may need multiple and comprehensive interventions due to moderate to severe behaviors caused by social, psychological, psychiatric or medical conditions.
Professional& Permanent	▪ Casey Family Services- Hartford ▪ Casey Family Service- Bridgeport ▪ Institute for Professional Practice ▪ Connecting Children and Families	Purchased and provided via child specific needs and agreements	Purchased and provided via child specific needs and agreements

APPENDIX II: Therapeutic Foster Care Contracted Bed Capacity

Service Type	Contracted Bed Capacity	DCF Area Office
Therapeutic Foster Care	65	Greater New Haven
Therapeutic Foster Care	19	Waterbury, Torrington
Therapeutic Foster Care	15	Bridgeport
Therapeutic Foster Care	200	metro New Haven, Greater New Haven, Meriden, Middletown
Therapeutic Foster Care	162	Statewide
Therapeutic Foster Care	45	Bridgeport, Norwalk-Stamford
Therapeutic Foster Care	35	Metro New Haven, Greater New Haven, Meriden, Middletown
Therapeutic Foster Care	18	Danbury, Waterbury, Torrington
Therapeutic Foster Care	35	Statewide
Therapeutic Foster Care	45	Danbury, Waterbury, Torrington
Therapeutic Foster Care	90	Hartford, Manchester, New Britain
Therapeutic Foster Care	70	Norwich, Willimantic
Therapeutic Foster Care	20	Norwich, Willimantic
Therapeutic Foster Care	57	Hartford, Manchester, New Britain
Therapeutic Foster Care Total	876	
Therapeutic Foster Care-Specialized	67	Hartford, Manchester, New Britain, Norwich, Willimantic
Therapeutic Foster Care-Specialized	27	Statewide
Therapeutic Foster Care-Specialized Total	94	
Treatment Foster Care	14	Manchester
Treatment Foster Care	25	Danbury, Waterbury, Torrington
Treatment Foster Care Total	39	
GRAND TOTAL	1009	

APPENDIX III: SFY 2007 PRIVATE PROVIDER EXPENDITURE DATA

SERVICE TYPE	EXPENDITURES
Therapeutic Foster Care	$20,226,373.31
Professional Foster Parents	$8,799,910.04
Specialized Foster Care	$2,608,633.58
Treatment Foster Care	$793,973.67
TOTAL	$32,428,890.60

APPENDIX IV: FOSTER CARE (THERAPEUTIC AND REGULAR) PER DIEM RATES

Therapeutic and Treatment Foster Care Rates
Effective July 01, 2007

Service Type	Per Diem	Rate for 31 Day Months	Rate for 30 Day Months	Rate for 29 Day Months
Regular Therapeutic Foster Care	$91.07	$2,823.17	$2,732.10	$2,641.03
Specialized Therapeutic Foster Care1	100.92	$3,128.52	$3,027.60	$2,926.68
Specialized Therapeutic Foster Care2	129.87	$4,025.97	$3,896.10	$3,766.23
Medically Fragile TFC	$98.96	$3,067.76	$2,968.80	$2,869.84
Treatment Foster Care w/ Recruiter	$100.74	$3,122.94	$3,022.20	$2,921.46
Multi-dimensional Treatment Foster Care	$98.61	$3,056.91	$2,958.30	$2,859.69
Professional Foster Care 1 (average. rate)	$148.43	$4,601.33	$ 4,452.90	$ 4,304.47
Professional Foster Care 2 (avg. rate)	$179.82	$5,574.42	$ 5,394.60	$ 5,214.78

Foster Care and Subsidized Guardianship* Rates
Effective July 01, 2007

Age/Service Type	Per Diem	Rate for 31 Day Months	Rate for 30 Day Months	Rate for 29 Day Months
Age 0-5 Foster Care	$25.73	$797.63	$771.90	$746.17
Age 6-11 Foster Care	$26.03	$806.93	$780.90	$754.87
Age 12 and over Foster Care	$28.24	$875.44	$847.20	$818.96
Medically Complex	$46.63	$1,445.53	$1,398.90	$1,352.27
Foster Care, Minor Parent and Child	$53.97	$1,673.07	$1,619.10	$1,565.13

*The amount of the monthly Subsidized Guardianship subsidy shall equal the Department's prevailing foster care rate that is applicable to the child's age and special needs, less the child's assets and income as determined by an asset test. See DCF policy 41-50-6.

