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State Practices in Treatment/Therapeutic Foster Care

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1. EXECUTIVE SUMMARY

The aim of this report is to determine how therapeutic foster care (also called treatment foster care; TFC) is implemented and supported by states. This report, funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), provides an overview of the key program elements of TFC defined by states and how states differentiate TFC from foster care. The report also provides a description of how states provide adjunct services, such as case management and behavioral health services to children in TFC. Finally, the report includes information on the different funding strategies employed by states to support TFC services. This report extends the existing knowledge base for TFC through key informant interviews with providers, advocates and state child serving agencies that use TFC.

Treatment foster care (TFC) is a family-based placement option for children with serious behavioral, emotional, or medical needs who can be served in the community with intensive support. These children cannot be served successfully in standard foster care but do not require group, residential, or inpatient care. Although rigorously evaluated models have demonstrated positive outcomes in mental health, behavioral health, and delinquency, most TFC programs select and adapt elements of these programs, defining required components within agency regulations and contract specifications. Common elements exist across state-implemented TFC programs.

Children served in TFC are most often in the care of a child welfare agency. In some states, juvenile justice agencies include TFC as an option for youth who are served outside their own homes. Less commonly, state behavioral health agencies may offer TFC as a treatment service that is available regardless of whether children are in child welfare custody, juvenile justice supervision, or under the custody and care of their own family.

Key elements of TFC include highly skilled caregivers (TFC parents) who are part of the child's treatment team, enhanced case management, and coordinated delivery of behavioral health and other community-based services. Case managers in TFC work with children, TFC parents, and the child's own parents to support implementation of the child's treatment plan, maintain placement in the TFC home, and work toward permanency. Challenges to TFC case management include retaining case managers with the skills, qualifications, and flexibility needed for the role, and securing funding that reflects the intensity of service delivery. Behavioral health services may be provided by community-based clinicians or clinicians within the TFC provider agency, frequently incorporating trauma-informed interventions or principles. Challenges to behavioral health care delivery include access to providers, particularly in rural areas and for children with complex and/or highly specialized needs.

Although TFC may be a cost-effective alternative to residential care, funding challenges limit its use in many states. States typically fund TFC using Medicaid funds for clinical and

therapeutic services and Title IV-E funds for daily care of eligible children. TFC may also be supported with funds from state child welfare, juvenile justice and behavioral health agencies, and provider agency fundraising.

States have employed a variety of strategies to increase Medicaid funding for TFC, such as defining TFC as a service in the state Medicaid plan, categorizing TFC as a rehabilitative service, and using waivers authorized by Section 1115 and Titles 1915(b) and (c) of the Social Security Act. Many states have also implemented managed care strategies to enhance the coordination, quality, and efficiency of service delivery; improve access to comprehensive services in the communities where children live; and enhancing providers' capacity to treat children with serious needs. Other strategies to increase funding for TFC include Medicaid State Plan amendments and Medicaid waivers, increased use of state funds, managed care systems, and performance-based contracting.

TFC is successfully utilized by several states as an alternative to congregate care. Many stakeholders have advocated for the establishment of a federal definition of TFC to streamline billing processes and quality standards.

2. BACKGROUND

2.1 Program Elements

Treatment foster care (sometimes known as therapeutic foster care, [TFC]) is a promising approach to serving children with serious emotional, behavioral, or medical needs in the least restrictive setting possible. TFC programs vary among jurisdictions, agencies, and providers, but are primarily characterized by and differentiated from foster care through the children served, caregivers, and services.

Children Served. TFC serves children with serious emotional, behavioral, or medical issues who cannot be served in standard foster care and might otherwise be placed in group, residential, or inpatient care (congregate care).

Caregivers. Trained caregivers, known as TFC parents, provide daily care and implement the child's treatment plan. TFC parents are essential members of the child's treatment team, with close supervision and support from TFC program staff.

Services. Children in TFC placements receive enhanced case management as well as a full array of services and supports addressing behavioral issues, social functioning, and communication.

2.2 Case Management and Behavioral Health Services

Both case management and behavioral health care are common services for children in foster care. However, in TFC, case management services are substantially more intensive, and nearly all children receive behavioral health services. TFC for medically fragile children is far less common, but also organized around intensive case management and skilled TFC parents (Diaz et al., 2004). Enhanced case management is considered to be a core support to the TFC service, providing both support and supervision to the TFC home. Compared with the service provided in traditional foster care, case management within TFC is more intensive, comprehensive, and flexible, with interactions focused on stabilizing and ameliorating serious externalizing and internalizing behaviors of the children in care.

Behavioral health services are also essential for children in TFC as many children typically require high levels of behavioral health services. These may include an array of services such as individual, group, and family therapy; school-based interventions; day treatment centers; crisis intervention; or medication monitoring. Children may also require specialized behavioral health treatment for issues such as substance use disorders or sexual acting out. As many children in TFC have experienced trauma, trauma-focused behavioral health services can be an important component of care. Counseling and other supports may also be provided to TFC parents to alleviate stress associated with their role. Behavioral health care services within TFC are typically funded through state Medicaid programs.

2.3 Funding TFC

TFC can be a cost-efficient alternative to congregate care, with improved outcomes for children. However, TFC is substantially more costly than standard foster care, and funding is frequently identified as a challenge that limits its broader use (Boyd, 2013). TFC programs rely on multiple funding sources, with the most common being Title IV-E and Medicaid. Title IV-E of the Social Security Act reimburses states for daily living expenses (care and supervision) for eligible children in child welfare custody, and sometimes those in care of juvenile justice authorities. Medicaid is the primary funding source for treatment services within TFC. Other funding sources include state child welfare funds, state behavioral health agency funds, juvenile justice community-based funds, and donations to provider agencies. Few private insurers cover TFC, and costs would be prohibitive for many families.

This report provides an overview of 1) key elements of TFC, variations in its implementation, and common implementation challenges; 2) strategies states use for two essential TFC services: enhanced case management and specialized behavioral health services; and 3) funding sources commonly used by states to support TFC. Further information is provided on common funding challenges for states and strategies used to address these.

3. METHODS AND DATA

Information in this report comes from key informant interviews, representing a variety of perspectives on TFC, and a review of relevant literature.

Interviews included representatives of state Medicaid agencies that help fund TFC and public agencies that place children in TFC, such as child welfare, juvenile justice, and behavioral health. Participants were drawn from agencies in 14 states, with an in-depth focus on six states with well-developed TFC programs and diverse approaches to implementation: Connecticut, Illinois, New York, North Carolina, North Dakota, and Tennessee. In these states, the study team interviewed representatives of all child-serving agencies placing children in TFC, state Medicaid agencies, and selected TFC provider agencies. Summaries of results from these six states are available in the **Appendix**. The study also interviewed state agency and providers in eight additional states, researchers, and representatives of advocacy organizations such as the Family Focused Treatment Association (formerly known as the Foster Family Treatment Association), which represents TFC programs across North America.

The literature reviewed included a 2012 assessment by a technical expert panel on TFC and more recent reports and research. The technical expert panel was sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare & Medicaid Services; and the Administration on Children, Youth, and Families (ACYF) (SAMHSA, 2013), as well as evaluations and evidence reviews of specific TFC models.

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4. FINDINGS

4.1 Elements of TFC Programs

TFC serves children whose needs cannot be met in traditional foster care, through a combination of three interlocking components: enhanced case management services, caregivers who are active members of the treatment team, and clinical services by provider agency and community professionals. In addition to the interlocking components (which are more fully described in Sections 4.5 through 4.6), in the states reviewed for this study, TFC contains specific program elements defined in state agency administrative rules or contractual requirements. These elements typically include:

Individualized treatment plans. A necessary element of TFC is an individualized treatment plan that guides the coordinated provision of services and use of procedures designed to produce a planned outcome in a child's behavior or general condition based on a thorough assessment. Individualized treatment plans also presume stated, measurable goals based on an assessment by a licensed clinician, a set of written procedures for achieving those goals, and a process for assessing the results.

A treatment planning team that meets every 30 or 90 days. An individualized treatment plan ensures children in TFC receive flexible services over time to meet their changing needs. Regular TFC treatment planning meetings help to ensure this process. In addition to TFC case managers and TFC parents, treatment team participants typically include biological, relative or adoptive families; provider agency case supervisors, skills coaches and clinicians.

Specialized training and credentialing for staff. The TFC model requires highly-trained caregivers who are full partners in the daily implementation of the child's treatment plan.

Additional training for TFC parents. TFC parents receive foster parent training and additional preservice and ongoing training requirements, sometimes specific to the children in their care.

Supervision and in-home support for TFC parents. TFC parents are provided frequent, sometimes weekly, supervision by highly trained supervisors, as well as other clinically-based support.