APPENDIX V: THERAPEUTIC FOSTER CARE DESCRIPTIVE DATA[9]

Data Period: State Fiscal Year 2007 (July 1, 2006 - June 30, 2007)

ELEMENTS	DATA
Total Number of Children Served in Therapeutic Levels of Foster Care During SFY 2007	1512
Sum of Children In-Care at Therapeutic Levels of Foster Care During SFY 2007	972
Sum of Children who Entered Therapeutic Levels of Foster Care During SFY 2007	540
Sum of Children who Exited Therapeutic Levels of Foster Care During SFY 2007	545
Sum of Children in-Care at Therapeutic Levels of Foster Care First Day of SFY 2008	967

GENDER: Total Number of Children Served in Therapeutic Levels of Foster Care During SFY 2007		
Gender	#	%
M	836	55.3%
F	676	44.7%
Grand Total	1512	100.0%

MEDIAN AGE: Total Children Served During SFY 2007:	11.14

AGE: Total Number of Children Served in Therapeutic Levels of Foster Care During SFY 2007			
Age	#	%	Average Age
0-5	321	21.2%	3.33
6-11	533	35.3%	9.19
12-17	631	41.7%	14.56
18-23	27	1.8%	18.82
Grand Total	1512	100.0%	10.36

MEDIAN AGE: Total Children Served: Age On Latest Exit from TFC Spell (or on 6/30/07 if still in care) During SFY07	12.50

AGE: Total Children Served: Age On Latest Exit from TFC Spell (or on 6/30/07 if still in care) During SFY07			
Latest_TFC_Exit-_Age	#	%	Average Age
0-5	247	16.3%	3.47
6-11	456	30.2%	9.07
12-17	678	44.8%	14.96
18-23	131	8.7%	19.04
Grand Total	1512	100.0%	11.66

[9] Includes data from Therapeutic, Therapeutic-Specialized, Treatment and Professional Parent foster care programs.

RACE/ETHNICITY: Total Children Served:		
Race and Ethnicity	#	%
BLACK/AFRICAN AMERICAN (Non-Hispanic)	556	36.8%
WHITE (Non-Hispanic)	453	30.0%
HISPANIC (Any Race)	424	28.0%
MULTI-RACIAL (Non-Hispanic)	56	3.7%
UNABLE TO DETERMINE (Non-Hispanic)	18	1.2%
AMERICAN INDIAN OR ALASKAN NATIVE (Non-Hispanic)	3	0.2%
ASIAN (Non-Hispanic)	2	0.1%
Grand Total	1512	100.0%

Total Length of Stay in TFC Placements With At Least 1 Day During SFY07			
Total_TFC_Stay_Days	#	%	Average TFC_Stay_Days
1-183	264	17.5%	87.94
184-366	297	19.6%	277.33
367-549	288	19.0%	458.28
550-732	242	16.0%	632.77
733-915	210	13.9%	841.50
916-1098	111	7.3%	982.33
1099-1281	42	2.8%	1185.81
1282-1464	16	1.1%	1354.31
1465-1647	9	0.6%	1553.56
1648-1830	11	0.7%	1705.82
1831+	22	1.40%	2486.338
Grand Total	1512	100.0%	550.12

Placement Setting Prior to First SFY07 TFC Placement		
Previous Setting	#	%
Safe Home	398	26.3%
Unavailable_Blank	137	9.1%
Age 6-11 Foster Care	135	8.9%
Age 0-5 Foster Care	128	8.5%
Professional Foster Care	98	6.5%
Age 12-18 Foster Care	92	6.1%
Residential Treatment-CPS	90	6.0%
Shelter,Temporary	63	4.2%
Permanency Diagnostic Ctr MH	35	2.3%
Therapeutic Foster Care	34	2.2%
Age 6-11 Foster Care, Preadoption	24	1.6%
Relative Care,Age 6-11	19	1.3%
Group Home	18	1.2%
Shelter,Temporary-Mental Health	18	1.2%
Hospital Care (Psychiatric)	17	1.1%
Relative Care,Age 0-5	17	1.1%
Residential Treatment-MH (Intensive)	17	1.1%
DCF: Riverview Placement	15	1.0%
Medically Complex - Foster Care	14	0.9%

Relative Care,Age 12-18	14	0.9%
DCF: State Receiving Home Placement	13	0.9%
Special Rate-Foster Care	13	0.9%
Residential Treatment-MH	11	0.7%
Age 0-5 Foster Care, Preadoption	10	0.7%
Age 12-18 Special Study Foster Care	10	0.7%
Age 6-11 Special Study Foster Care	10	0.7%
Hospital Care (Medical)	10	0.7%
DCF: High Meadows Placement	8	0.5%
Specialized Foster Care	8	0.5%
Age 12-18 Foster Care, Preadoption	7	0.5%
Residential Treatment - JJ	5	0.3%
Group Home-Mental Health	4	0.3%
Medically Complex- Foster Care- Private	4	0.3%
Detention Center, Juvenile	2	0.1%
Permanent Family Residence	2	0.1%
Sub-Acute Residential - Hospital License	2	0.1%
Training Home,DMR Community	2	0.1%
Age 0-5 Special Study Foster Care	1	0.1%
DCF: Long Lane Placement	1	0.1%
FCAP Foster Care (CPS)	1	0.1%
Group Home-Juvenile Justice	1	0.1%
Medically Complex - Relative Care	1	0.1%
Medically Complex - Special Study	1	0.1%
Residential Treatment- SA	1	0.1%
Treatment Foster Care	1	0.1%
Grand Total	1512	100.0%

SIBLINGS IN TFC DURING SFY 2007		
ELEMENTS	# SIBLINGS	#SIBLING GROUPS
Total Number of Children Served in Therapeutic Levels of Foster Care During SFY 2007	567	230
Sum of Children In-Care at Therapeutic Levels of Foster Care During SFY 2007	295	---
Sum of Children who Entered Therapeutic Levels of Foster Care During SFY 2007	272	124
Sum of Children who Exited Therapeutic Levels of Foster Care During SFY 2007	190	---
Sum of Children in-Care at Therapeutic Levels of Foster Care First Day of SFY 2008	377	---

APPENDIX VI: Sample DCF Therapeutic Foster Scope Of Service/ Contract

A. Description, Contract Capacity and Unit of Service

1. Service Description

This service includes the recruitment, training and approval of families to provide care for children and/or youth who require substitute care due to abuse, neglect or other risk factors and due to the behavioral emotional challenges they present.

2. Contract Capacity

The Contractor will serve children referred by or approved by DCF's _____Area Offices. The program capacity will be ___children in placement. Any placements beyond this capacity must have the approval of the DCF Central Office Contract Manager.

3. Funding

a. Purchase of Service Price

The Contractor will be paid a per diem rate of $ _____ per child from which the Contractor must make a per diem payment to each foster family that is a minimum of $____ per day. The per diem rate to the Contractor may be adjusted during the contract period to include Cost Of Living Adjustments (COLA) increases or pass through modifications. Any COLA received by the Contractor shall increase the per diem amount paid to each foster family at the same rate as that COLA. Per diem rates are established by the Commissioner of DCF or his/her designee

b. Payment Terms

Retrospective monthly payments, based upon invoices submitted for the previous month in a format approved by DCF, will be made through the DCF LINK system. In the event that a teen mother and her baby are placed in one of the Contractor's foster homes, payment will include both the program per diem rate for the teen and the current DCF per diem rate for a foster child age 0-5.