Access to behavioral health services. Behavioral health services are essential for children in TFC as many children typically require high levels of care. These services may include individual, group, and family therapy; school-based interventions; day treatment centers; crisis intervention; or medication monitoring.

24/7 crisis support. Support for TFC parents and children can range from crisis plans, to 24/7 access to their case manager or a crisis clinician, to access to respite care.

Structured activities to connect the child to the community. Structured TFC activities may involve activities designed to teach or re-teach adaptive, pro-social skills and responses that equip children in TFC with the means to deal effectively with the unique conditions or individual circumstances that have created the need for treatment.

4.2 Differences between TFC, Foster Care and Congregate Care

TFC differs from standard foster care in the needs of children served, the role of caregiver parents, and services provided within the treatment model. **Exhibit 1** summarizes key distinctions between standard foster care and TFC.

TFC differs from congregate care¹ primarily through setting, with congregate care providing services to a higher number of children compared to the one or two children served through TFC homes. Many states are seeking to increase TFC services as a means to reduce the number of children in congregate care settings, citing the intensive support and home-like setting as appropriately meeting the needs of many children. In some states, congregate care is limited to children who are imminently at risk of harming themselves or others. Some states, such as Connecticut and Illinois, use TFC as a step down from congregate care.

Exhibit 1. Distinctions Between Standard Foster Care and TFC

Dimension	Standard Foster Care	TFC	Why Is This Important?
Program components	Required standards are defined in state statute or administrative regulations.	Some TFC programs are rigorously tested evidence-based or evidence-informed models with strict implementation. More commonly, states incorporate only elements of these models into TFC programs defined in state agency administrative rules or contractual requirements.	Evidence-based or evidence-informed models ² build on rigorous research and incorporate all relevant components of TFC. Although adaptation may dilute their potential impact, state-defined models generally specify higher implementation standards for TFC than for standard foster care.

(continued)

¹ We define congregate care as a placement setting of group home (a licensed or approved home providing 24-hour care in a small group setting of 7 to 12 children) or institution (a licensed or approved child care facility operated by a public or private agency and providing 24-hour care and/or treatment typically for 12 or more children who require separation from their own homes, or a group living experience). These settings may include child care institutions, residential treatment facilities, or maternity homes.

https://www.acf.hhs.gov/sites/default/files/cb/cbcongregatecare_brief.pdf

² See "Program Models" section on page 4-45 for a discussion of evidence-based and evidence-informed models.

Exhibit 1. Distinctions Between Standard Foster Care and TFC (continued)

Dimension	Standard Foster Care	TFC	Why Is This Important?
Treatment services	Community services are identified by a child welfare treatment team.	Services for a child are delivered or arranged by the TFC provider, with coaching and supervision for the TFC parents who care for the child.	Credentialed treatment providers deliver care tailored to the child's home environment.
Child entry	Children are in custody of a child welfare agency because they have experienced abuse or neglect.	Children have serious mental, emotional, behavioral, or medical issues, and may be in child welfare, juvenile justice, or parental custody.	TFC placements are based on children's needs, and are ideally available to all children, regardless of custody status or agency involvement.
Agency case manager credentials	A bachelor's degree is typically required.	TFC case managers are usually required to have a bachelor's degree with experience, and sometimes a master's degree.	Highly skilled case managers respond to behaviors in the home environment, and model therapeutic responses.
Caregiver role	Foster parents provide care and supervision.	TFC parents provide care and supervision, implement the child's treatment plan, and work closely with other members of the therapeutic team.	Trained TFC parents provide expert and consistent therapeutic response in the child's natural situations.
Caregiver training	Foster parent training typically uses curricula such as Model Approach to Partnerships in Parenting (MAPP) or Parent Resources for Information, Development, and Education (PRIDE)	TFC parents receive foster parent training and additional preservice and ongoing training requirements, sometimes specific to the children in their care.	TFC parents need training that equips them to respond to children's extensive needs.
Number of children in home	Agency specifies maximum number of children in home, often as many as six. ³	TFC homes are usually limited to one or two TFC children, although exceptions may be made for sibling groups and special circumstances.	Fewer children in the home increases the time and attention the TFC parents have available to the therapeutic process.

(continued)

³ Standards for the number of foster children placed in a home vary by state and other factors such as children's needs.

Exhibit 1. Distinctions Between Standard Foster Care and TFC (continued)

Dimension	Standard Foster Care	TFC	Why Is This Important?
Medicaid funding	Medicaid reimburses behavioral health care services delivered by external providers.	State Medicaid agencies use varied approaches to defining TFC and paying for it, including through state plan amendments and waivers.	Increased access to Medicaid funding ensures support for intensive behavioral health services.
Other funding	Federal Title IV-E and child welfare agency funds support care and supervision.	In addition to Title IV-E and child welfare agency funds, TFC may be supported by juvenile justice, behavioral health, and provider agencies through grant and fund raising.	Additional funding streams beyond those used for foster care are needed to meet the higher costs of TFC.

4.3 Program Models

State TFC programs often do not follow specific implementation standards defined by model developers. Evidence-based TFC models have been the subject of rigorous evaluations and have demonstrated improved outcomes in participants’ behavioral health, and delinquency experiences. Examples include Treatment Foster Care Oregon (formerly known as Multidimensional Treatment Foster Care) and Together Facing the Challenge. Evidence-informed TFC models are based on research and follow strict implementation standards, but have not been rigorously evaluated. The Pressley Ridge TFC and Bair Foundation programs are examples of evidence-informed models.

In practice, most state TFC programs incorporate and adapt elements of evidence-based and evidence-informed models, but allow more flexibility in their implementation. States typically define their own programs rather than adopting tested programs because of the cost of implementing more-intensive models and difficulties in finding providers and caregivers who can adhere to their rigid requirements. Specifications for state programs are defined in administrative regulations and contract requirements.

States use a variety of processes to oversee and improve TFC programs. States monitor TFC provider agencies to confirm that services meet the funding agency’s requirements. Monitoring may address agency accreditation; staff credentials; TFC parent training; and key processes such as treatment plan documentation, required levels of contact, and after-hours responses. States may also compile indicators to assess improvements that are based on child outcomes such as length of stay, unplanned respite placements, step-downs to less-intense care, or reunification with family. Collaboration among state agencies using TFC placements and TFC providers has informed improvements in processes and increased quality of care through training and development of a state-supported TFC program model.

4.3.1 Evidence Based TFC Programs

While most states do not explicitly require implementation of a specific evidence-based TFC model, there are some states that do support evidence-based models and some states who incorporate evidence-informed elements in state program requirements. Examples include North Carolina’s TFC program, which encourages provider agencies to select one of four models (Treatment Foster Care Oregon, Together Facing the Challenge, Teaching-Family Model, or Pressley Ridge TFC⁴). Three of these models, excluding Pressley Ridge TFC, have been reviewed by the California Evidence Based Clearing House for Child Welfare⁵ and have been determined to have strong research evidence for positive child welfare outcomes. Pressley Ridge TFC is considered to be a promising practice. The Illinois TFC pilot program will require providers to use evidence-based models.

Tennessee has taken a slightly different approach to establishing its TFC program by defining a state-specific model based on stakeholder inputs. In 2016, the state led a two-day TFC learning collaborative that included child welfare officials, TFC parents, nationally recognized TFC advocates and program developers, and provider agencies. The goal is that collaborative development will define an optimal level of TFC services and ensure its provision across provider agencies. This effort is ongoing.

Evidence Based and Evidence-Informed Models Supported by North Carolina

Treatment Foster Care Oregon

- ❖ A model of foster care treatment for children 12–18 years old with severe emotional and behavioral disorders and/or severe delinquency
- ❖ Aims to create opportunities for youths to successfully live in families rather than in group or institutional settings, and to simultaneously prepare their parents (or other long-term placement) to provide them with effective parenting.
- ❖ Elements include a reinforcing environment, daily structure, close supervision and avoidance of deviant youth peers.

Together Facing the Challenge

- ❖ A training and consultation model for TFC supervisors and treatment foster parents
- ❖ The aim of the program is to improve outcomes for youth living in treatment foster care settings

Teaching-Family Model

- ❖ Utilizes a married couple to provide supervision, skill building, and support for youth with behavioral issues in residential settings

Pressley Ridge TFC

- ❖ Utilizes traditional foster care model with foster parents who are given advanced clinical and technical training and support in order to best serve the youth placed in their home
- ❖ Care is guided by a tailored treatment plan with measurable outcomes.