Annual payments cannot exceed 100% of the Contract amount without a contract amendment.

c. Over-night Pre-Placement Visits for Children "Stepping Down" from a Residential Setting or Hospital

With prior approval from a DCF Area Office Program Supervisor, the Contractor will be reimbursed, at the contract rate, for one day of service for each over-night that a child from a residential facility or hospital spends with a potential foster family.

d. Payments While a Child is Hospitalized

The Contractor may be reimbursed for up to 14 days while a child is hospitalized if there has been an agreement that the child will be returning to the same foster home. This agreement must include the approval of a DCF Area Office Program Supervisor. Additional days will be considered on a case-by-case basis and must be approved by the child's DCF Area Office Program Director.

B. Service Delivery Requirements

1. Target Population

The target population includes DCF active children ages 3 – 17 who, at the time of intake, need clinical interventions in order to address the trauma of their past as well as current thought and behavior issues. These children are not a danger to themselves or others in a community setting and need:

a. extra supervision

b. regular individual and/or group and/or family therapy
c. social skills development
d. a treatment environment and specific therapeutic interventions provided by skilled foster parents

These children have not been successful in "regular" foster care, have a history of challenging behaviors and/or a current high clinical need that preclude that basic level of care. These are children who may be at risk for hospitalization or for residential treatment or who are "stepping down" from those placements. This is not a program for children whose treatment issues have been sufficiently addressed and whose primary need is for a "permanent" family, i.e. children with no identified permanent resource are eligible for this program if they have "treatment" needs that must be addressed prior to being settled in a "forever family."

A teen mother and child, as well as a pregnant teen, are appropriate referrals for placement if the teen has the clinical needs described above.

2. Intake

The Contractor will receive referrals and will have access to background information and the child's DCF record. The Contractor will make an assessment based upon the material presented by DCF. The contractor will adhere to referral response expectations established by DCF Area Offices. In addition, the Contractor will participate in meetings with DCF prior to the placement of the child, as requested, to both assess child needs and family strengths and to identify initial placement responsibilities

3. Staffing

Contract agency staff will be experienced and educated in child welfare, including placement, cultural and clinical issues. Contract staff will share 24 hr coverage with phone and/or beeper availability to foster families for emergency situations. Maximum caseloads will be 9 children with the exception that in situations where siblings are placed together or when, as an interim measure, other staff are being trained, a caseload may increase to 12. The Contractor will provide on-going training for staff so that they will have the skills to better engage and support children and families.

4. Recruiting, Studying and Approving Foster Families

The Contractor will:

a. follow the background check process as outlined by DCF that will include fingerprint results from both Connecticut State Police and the Federal Bureau of Investigation (FBI).

b. use the home study format prescribed by DCF.

c. use the PARENT RESOURCES FOR INFORMATION, DEVELOPMENT AND EDUCATION (PRIDE) curriculum for each training group series. Other topics may be required by DCF.

d. keep a written record of the pre-approval training attendance policy and all pre-approval training that is conducted including hours, trainers, and attendance lists.

e. limit the foster placement capacity of foster homes to one child with the exception of siblings. Further exceptions to this rule would necessitate written approval from the DCF Area Office Director.

f. make no placements of children in homes in which licensed day care services are provided unless, on a case-by-case basis, a waiver is obtained from the DCF Commissioner.

g. Approve only families who have employment schedules that allow them to be available to meet the treatment needs of the child.

5. Re-Approving Foster Families

In the foster family re-approval process, the Contractor will follow the expectations set forth by DCF and will review the entire record, taking note of HOTLINE reports, critical incidences, and the parent(s) participation in training.

6. Contact With Clients and Foster Parents

The Contractor will ensure that case managers/social workers have face-to-face contact with their children in placement and with foster parents as often as necessary to ensure progress on treatment goals, to enhance personal relationships crucial to the child's treatment, to give the child an opportunity for confidential discussion and to support the foster family. Face-to-face contact between the child's case manager/social worker and the child and foster parent will occur at least every other week. The contractor's case manager/social worker will visit the foster home at least once every four weeks.

7. Addressing the Trauma of Placement for Children

The Contractor will educate foster parents about the trauma inherent in a child's experience of placement and how to implement creative ways to make the initial days and weeks of placement as welcoming as possible.

8. Building Competencies

The Contractor will strengthen the competencies of each foster parent so they can actively participate in the planning and implementation of therapeutic interventions for their foster children. These competencies include knowledge of and skill at being both a primary "encourager" for each child's emotional growth and a "teacher/coach" for each one's behavioral growth. Contractors will help foster parents serve as role models for birth families during visitation in the foster home unless contra-indicated. In addition, the Contractor will require foster parents to keep written logs or records as necessary.

9. Providing Case Management Services as Delegated by DCF

While legal and final decision making responsibility remains with DCF, day-to-day activities of children served through this contract will be managed by the Contractor. Contractor case management activities will include:

a. Working with surrogate parents and other appropriate professional to assure that a full and appropriate educational program is provided for every child served under this contract.

b. Ensuring that the health needs of the children are being met as specified by the child's health care provider in conjunction with appropriate professionals and the child's foster caregivers. These include, but are not limited to:
   i. notification to DCF of any changes in the child's physical health status
   ii. contributing written notes and forms, as appropriate, to the child's DCF medical record
   iii. regular review with foster caregivers of any prescribed medication
   iv. regular review with foster caregivers of any medical procedure(s) to be provided and managed and/or coordinated by the foster caregiver
   v. timely documentation and communication to health care providers regarding any health care concerns.

c. Maintaining relationships between children and their families of origin by facilitating and/or providing counseling or other activities that will lead to family reunification or to the development of a permanent placement of the child. Foster homes will be included as locations for visits between children and birth families unless there is a safety concern.

d. Discuss, in partnership with DCF, permanency options with therapeutic foster families and to do upfront concurrent planning.

e. Assisting with arrangements and/or transporting children to required medical appointments and activities. The Contractor will assure that all children are accompanied by the caregiver when attending a medical appointment.

f. Assisting foster parents manage crisis situations and challenging/disruptive behavior so that children can be stabilized in the foster home.

g. Assuming the leadership role as delegated by DCF in order to assist in the implementation of the child's permanency goal as identified on the DCF *On-Going Individual Treatment Plan.*

h. Monitoring case activity including supervisory review of records.

i. Cooperating with visits, both announced and un-announced, by DCF to contractor foster homes.

10. Training and Support of Foster Parents

The Contractor will:

a. ensure that both staff and foster parents complete mandated reporter training provided by DCF

b. provide on-going training for foster parents in accordance with DCF policy, practice and planning guidelines. Each foster family is to receive at least 20 hours of post-approval training yearly related to the needs of this population of children and their caregivers biennially

c. include, in written policy/procedure materials, an explanation of the process for instructing new staff and foster parents in reporting of abuse and neglect

d. submit for review to DCF, when requested, the curriculum for the basic post-approval training of foster parents. Included with the curriculum should be a statement about the number of hours needed to complete the curriculum, a list of trainers and the agency's attendance policy. Conduct training and keep records of hours, trainers and attendance lists

e. provide foster parents, their birth children and their foster children, opportunities for support, growth, and education through formal and informal forums, such as group meetings, workshops, recognition events, and social activities

f. provide both emergency and planned respite through providers known to the child who have received appropriate child specific training from a qualified medical provider and who are prepared to meet the child's needs on a temporary basis. All respite services will be funded by the Contractor. Families caring for children with complex medical needs are eligible for a minimum of fourteen days of respite annually.

11. Commitment to Children in Care

a. In the event of a child or foster family crisis, Contractors will make every effort to keep the child in their program. This would include efforts to make temporary and permanent re-placements of the child with another family supervised by the Contractor.

b. If, after deliberation among DCF, the foster family and the Contractor, a child's removal from the home and the Contractor's program is deemed appropriate but not necessarily immediate, it is

expected that the Contractor and family will maintain the placement for at least 21 days while DCF seeks a new placement resource.

c. If a family insists on the removal of a child against the advice of the Contractor and DCF, the family will not be considered for any new placement.

d. The Contractor will assure that the foster family's school, church, community and/or other activities shall not interfere with the parent's ability to meet the needs of their foster child.

e. Extensive family commitments shall be discussed with and must have the support of the agency staff.