4.3.2 State-defined TFC Programs

Most TFC programs are defined by the sponsoring state agency. State-defined programs may incorporate elements of evidence-based models such as Treatment Foster Care Oregon or Together Facing the Challenge, but with greater flexibility and less intensity in their

⁴North Carolina Practice Improvement Collaborative, <https://ncpic.net/>

⁵ California Evidence-Based Clearinghouse for Child Welfare, www.cebc4cw.org

implementation. Requirements for state-defined models are specified within administrative regulations and provider service contracts. These specifications define the TFC program in terms of children served, services provided, and other requirements, such as those listed at right.

- Possible Elements of State-Defined Programs**

 - ❖ Children served (defined in terms of assessment process, diagnoses, or service needs)
 - ❖ Services by TFC provider agency (e.g., case management intensity, clinical/therapeutic services, crisis intervention, in-home support)
 - ❖ TFC parent qualifications (licensure, additional training)
 - ❖ Case manager qualifications (degree, experience)
 - ❖ Agency accreditation
 - ❖ Daily rates paid to provider agency, sometimes specifying minimum rates paid to TFC parents

4.3.3 Intensive TFC

Within state-defined TFC programs, many states define multiple levels of TFC, based on children’s assessed needs. Some states support intensive TFC programs. This approach recognizes the more-intense needs of some children in TFC placements, with higher payment levels corresponding to services delivered. Examples from three states with higher-level intensive TFC options are shown in **Exhibit 2**. The TFC models used in these intensive programs varies by state. Intensive TFC is typically differentiated from non-intensive TFC through frequent and more intensive clinical contact and more intensive training and support for the TFC parents. Intensive TFC models often include respite services so that the TFC parent may receive support for the more rigorous parenting demands. North Carolina and Illinois require the use of an evidence-based TFC model in order to reimburse for intensive TFC services. Connecticut’s intensive TFC model is based on evidence-based practices.⁶

Exhibit 2. Examples of Intensive TFC Options

State	Intensive Model Name and Features
Connecticut	<p>Family and Community Ties (FCTFC)</p> <ul style="list-style-type: none"> ▪ Combines a wraparound approach to service delivery with “professional parenting” for children with serious behavioral problems. Differentiated by (a) the frequency and intensity of clinical contact and (b) flexibility in providing “whatever it takes” to preserve the placement of a child in a family setting. ▪ Serves children stepping down from congregate care. ▪ Foster parents serve as full members of the treatment team and complete intensive training in behavior management.

(continued)

⁶ For more information on the Connecticut model see Appendix: Treatment Foster Care State Profile: Connecticut.

Exhibit 2. Examples of Intensive TFC Options (continued)

State	Intensive Model Name and Features
Illinois	<p>TFC Pilot Program</p> <ul style="list-style-type: none"> ▪ Serves children who are entering care with a significant trauma history, those in congregate care who have been prepared to step down to family care for at least 1 year, and those with high levels of need who can be diverted from congregate care as they enter or who are in foster care and require a level of care comparable to congregate care. <p>Services and TFC parent roles are defined by the evidence-based model selected by provider agencies included in the pilot.</p>
North Carolina	<p>Intensive Alternative Family Treatment (IAFT)</p> <ul style="list-style-type: none"> ▪ This intensive TFC model involves daily clinical and administrative supervision and weekly face-to-face supervision for the IAFT parent(s), staff, and supervisors ▪ Serves children with challenging behavioral issues who will benefit from clinically focused therapeutic treatment to avoid placement in a more-restrictive level of care and from improved family functioning upon return to a less-restrictive setting. ▪ Family members or other designated support people are involved throughout the entire treatment process; parenting is shared between the family of permanence and the IAFT treatment parent to promote success at transition to home or a lower level of care.

4.4 Children Served

Children are placed in TFC because they have needs that cannot be sufficiently met in standard foster homes or by their own family. These are most often behavioral or emotional needs, but can also be physical health issues. Without the option of TFC, children with similar needs would be placed in congregate care settings. TFC thus represents the least restrictive placement option for these children, in keeping with federal policy. Although states and agencies vary, children served in TFC are most often adolescents.

Children served in TFC are most often in the care of a child welfare agency. In some states, juvenile justice agencies include TFC as an option for youth who are served outside their own homes. Less commonly, state behavioral health agencies may offer TFC as a treatment service that is available regardless of whether children are in child welfare custody, juvenile justice supervision, or under the custody and care of their own family.

Children may enter TFC as their first out-of-home placement, as a step down from more-restrictive settings, or as a step up from standard foster care. Placement in TFC is typically based on an

Recruiting and Retaining TFC Parents

Maintaining an adequate supply of TFC parents is a common challenge for state and provider agencies. Some strategies reported by states and provider agencies include the following:

- ❖ Word-of-mouth referrals from current TFC parents
- ❖ Appeals through faith-based communities
- ❖ Outreach at community events
- ❖ Google advertising
- ❖ Advertising through juvenile crime prevention councils to reach caregivers open to placement of justice-involved youth
- ❖ “Share and support” groups for TFC parents

assessment process focused on identifying the option that best meets the child's needs and circumstances. The decision may involve the child's case team, other professionals involved with the child, family members, foster parents, and juvenile court officials (for justice-involved youth). Agencies may also use a structured assessment such as Child and Adolescent Needs and Strengths (CANS), which may be integrated into the treatment planning and interventions by TFC program staff.⁷ Depending on agency processes, provider agencies and managed care organizations may also be involved. Children typically remain in TFC until they can return to their families or a standard foster home, are adopted, or are ready to live independently.

4.5 TFC Parents

TFC requires highly skilled caregivers who act as full partners in the daily implementation of the child's treatment plan. They are typically unrelated to the child, but some TFC programs engage children's relatives or even parents to provide TFC. In addition to providing the nurturing and supervision expected of all foster parents, TFC parents work closely with their child's case manager to plan, implement, and monitor components of the child's service plan. This may focus on behavior management, skills training, or medical care. TFC parents are also expected to support the child's participation in school and recreational activities, to participate in treatment team meetings, and sometimes to mentor a child's parents in effectively responding to their children's needs.

Management and support of TFC parents reflects their expanded role. TFC parents must meet training requirements beyond those for other foster parents, including both pre-service and ongoing training. Enhanced training may address issues common to children in TFC, such as trauma, substance use or sexual acting out, or may be tailored to a specific child's needs. TFC parents also receive a higher daily compensation rate than do standard foster parents, although the magnitude of this difference varies among programs. Finally, TFC parents typically care for fewer children at any time than do other foster parents. Although one or two TFC children per home is preferred, exceptions may be made to keep siblings together or if the supply of TFC homes falls short of what is needed.

Despite enhanced support and compensation, recruitment of TFC parents is a challenge for most programs. TFC parents are asked to meet the needs of young people with severe emotional and behavioral problems in their homes 24/7 while also coordinating with case managers; other service providers; and sometimes, birth families. Recruitment challenges are compounded by the goals of serving children near their home communities, matching TFC parent skills to children's needs, and providing culturally competent care. The demands of the role can be the equivalent of full-time employment, yet daily rates for TFC parents

⁷ Some TFC programs, not within the scope of this study, have developed strategies of integrating the CANS into their treatment planning and intervention along with trauma models such as the ARC, Trust Based Relational Interventions (TBRI), 3-5-7, and Trauma Systems Therapy (TST).

rarely reach this level. However, TFC parents interviewed for this study noted that the intrinsic rewards from making a difference in a child's life played a key role in their decision to provide care.

4.6 Case Management and Community Services

Enhanced case management is the core service of TFC, with an emphasis on intensive, comprehensive, and flexible implementation. TFC case managers typically visit children and caregivers at least weekly, rather than the monthly visit typical for standard foster care. Provider agencies may offer 24/7 access to a case manager or dedicated caseworker. Case management plans focus on ameliorating behaviors that prevent a child from functioning in standard foster care, with services including crisis support, anger management, daily living skills, and social skills. Case management also includes team meetings that coordinate care across caregivers, family members, service providers, and others.

Reflecting this more-intensive level of service, TFC case managers typically carry lower caseloads than those in standard foster care, with requirements varying by state. They may also have to meet higher education and experience requirements. For TFC programs serving medically fragile children, the case manager is often a registered nurse.

Case management supporting TFC prioritizes issues that may affect children's ability to remain in family-based care and successfully transition to permanency. The process frequently includes family team meetings designed to engage key players in the child's life in the treatment plan. In addition to case managers and TFC parents, participants typically include biological, relative, or adoptive families; provider agency case supervisors; skills coaches; and clinicians.