12. Relationship to Other Providers

The Contractor will be an active participant in DCF initiated statewide meetings of foster care providers.

13. Treatment Planning and Implementation

The Contractor will:

a. establish "treatment teams" composed of the child's DCF social worker, the Contractor's social worker/case manager and the foster parents, with auxiliary members as appropriate (e.g. child's therapist, DCF and private agency supervisors).

b. develop a written treatment plan, complementary to and expanding upon the child's DCF *On-going Individual Treatment Plan*, within 30 days of placement and approved and signed by a Master's level staff person. Goals will be measurable, time-limited and divided into achievable steps. This treatment plan will be reviewed and up-dated quarterly with notes on progress toward goals. Foster parents will be active participants in the development, implementation and review of the plan.

c. insure that staff and foster parents attend DCF's treatment plan reviews for each child in placement

d. hold quarterly case specific treatment planning meetings in conjunction with or in addition to the DCF case review process and invite the child's DCF Social Worker to these meetings.

14. Discharge Decisions

The discharge of children from the program will be the result of a plan between DCF and the Contractor. In the event of an emergency hospitalization the Contractor must notify DCF immediately. Plans for a child to return to a Contractor's foster home after hospitalization will be made on a case-by-case basis between DCF, the family and the Contractor.

C. Data and Outcome Reporting Requirements

The Contractor will submit data reports on a quarterly basis to DCF using report forms provided. Other report requests may be made by DCF. The Contractor will maintain both child and foster family records according to DCF directives.

APPENDIX VII: SYSTEM OF CARE OVERVIEW

Guiding Principles of Systems of Care[10]

In Systems of Care, State, county, and local agencies partner with families and communities to address the multiple needs of children and families involved in child welfare and other service systems. At the heart of the effort is a shared set of guiding principles that include interagency collaboration; individualized strengths-based care; cultural competence; child, youth, and family involvement; community-based services; and accountability. These principles are essential elements of any successful System of Care. The implementation of these principles reflects the common goals of the agency, community, and family to ensure the safety, permanency, and well-being of children, youth, and families.

Interagency collaboration

Engages child- and family-serving agencies from the public, private, and faith-based sectors.

Individualized strengths-based care

Acknowledges each child and family's unique set of strengths and challenges and builds care plans that optimize those strengths while meeting the challenges.

Cultural competence

Refers to a defined set of organizational values and principles, as well as behaviors, attitudes, policies, and structures that enable systems to work effectively cross-culturally.

Family and youth involvement

Requires mutual respect and meaningful partnership between families and professionals at all levels.

Community-based services

Engaging home, school, and community-based resources as the optimal method for providing care and support to children and families.

Accountability

Refers to the continual assessment of practice, organizational, and financial outcomes to determine the System of Care's effectiveness in meeting the needs of children and families.

[10] Health and Human Services Administration for Children & Families, Children's Bureau

APPENDIX VIII: WEB RESOURCES

Department of Children and Families Mission: http://www.ct.gov/dcf/cwp/view.asp?a=2565&q=314338

DCF Office of Foster Care Services (OFCS) Home Page: http://www.ct.gov/dcf/cwp/view.asp?a=2552&q=314442

Policy and Regulations Regarding Foster Care: http://www.ct.gov/dcf/cwp/view.asp?a=2561&q=318062

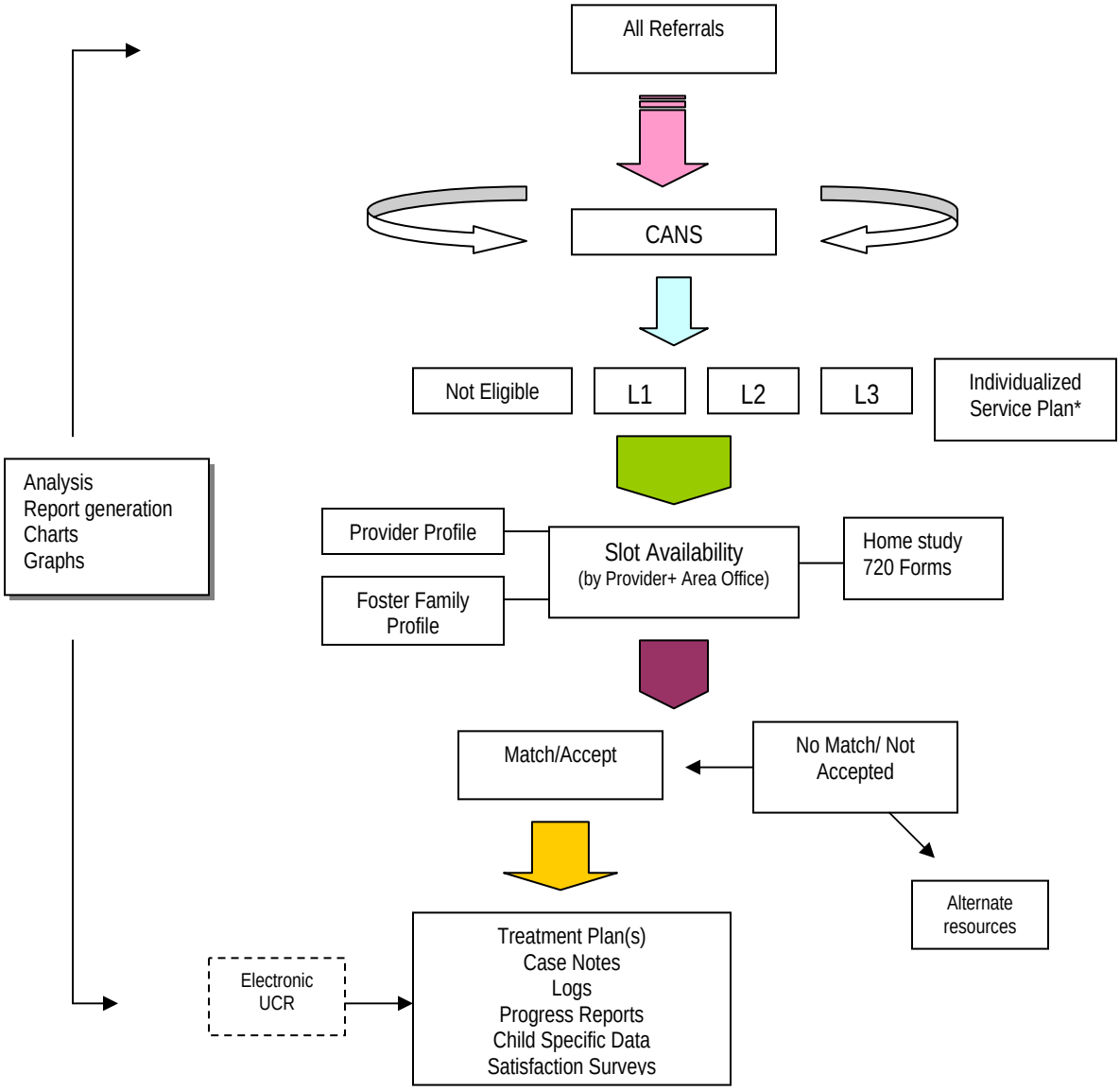
Connecticut Behavioral Health Partnership (CTBHP): http://www.ctbhp.com

Foster Family-Based Treatment Association: http://www.ffta.org/

Child and Adolescent Needs and Strengths (CANS): http://www.buddinpraed.org/cans/

Substance Abuse and Mental Health Services Administration (SAMHSA): http://systemsofcare.samhsa.gov/

APPENDIX IX
THERAPEUTIC FOSTER CARE
ELECTRONIC REFERRAL SYSTEM



*This type of child specific arrangement is reserved for those limited occasions when traditional services are not sufficient to meet their needs