Intensive case management and crisis intervention in TFC programs may take a number of forms. In North Carolina's enhanced TFC model, case managers are in daily contact with the TFC home, working closely with TFC parents. Although TFC is an inherently individualized service, one state highlighted this flexibility in describing its enhanced TFC model as providing "whatever it takes" to maintain the child in the home. The statewide TFC provider in North Dakota provides an example of this. TFC case managers are licensed social workers and provide multiple types of targeted case management: assessment, monitoring, case planning, referral, and linkages. While TFC case managers in North Dakota often refer children to community-based therapists, they are concurrently developing internal capacity to directly provide therapy. This intensive level of service may make adequate funding and appropriate payment to provider agencies challenging.

A key role of the TFC case manager is facilitating the child's treatment plan by supporting access to needed behavioral health, medical, social, and educational services. In addition to behavioral health services (discussed below), the treatment plan may specify community activities such as tutoring, recreation, and enrichment. In many states, the TFC case

manager is an important part of existing state partnerships between behavioral health and child welfare agencies.

Respite care, which is considered a critical support to TFC, may also be part of the treatment plan, with substitute caregivers trained by the provider agency and a specified number of respite hours available to the TFC parents each month. North Carolina, for example supports a Medicaid behavioral health service known as IAFT, which is an intensive form of TFC. This service features respite for TFC parents as a key element of care.

4.7 Behavioral Health Care

Behavioral health services are essential for children in TFC as many children typically require high levels of behavioral health services. These may include individual, group, and family therapy; school-based interventions; day treatment centers; crisis intervention; or medication monitoring. Children may also require specialized behavioral health treatment for issues such as substance use disorders or sexual acting out. Counseling may also be provided to TFC parents to alleviate stress associated with their role. Behavioral health care services within TFC are typically funded through state Medicaid programs.

TFC providers support children's access to behavioral health care in several ways. Many programs access the behavioral health services in a child's treatment plan through community providers or community-based behavioral health centers. Larger providers and providers in communities that lack sufficient behavioral health care resources may have clinicians on staff to ensure access to services for children in TFC. Additionally, foster care agencies in some states provide counseling to children on a limited basis, either through training their case workers, or through dedicated clinical staff. TFC parents also fill a therapeutic role as they are important members of the treatment team and are the key component of behavioral health interventions with children and families in TFC.

While TFC itself is an intervention that addresses the needs of children who have experienced trauma, many states have incorporated an additional emphasis on trauma-informed care in their TFC programs. This approach acknowledges that children in TFC have frequently experienced trauma because of child abuse and neglect or other events, understands child behavior as adaptive response to trauma, and works to avoid situations that may inadvertently recreate trauma. TFC is consistent with a trauma-informed approach in that services are highly individualized and focused on helping children overcome specific challenges. These principles are embedded in the structure of evidence-based TFC models and frequently incorporated into state program guidelines, training, and service delivery. TFC program definitions may encourage or require use of trauma-informed treatment models. Models identified by states participating in this study are shown in the box [below]. ^{8,9,10}

⁸ The National Child Traumatic Stress Network, Trauma-Focused Cognitive Behavioral Therapy http://www.nctsn.org/sites/default/files/assets/pdfs/tfcbt_general.pdf

Examples: Trauma-Informed Behavioral Health Approaches

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

- ❖ Sessions divided approximately equally between youth and parents/caretakers.
- ❖ Addresses multiple domains of trauma impact, including posttraumatic stress disorder (PTSD), depression, anxiety, externalizing behavior problems, relationship and attachment problems, school problems, and cognitive problems.
- ❖ Includes skills for regulating affect, behavior, thoughts and relationships, and trauma processing, and skills for enhancing safety, trust, parenting skills, and family communication.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

- ❖ Group intervention for chronically traumatized adolescents, including those in child welfare and juvenile justice services.
- ❖ Cognitive-behavioral approach that helps teens cope with stress, enhance self-efficacy, connect with others in supportive relationships, and cultivate awareness.
- ❖ Meaning making, understanding trauma impacts in the context of youths' culture, is a central component of SPARCS.

Attachment, Self-Regulation, and Competency (ARC)

- ❖ Implemented in individual, group, and family treatment to address how a child's system of care can become trauma informed and better support trauma-focused therapy.
- ❖ Adapted to child's needs, circumstances, caregivers, treatment, and community.
- ❖ Grounded in attachment theory and early childhood development.

Some states develop innovative strategies to ensure timely and responsive behavioral health services for children in TFC. Connecticut's child welfare program has developed several strategies to facilitate access to behavioral health services that may reduce the need for more-intensive services for children in TFC, as shown at right. Tennessee's Medicaid managed care program, TennCare, has also identified a Best Practice Network that includes behavioral health providers who have committed to working with children in child welfare custody and have received training in trauma-informed approaches such as those shown.

Innovative Service Delivery: Flexible Behavioral Health Care

- ❖ Connecticut's Mobile Crisis Team includes master's-level clinicians available for consultation 24/7.
- ❖ Crisis Teams can travel anywhere in the state between 6 a.m. and 10 p.m. for face-to-face assessment
- ❖ Connecticut schools have established memoranda of understanding with local crisis providers.
- ❖ Both strategies support fast response to behavioral health crises, avoiding trips to emergency rooms or law enforcement involvement.

Timely access to specialized behavioral health care is frequently a challenge, particularly in rural areas, where children may face long wait times for specialized services. A provider in New York reported contracting directly with a community provider who agreed to see children within 24 hours; previously, the provider encountered wait times of up to two months for an initial behavioral health visit. TennCare includes standards for access and availability in contracting language for its managed care organization. TennCare has also

⁹ Structured Psychotherapy for Adolescents Responding to Chronic Stress, <https://www.nctsn.org/interventions/structured-psychotherapy-adolescents-responding-chronic-stress>

¹⁰ The National Child Traumatic Stress Network, Attachment, Self-regulation and Competence: A Comprehensive Framework http://www.nctsn.org/sites/default/files/assets/pdfs/arc_general.pdf

attempted to increase behavioral health provider capacity in the eastern and rural parts of Tennessee through promoted telehealth as an option to enhance access to care within the state.

4.8 Funding

4.8.1 TFC Funding Overview

TFC programs rely on many different funding sources; however, programs are primarily funded through Title IV-E and Medicaid, with Title IV-E reimbursing states for daily living expenses such as care and supervision, and Medicaid supporting treatment services. Other funding sources states use to support TFC include state child welfare funds, state behavioral health agency funds, juvenile justice community-based funds, and donations to provider agencies. Very few private insurers cover TFC. Many families find it difficult to cover TFC services privately due to the prohibitive cost of care.

Because Medicaid programs vary among states, mechanisms used to fund treatment services through Medicaid are also diverse. State Medicaid agencies may amend their state plan to define the treatment services covered as part of TFC, or to create a paraprofessional caregiver rate through which TFC parents can be paid. States may also define TFC as a rehabilitative service intended to help children return to functioning at an age-appropriate level, although not all TFC services fit within this categorization. Some states access Medicaid funding through waivers, which are time-limited, budget-neutral modifications to the Medicaid program's requirements, to support community-based care or modify definitions for service eligibility, benefits, cost sharing, or provider payments.

These complex funding arrangements create challenges for supporting TFC. Title IV-E funds are available only to children who are in public agency custody and meet other requirements based on family income and placement circumstances. Public agencies must use their own resources for the care and supervision costs for children who are not eligible for Title IV-E funding. Provider agencies that offer TFC in multiple states must meet the requirements of each state's Medicaid program. Medicaid does not typically cover care and supervision costs, and some components of case management may not align with Medicaid-reimbursable service definitions. This array of funding mechanisms can be challenging to administer, and may fall short of what is needed to adequately support TFC for all the children who could benefit from it. TFC organization varies among states and among public agencies through which children access TFC. These agencies include state and local child welfare agencies, state behavioral health agencies, and state juvenile justice authorities. Public agencies contract for TFC services with private child-placing agencies, typically known as providers. These providers operate in accordance with contract specifications and public agency regulations to recruit and supervise TFC parents, employ case managers and clinical staff, and arrange services for children. Because children in TFC placements are most often in child welfare custody, juvenile justice and behavioral health agencies may work through

contracts established by the child welfare agency. In some states, a managed care organization monitors placement and oversees providers on behalf of the child-serving agency.

Comparing costs within or among states is difficult because states use different systems to define the child’s level of care. Payment may be based on a comprehensive assessment of child needs, presence of specific issues such as sexual acting out or substance use, or child age, as shown in the examples at right. States also vary in whether specific expenses, such as summer camp fees, are included in the daily rate or compensated as incurred. Rates paid to provider agencies vary by these same parameters and by which services are included in the agency rate, as discussed below.

TFC is far less costly than congregate care and preferred as a less restrictive placement option. However, it is substantially more costly than standard foster care, reflecting costs of TFC parents, case management, and other enhanced services. TFC parents receive a higher daily payment than other foster parents, based on the

higher demands of the children in their care and more-stringent requirements for pre-service and in-service training. TFC case managers visit children and caregivers frequently for service delivery and coaching and must meet enhanced professional requirements. Finally, TFC provider agencies may provide services not offered in standard foster care, such as clinical supervision, 24/7 support for TFC parents, and treatment team meetings. Thus, states are keenly interested in funding sources and strategies by which they can continue to support and strengthen TFC programs.

Examples: Daily Rates to TFC Parents

Connecticut

- ❖ Basic TFC: \$55 plus \$10 for incidentals
- ❖ More-intensive TFC (Family and Community Ties): \$82

New York

- ❖ Special: \$42 maximum
- ❖ Exceptional: \$64 maximum

North Dakota

- ❖ TFC: \$45
- ❖ Children with problematic sexual behavior or substance use disorder: \$58

4.8.2 Federal Funding Sources

All states use two federal funding sources to support TFC. Title IV-E of the Social Security Act provides federal matching funds (known as Federal Financial Participation) for state child welfare expenditures on specified eligible services for children who meet program eligibility requirements... Medicaid funds, administered by state Medicaid programs, are jointly funded by states and the federal government. Each funding source has specific requirements and limitations that define how it is used for TFC.

Title IV-E. Funds may be used for daily care and supervision of children (room and board), administrative costs for program management, and recruiting and training foster parents. Title IV-E funds thus cover only the portion of the daily rate paid to the provider agency for these components of the TFC program. Eligibility for Title IV-E funded services is limited to children in custody of a state agency who meet income guidelines and other eligibility criteria related to their placement in foster care. The custodial agency is most often child welfare, but can also be a juvenile justice agency that has established an agreement with the child welfare agency. In Maryland, for example, the Department of Juvenile Services is part of the state's Title IV-E Plan.

Federal Funding Sources for TFC

Title IV-E

- ❖ Administered by state and tribal child welfare agencies
- ❖ Funded by the Children's Bureau of the Administration for Children and Families
- ❖ Pays for daily care and supervision
- ❖ Eligibility is restricted to children in custody of a public agency, usually child welfare, and who meet additional need-based, clinical and foster-home licensing criteria.

Medicaid

- ❖ Administered by state Medicaid agencies
- ❖ Funded by state Medicaid agencies and CMS
- ❖ Pays for health care services, including behavioral health and rehabilitation services
- ❖ Eligibility is based on age, income, and disability status

Medicaid. States work within federal guidelines to establish and operate Medicaid programs, including certain basic benefits required for all state Medicaid programs and optional benefits chosen by each state. Medicaid program benefits for children and adolescents are defined by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, which tend to be more comprehensive than adult benefits in the state. Income eligibility for Medicaid may be extended by states through the Children's Health Insurance Program (CHIP). Medicaid-covered services include health care, clinical and therapeutic services, and rehabilitation services, but not room and board. States may amend their list of covered services with approval from the Centers for Medicare and Medicaid Services (CMS) and also may request flexibility in federal guidelines through budget-neutral demonstrations and waivers authorized by Sections 1115 and 1915 (b) and (c) of the Social Security Act, described on the following page. Medicaid programs may fund TFC using bundled rates, in which provider agencies receive a fixed payment designed to cover a defined package of required services for TFC, or through unbundled services billed on a fee-for-service basis.

4.8.3 Other Funding Sources

States typically use Medicaid funding to support clinical and therapeutic services and use Title IV-E funds to support care expenses. However, Medicaid-funded services vary by state, and Title IV-E funds cannot be used for children who are not in custody of a public agency. Neither program can cover children whose families exceed income eligibility thresholds. States therefore use a variety of additional resources to supplement funds available through Title IV-E and Medicaid and to cover children and services excluded by each. These include funding from state child welfare, juvenile justice, and behavioral health agencies, as well as

local taxes and donations to provider agencies. Some counties set aside a portion of collected local taxes to support county child welfare agencies. These funds can be used to support TFC services. Some provider agencies, as non-profit or faith-based organizations, conduct various fund-raising activities which may support TFC services. **Exhibit 3** summarizes strategies and funding sources used to support TFC in six states. See also the detailed state profiles in the Appendix to this report for more information.

Exhibit 3. Examples of State Funding Strategies and Sources for TFC

State	Funding Strategies and Sources
Connecticut	<ul style="list-style-type: none"> ▪ Children enter TFC through the child welfare agency. ▪ Title IV-E funds pay room and board for eligible children. ▪ Child welfare agency health advocates ensure that all eligible children are enrolled in Medicaid. ▪ TFC rates paid to providers are bundled and expected to include all necessary services. Children may receive additional behavioral health services from community providers who bill Medicaid directly. ▪ State funds cover room and board fund for children who are not eligible for Title IV-E.
Illinois	<ul style="list-style-type: none"> ▪ Children enter TFC through the child welfare agency. ▪ Title IV-E funds pay room and board for eligible children. ▪ Provider agency daily rate is bundled, but child welfare agency submits claims for reimbursable behavioral health services. Claims are based on encounter data generated by providers. ▪ Under pilot TFC program, payments to provider agencies will be unbundled to provide more information about how services relate to outcomes. ▪ State sets single daily rate applied to all provider agencies outside of TFC pilot program.
New York	<ul style="list-style-type: none"> ▪ Children enter TFC through the child welfare agency. ▪ Title IV-E funds pay room and board for eligible children. ▪ Medicaid funding supports therapeutic services for children. ▪ State plans include shifting Medicaid payments from fee-for-service payments to managed care, consolidating 1915(c) waivers into bundled services, and defining additional home and community-based services for all children in care. ▪ Counties have discretion to supplement state rates. New York City uses funds from a city tax levy for this purpose. ▪ State sets maximum rates for payments to agencies and TFC parents based on previous year's spending.

(continued)

Exhibit 3. Examples of State Funding Strategies and Sources for TFC (continued)

State	Funding Strategies and Sources
<p>North Carolina</p>	<ul style="list-style-type: none"> ▪ Children enter TFC through child welfare, juvenile justice, or behavioral health agencies. ▪ Title IV-E funds pay for room and board for eligible children in child welfare agency custody. ▪ For children served by juvenile justice system, room and board are funded by Juvenile Crime Prevention Councils. ▪ For children not in public agency custody, room and board costs are covered by custodial parents or provider agency fundraising. ▪ TFC is a Medicaid service, with all treatment costs covered by Medicaid through a 1915(b)(c)/mc waiver; Intensive Alternative Family Treatment (an intensive TFC service provided in the state) funding is considered an EPSDT benefit. ▪ Behavioral health services, including those for children in TFC, are managed through local management entities/managed care organizations (LME/MCOs). ▪ LME/MCOs may increase the established daily treatment rates as a performance incentive for providers.
<p>North Dakota</p>	<ul style="list-style-type: none"> ▪ Children enter TFC through child welfare or juvenile justice agencies. ▪ Title IV-E funds pay for room and board for eligible children in either child welfare or juvenile justice custody. ▪ TFC per diems are unbundled; provider agency may bill Medicaid or private insurers for services. ▪ Juvenile court orders are written to comply with child welfare standards for Medicaid eligibility for TFC services. ▪ Per diems are based on level of service, not placement setting, to create incentive for least-restrictive settings.
<p>Tennessee</p>	<ul style="list-style-type: none"> ▪ Children enter TFC through child welfare or juvenile justice agencies. ▪ Title IV-E funds pay room and board for eligible children. ▪ Medicaid funds pay for clinical and therapeutic services defined by state plan. ▪ Most children in TFC are served through TennCare Select managed care services, which provides comprehensive services that may extend beyond those funded by Medicaid. ▪ The state uses performance-based contracting for provider agencies. Daily rates are based on the child’s needs rather than placement settings, and annual reconciliation is based on achievement of performance measures. ▪ Providers may negotiate rates for children with unique needs, such as complex medical conditions.

4.8.4 TFC Funding Challenges and Strategies

States vary in the number of children placed in TFC and the agencies through which they enter, in what services are available through state Medicaid plans and waivers, and in available nonfederal funds. Therefore, funding strategies were diverse and included expanding Medicaid coverage for TFC services, using managed care models to support behavioral health and related services, and creating incentives for TFC quality and efficiency, as shown in **Exhibit 3**.

Medicaid coverage for TFC. TFC is specified as a covered service in State Medicaid Plans in several states. This is an important distinction as it indicates that the TFC service must be available to all Medicaid-eligible children who have a medical need for the service regardless of their custody arrangement. Because TFC is conceptualized as a covered behavioral health service in North Carolina’s state plan, TFC is available to children in the custody of parents or kin, as well as those in child welfare or juvenile justice custody. Some states, including Oklahoma and Oregon, have specified a paraprofessional service definition that allows reimbursement for time spent by TFC parents in specific activities such as skills training.

Defining TFC as a Medicaid Service: North Carolina

- ❖ Under Medicaid service definition, TFC in North Carolina is defined as 24-hour services that include intensive, individualized supervision and structure.
- ❖ Activities included as a part of TFC are rehabilitative in nature and include development or maintenance of daily living skills, anger management, social skills and crisis management and support.
- ❖ Services are defined as Child Residential Level I, Level II-Family Type or Intensive Alternative Family Treatment (IAFT) depending on the intensity of delivery.

In states where TFC is not specified as a service in the state’s Medicaid plan, clinical and therapeutic services that are heavily used by children in TFC can still be billed to Medicaid by the provider or state agency. However, other essential program components not covered by Medicaid may require use of state funds. These components may include training, supervision, behavior coaching for children and parents, and administration.

States work to expand Medicaid coverage for TFC through state plan amendments or creating waivers that include TFC, as described at right. In New York, for example, the State uses 1915(c) waivers to create a bundle of state plan services, with additional home and community-based services defined under Section 1115. However, such requests may involve lengthy negotiations with CMS to craft service definitions and funding algorithms.

TFC as a rehabilitative service. A related issue is whether the state plan defines TFC so that it falls under the rehabilitative option, which includes a variety of services to treat mental and physical health conditions. Because the definition of “rehab” services can be broad, services that are not included in other Medicaid service categories may be eligible for funding under this option. However, funding through the rehab option requires states to define and deliver components of TFC services in terms of rehabilitation that ensures

Medicaid Waivers for TFC

States described using the following waiver programs to access Medicaid funding for TFC:

- ❖ **Section 1115 demonstrations** test innovative service delivery models to provide services not typically covered by Medicaid, improve access to care, support quality of care, strengthen provider networks, and reduce costs.
- ❖ **Section 1915(b)** waivers allow states to use cost savings achieved through managed care to provide additional non-Medicaid service.
- ❖ **Section 1915(c)** waivers support home and community-based services for individuals who might otherwise be served in institutions.
- ❖ **Section 1915 (b)(c)** waivers allow concurrent implementation of two types of waivers and allow a managed care delivery system for Medicaid state plan services as well as long term services and supports.

children return to functioning at an age-appropriate level. This can be juxtaposed to rehabilitative services in which services help individuals learn or reach developmental milestones or skills they have not yet acquired. TFC services are conceptualized as rehabilitative services which necessitates that services be provided in terms of relearning skills, for example, retraining in problem solving skills and remediation of social skills, which are examples of rehabilitative services. If the same services were defined as training, they would constitute rehabilitative services and not be covered.

Bundled and unbundled services. State Medicaid agencies fund TFC services through bundled and unbundled payments. With a bundled rate, provider agencies receive a fixed payment per child on a regular basis to cover a minimal standard of required services, such as individual therapy, family therapy, and other therapeutic services. With an unbundled rate, the provider must document and bill for every individual service provided on a fee-for-service basis. Unbundled services may have an upper limit on individual services or services per day, as in Oklahoma, which has hourly rates for approved, unbundled services combined with a daily upper limit. Each approach has potential advantages and risks. Provider agencies tended to advocate for the simplicity and flexibility inherent in bundled rates, but some states prefer the value of unbundled rates for understanding the relationship between service delivery and outcomes, as in Illinois' pilot TFC programs. Several provider agencies and advocacy organizations advocated for a combination of a bundled rate covering essential TFC services with the opportunity to add additional services on a fee-for-service basis for exceptionally demanding situations.

Managed care strategies. Several states described current and planned strategies for using managed care to improve the coordination, quality, and efficiency of TFC service delivery.

- **New York** plans to transition all foster children into its managed care model, which currently serves only a small percentage of children in foster homes directly managed by the child welfare agency. The state is also exploring how to bring into managed care current TFC services that are not encounter-based, such as social work services and nursing services. The shift to managed care is expected to improve access to needed care by holding managed care organization accountable for making comprehensive services available to children in their communities, and providing an effective array of services that support family reunification.
- **North Carolina** manages TFC and all other behavioral health services through regionally-based local management entities/managed care organizations (LME-MCOs) that coordinate services through the state's 1915(b)(c) waiver. LME-MCOs manage TFC services by contracting with multiple network providers that authorize TFC placements based on provider agency assessments; hiring, training, and supervising therapeutic foster parents; and participating in a statewide collaborative effort to improve TFC outcomes.
- **Tennessee** insures most children in TFC through the state's Medicaid managed care organization for children in foster care, TennCare Select. TennCare Select provides children with access to community-based behavioral health services through its provider network, including a Best Practice Network of primary care, dental, and

behavioral health providers who have committed to working with youth in Division of Child Services custody. Best Practice Network primary care practitioners provide “medical homes” for children assigned to them and coordinate all physical and behavioral health care.

Performance management and improvement

strategies. States use a variety of strategies to encourage the delivery of high-quality services and efficient use of resources. As with traditional foster care, states license and monitor TFC homes and monitor provider agency adherence to contractual and regulatory requirements. In many states, rates paid to provider agencies are based on child needs and the level of service required rather than on placement setting, creating incentives to maintain children in the least-restrictive placement possible. Many states also compile quality indicators to examine relationships between service delivery processes and child outcomes. These quality indicators inform cost monitoring, using measures such as those at right. In Illinois’ pilot TFC program, provider agencies will also be evaluated based on process measures such as TFC parent recruitment and training. Tennessee conducts annual reconciliations with each provider agency, in which the year’s payment is adjusted up or down on the basis of three performance indicators: timely exits to permanency, days spent in care, and reentries into the system.

TFC Quality Indicator Examples

- ❖ Lifetime placements per child
- ❖ Children on runaway status
- ❖ Child deaths
- ❖ Steps down to lower levels of care
- ❖ Youth arrests
- ❖ Child reunification with family or kin
- ❖ Educational attainment

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5. DISCUSSION

5.1 Importance and Benefits of TFC

TFC can be an important strategy in ensuring that children with significant behavioral health needs yet do not require congregate care, can remain in a community, live in a family home, attend a community school, and participate in as many typical experiences of childhood as possible. Reducing the use of congregate care is a federal policy goal, and many state agencies and providers emphasized TFC's potential benefits for children. However, states face several challenges in making TFC more widely available to children who could benefit from it. These include identifying and supporting effective TFC programs, recruiting TFC parents and funding challenges.

5.2 Identifying and Supporting Effective TFC

Rigorous evaluations have demonstrated improved outcomes in TFC compared with congregate care. However, these evidence-based models comprise a small portion of TFC programs in practice. In developing contractually defined programs, states may modify or dilute key components of tested models to reduce cost or make them easier to implement. Further evaluation would be needed to learn whether such modified programs can deliver outcomes similar to those achieved by tested models or isolate key TFC components that aid a child's success. An interim strategy for balancing flexibility and effective programs would be for a state agency to identify a limited number of strong TFC models from which provider agencies could choose. This strategy has already been implemented in North Carolina and Illinois.

5.3 Recruiting TFC Parents

Many states struggle to recruit the foster parents they need; finding and retaining families who are willing and able to meet the challenges of TFC magnifies the task. Provider agencies note the need for funding levels that allow them to compensate TFC parents in proportion to their efforts and maintain adequate staff resources to provide consistent support for TFC parents.

Common recruitment challenges include geographic variation in need, low reimbursement rates for TFC parents, and an insufficient supply of parents who are willing and able to work with older children, LGBT children, non-native English speakers, and certain high-needs children (e.g., those with violent and aggressive tendencies, past gang affiliation, criminal histories, and histories of inappropriate sexual behavior).

5.4 Importance of Access to Case Management and Behavioral Health Services

TFC has been described as a clinical intervention in which the child is placed in a specialized home offering intensive services and support (Boyd, 2013). Consistent with this perspective, some states, such as North Carolina and Illinois, conceptualize the implementation of TFC as supported or nested within a comprehensive behavioral health approach, supported by enhanced or intensive case management, rather than just as a placement option. Others build their TFC programs as a bridge between standard foster care and residential care, borrowing elements of rigorously evaluated models and sometimes including varying levels of intensity to reflect child needs.

No matter how TFC is defined, enhanced case management and behavioral health services are central to its delivery. Case management supports TFC parents in daily implementation of the child's treatment plan and facilitates ongoing engagement of family members with whom the child may eventually be reunified. Equally essential, the case management process facilitates access to the broad array of community services that may be needed. The "whatever it takes" approach to service delivery may challenge funding and reimbursement structures designed for more predictable service delivery. Additionally, providers frequently encounter difficulty attracting and retaining qualified case managers who are willing to operate at the level of flexibility required for serving children with intense and complex needs. Providers also report similar difficulties in attracting and retaining TFC parents.

Behavioral health is nearly always a core component of the TFC treatment plan. Challenges encountered in service delivery include the shortages in availability of specialized services for children, including evidence-based approaches tailored to children who have experienced extensive trauma. Access is particularly challenging for rural areas. State strategies to address these challenges include incorporating access and quality standards into managed care contracts, building flexible response systems available in schools and communities, and telehealth.

5.5 Funding Challenges

TFC is a placement option that potentially offers both improved outcomes and reduced costs in caring for children with serious needs. Although many states and agencies are expanding TFC programs or wish to do so, current funding structures frequently lack the necessary depth and flexibility. Funding limitations may limit states' ability to serve children in the least restrictive setting possible, discourage participation by provider agencies, increase turnover among TFC parents and case managers, or force states to dilute key components of TFC care.

Many states identified innovative strategies to extend TFC funding. States have increased the dollars available for TFC through Medicaid State Plan amendments; Medicaid waivers; and use of state and local funds from child welfare, juvenile justice, and behavioral health agencies. States have also implemented structural strategies to increase the impact of dollars spent through managed care delivery systems and performance based-contracting for quality TFC.

Stakeholders participating in this study consistently urged establishment of a federal definition for TFC as an optional Medicaid service. Within states, a federal definition could facilitate efforts to include TFC in amended state plans. Across states, a federal definition would also facilitate development of standard billing processes for TFC services, quality standards for program components, and evaluation of TFC processes and outcomes.

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6. APPENDIX: STATE PROFILES

TREATMENT FOSTER CARE STATE PROFILE: CONNECTICUT

Overview of State Program

TFC in Connecticut is administered within a collaborative state system in partnership with stakeholders in the private sector. The Connecticut Department of Children and Families (DCF) is a state-administered child welfare system with six regional offices. The state agency establishes policy and oversees contracts related to TFC. Unlike many states, in Connecticut, the state agency for mental health services for children is located within DCF.

The state TFC program includes services for children with

behavioral health or complex medical needs. In addition, FCTFC, a more-intensive model designed as a step down from congregate care, offers an enhanced level of TFC services. A limited number of children who do not meet all criteria for FCTFC receive an intermediate level of care. These children receive enhanced services with special rates and behavioral health carve-outs for services such as care planning and targeted care coordination. DCF also provides behavioral health or medically complex TFC placements for children who are involved with juvenile justice through the Court Services Division or probation program.¹¹

Connecticut has undergone a relatively recent transformation in their structure and provision of TFC services. In response to an observed increase in clinical needs among children in Connecticut, a needs assessment was conducted in 2009. This led to the creation of the Connecticut Behavioral Health

State terms for TFC: Therapeutic foster care (TFC), which includes a more-intensive service level called family and community ties (FCTFC)

Number of children served: 1,259 children in TFC in 2016. 108 in FCTFC.

Child welfare custody required: Yes

Program model: TFC services are based on nationally recognized best practices and selected or developed by provider agencies. The state does not require or endorse a specific model.

How services are provided: Contracted by the Connecticut Department of Children and Family Services Division through 16 TFC provider agencies.

Financing: Connecticut funds TFC services with IV-E and Medicaid (Title XIX) funds. Children in FCTFC receive behavioral health services through their FCTFC provider agencies, with the cost of these services reflected in higher daily rates. Children in TFC may also receive additional behavioral health services through community providers, who bill Medicaid directly.

The **Connecticut Behavioral Health Partnership** includes DCF, the Department of Social Services, the Department of Mental Health and Addiction Services, Beacon Health Options, and an Oversight Council. It was established to develop an integrated behavioral health service system for Connecticut's Medicaid populations, including children and families who are enrolled in Medicaid, the state Children's Health Insurance Program, and the DCF Limited Benefit programs for children with special behavioral health needs who do not qualify for Medicaid. The partnership's goals include increasing access to community-based behavioral health services, providing services in the least restrictive settings, facilitating interaction among providers, and increasing provider supply.

Source: <http://www.ctbhp.com/about.html>

¹¹ Services provided to children in the custody of the juvenile justice system who are inmates of a public institution are not reimbursable by Medicaid. More information is available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf>

Partnership Oversight Council, which took the lead in responding to assessment findings. Formerly, provider agencies served specific regions, and TFC services were restricted to providers operating within each catchment area. In 2010, Connecticut began transforming how TFC was offered by the 16 agencies providing TFC, including five offering FCTFC.

The newly adopted approach to TFC service provision in Connecticut requires a high level of commitment from prospective TFC parents in terms of time, additional training, and ongoing engagement with the child and providers. The redesigned program emphasizes service development within communities to maintain children in family settings and provide individualized care. Every service is focused on facilitating permanency, whether reunifying children with families or relatives or supporting community ties by serving children in the least-restrictive setting possible.

Program Models

In Connecticut, placement types for children include (1) core foster care (traditional foster care); (2) kinship care (including fictive kin);¹² and (3) TFC, which includes TFC, medically complex TFC, Family and Community Ties (FCTFC), and children who have special needs, falling somewhere in between TFC and FCTFC.¹³ FCTFC provides a higher level of clinical care and greater flexibility in preserving placement, and serves as a step down from congregate care.

DCF bases the TFC program on nationally recognized best practices, but has not adopted a specific program model. A provider reported using the Common Sense Parenting model, as well as *Caring for Children who Have Experienced Trauma: A Workshop for Resource Parents*.^{14,15} The North American Family Institute (NAFI) of Connecticut, which contracts with DCF to provide training and services, indicates on their website that they use [Treatment Foster Care Oregon](#).¹⁶

¹² The term “fictive kin” refers to close relationships that are not defined by blood or marriage.

¹³ The term “core” foster care was used by both DCF and DCF CBMH staff to refer to what would typically be called regular or traditional foster care.

¹⁴ The California Evidence-Based Clearinghouse for Child Welfare
<http://www.cebc4cw.org/program/common-sense-parenting/detailed>

¹⁵ The National Child Traumatic Stress Network <http://nctsn.org/products/caring-for-children-who-have-experienced-trauma>

¹⁶ NAFI Connecticut, Inc. <http://www.nafict.org/nafinfi/Programs/EvidenceBased.aspx>

Service Descriptions

TFC: This service is an intensive, structured, clinical level of care provided within a safe and nurturing family environment to children with serious emotional disturbance.

Children in TFC receive daily care, guidance, and modeling from specialized, highly trained, and skilled foster parents. TFC families receive support and supervision from private foster care agencies with the purpose of stabilizing and/or ameliorating a child's mental/behavioral health issues, facilitating children's timely and successful transition into permanent placements (e.g., reunification, adoption, or independent living), and achieving individualized goals and outcomes based upon a comprehensive, multifocal care plan.

Source: DCF TFC Contract

FCTFC: This foster care model combines a wraparound approach to service delivery with professional parenting for children with serious psychiatric and behavioral problems. This service is differentiated from other foster care services by (a) the frequency and intensity of clinical contact and (b) flexibility in providing "whatever it takes" to preserve the placement of a child in a family setting. Within this program, foster parents will serve as full members of the treatment team and will complete intensive training in behavior management. Approximately 8.5 percent of youth in TFC are receiving care under the FCTFC model.

Source: DCF TFC Contract, 2016 Program Report Card: FCTFC, DCF.

Licensure and Training

DCF conducts licensing for foster parents; TFC provider agencies approve licensure for TFC families. According to provider and state agency staff, approximately 150 children are in core foster care homes where the foster parents have completed TFC trainings and receive agency support, but the foster parents have not elected to seek licensure as TFC homes. DCF reports using such placements when this represents the best accommodation of a child's needs.

As described by a provider agency, TFC trainings available to staff include such topics as the placement process, stakeholder roles, trauma, mental health diagnoses, crisis intervention, aspects of permanency, and health-focused skills such as CPR and Universal Precautions.

Additional trainings may focus on

clinical techniques such as de-escalation and motivational interviewing, as well as working with children who are LGBT, have engaged in substance use, have experienced trauma, or have been trafficked.

All foster care families participate in 30 hours of training, *pre-licensing*, or *pre-service*. DCF contracts with NAFI-Connecticut and the Connecticut Association for Foster and Adoptive Parents to provide initial trauma-informed training to TFC families using Trauma Informed

Criteria for TFC Eligibility

- ❖ Because of a mental disorder, a child has substantial impairment in *at least two* areas:
 - Self-care, school functioning, family relationships
 - Ability to function in the community
- ❖ Child is at risk of removal from home or has already been removed from home.
- ❖ Mental disorder and impairments have been present for more than 6 months, or are likely to continue for more than 1 year without treatment.
- ❖ Child displays psychotic features, risk of suicide, or risk of violence due to a mental disorder.
- ❖ Child meets special education eligibility.

Partnering for Safety and Permanence - Model Approach to Partnerships in Parenting (TIPS-MAPP).¹⁷ Provider agencies also provide *post-licensing*, or *in-service*, trainings. TFC families receive seven additional hours of child-specific training and are subsequently required to have 20 hours of post-licensing training.

One provider agency indicated that they provide a 24-hour training course to all TFC parents on caring for children who have experienced trauma. Families participating in FCTFC have additional clinical training requirements that vary according to specific therapeutic needs of individual children. To encourage participation, one provider offers child care and dinner at monthly post-licensing trainings. They have encouraged parents to attend trainings offered elsewhere by reducing their trainings to alternate months and providing information on trainings elsewhere. DCF and contractors work together to offer flexible training arrangements to accommodate TFC families.

Child Entry and Exit

Eligibility for TFC is initially assessed by the DCF regional resources clinical team and social worker through the Child and Adolescent Needs and Strengths assessment tool. It may be determined that TFC should be the child's first placement. Following the assessment, the goal is to place a child within 45 days from the date of referral. The needs of a child, and associated placement, are re-evaluated every 6 months.

Children must be 6 to 17 years of age to be eligible for TFC services so that they can actively participate. Typically, a child has a behavioral health diagnosis, but not in all cases. Eligibility criteria may be waived for a child who would benefit from TFC, as in the case of adolescents who are pregnant and/or parenting.

For the FCTFC program, no assessment is conducted because eligibility is based on referrals from congregate care and residential settings to a regional office. Children referred to FCTFC services range in age from 6 to 17 and have behavioral, emotional, physical, and psychiatric needs. The program particularly emphasizes serving children who have traditionally been served out of state because of their specialized needs, or in-state in a congregate care setting. Referred children have complex treatment needs and a history of involvement with multiple agencies. Presenting conditions may include trauma, hyperactivity, aggression towards self or others, history of suicidality, fire-setting, legal involvement/charges or running away, depression, difficulty relating to peers, psychosexual behavior problems, impaired reality, impulsivity, substance use, attachment challenges, or pervasive developmental disorders, or they may be a victim of domestic minor sex trafficking.

The most common exit from TFC is a return to family of origin or kin, with most children doing so within 1.5 to 2 years. According to the DCF 2016 Program Report Card, 32% of

¹⁷ NAFI Connecticut, Inc. <http://www.nafict.org/nafinfi/Programs/EvidenceBased.aspx>

children who were discharged achieved permanency (e.g., reunified, placed with kin, or adopted). According to one provider, 20% of 82 TFC children served in 2016 achieved permanency through adoption. They noted they undertake extreme recruitment to find a kinship connection, so as to achieve permanency within 2 years, and older teens themselves help with recruitment. Children may also leave one TFC home for another foster home or for a group setting. In State Fiscal Year 2016, 23% of children experienced a planned or unplanned disruption and 77% remained stable, whether remaining in care, being discharged to a permanent family, or being discharged to an Independent Living Program setting. According to the 2016 DCF program report card, 12% of children were moved to a higher level of care (e.g., psychiatric hospitals, therapeutic group homes, or incarceration) in 2016, a comparable percentage to previous years.

TFC Home Supply

Both provider agencies and state officials reported that the current pool of TFC homes is not sufficient to meet the need for the service. Recruitment is an ongoing challenge, as the need for TFC families keeps increasing. In addition to the number of homes needed, one provider reported difficulty in maintaining a supply of TFC homes that would enable children to stay in their communities of origin and in their own schools.

Recruitment and Placement

Provider agencies in Connecticut have primary responsibility for foster parent recruitment, and DCF requires providers to have recruitment and retention plans. A provider described identifying parents through individual referrals and through recruitment and awareness events at schools. Providers send out email blasts and engage in external advertising and marketing efforts. As a retention strategy, one provider agency recognizes foster families who exceed annual training hours with a "Going Extra Miles" award at their annual foster care parent banquet. Staff in DCF's Community-Based Mental Health (CBMH) division noted the need to move beyond generalized recruitment to child-specific strategies.

Providers screen prospective parents to ensure they are financially stable, have space in their home, are willing to participate in therapy, understand what TFC will entail, and are willing to use the provider model. One provider noted challenges in identifying homes open to accepting LGBT children, although DCF indicated that discussion of attitudes towards sexual orientation is part of the screening process. Children who have experienced domestic sex trafficking may also be difficult to match with homes.

DCF regional offices are responsible for making placements across the state. Connecticut has strict limitations on the number of children in need of TFC who may be placed in a home, allowing just one TFC child per home. However, a waiver system may infrequently allow one additional non-related TFC level child in the home in TFC homes with a history of success.

Behavioral Health Access

CBMH provides input and support to DCF staff and provider agencies regarding selecting and implementing TFC training. CBMH consultants can assist a TFC home in developing a response specific to a child's needs. In addition, regional resource groups are available to consult with DCF child welfare staff on community mental health services specific to TFC children.

Children in TFC typically receive therapy from a community behavioral health provider, with case management and family support by the TFC provider agency. Case managers visit the home weekly in TFC, as opposed to monthly visits in core foster care. TFC provider agencies have behavioral health staff, including a care manager. One provider requires that all behavioral health staff have master's degrees to equip them for in-home service delivery. This provider also has a clinician who offers trauma-focused cognitive behavioral therapy in the TFC home; the agency is trying to determine whether such an approach fits within their scope of services.

Children in TFC are primarily served by their provider agency. If the child has behavioral health needs that cannot be met by that provider, DCF CBMH may provide services directly. For children receiving FCTFC care, a clinical team is assigned and connected to the foster family, to provide behavioral health services to the child.

DCF was charged by the state legislature to create a statewide behavioral health plan for children in custody. The process has been supported through a public-private partnership that includes DCF and several Connecticut foundations.¹⁸ The service array for children in TFC includes inpatient and residential treatment facilities, with intensive short-term services to reintegrate children into less-intensive services after hospitalization. Other community-based options include day treatment, traditional and intensive outpatient services, mobile crisis response teams, and school-based cognitive behavioral interventions. However, these services are not uniformly available across the state, and access issues may delay services in some areas.

Contingent on obtaining additional funding, the DCF plans to establish regional Alternative Behavioral Health Assessment Centers. The state sees these as an emerging best practice for conducting assessments with children and avoiding the trauma associated with an emergency department visit. Currently, DCF relies on a mobile crisis team, comprised of masters-level clinicians who respond 24/7 and can travel anywhere in Connecticut between 6 a.m. and 10 p.m. for a timely, face-to-face assessment of children in TFC. Also, relevant to children in TFC, Connecticut schools have established memoranda of understanding with

¹⁸ *Connecticut Children's Behavioral Health Plan*
http://www.plan4children.org/wp-content/uploads/2014/10/CBH_PLAN_FINAL-_2_.pdf

local crisis providers as first responders as a strategy to avoid trips to emergency rooms or involvement of law enforcement.

Financing

Funding for TFC services comes from the Connecticut board and care fund, which is in turn supported by Federal IV-E funds for eligible children. DCF health advocates ensure that all eligible children are enrolled in Medicaid. Connecticut considers its TFC rate to include all necessary TFC-related services, so that providers would not bill Medicaid separately.

However, TFC children receive behavioral health services through community providers, who bill Medicaid. The higher daily rate paid to agencies for children in FCTFC placements reflects those children's greater service needs.

Connecticut Payment Scale

The payment scale is structured by level of need and age. A recent rate increase was effective May 1, 2016. TFC parents receive \$55 per day, and \$10 for incidentals per child per day (e.g., lessons, camp, enrichment) with the remaining \$71 going to the provider to cover agency administrative costs for a total daily rate of \$136.45.

FCTFC parents receive \$82 per day, and \$268 goes to agency administrative costs, for a total rate of \$350. This higher rate includes additional clinical services (e.g., trauma-informed therapy, mentoring, pet therapy).

As noted elsewhere, special rates may be negotiated for children who need enhanced TFC services but do not qualify for FCTFC.

Medically Complex TFC parents receive somewhere in the range of \$30 to \$82 per day and \$53 for administrative costs. The rate for non-clinical/non-medical siblings is \$26 for 0–17-year-olds and \$29 for those over 17 years of age.

Monitoring and Quality Improvement/Assurance

DCF is the primary agency responsible for monitoring and evaluation. DCF monitors TFC referral data, analyzing it by provider, region, dates, and demographics. Providers monitor client-level data for admission and discharge, and DCF TFC clinicians review these data are reviewed on a quarterly basis. Internal reports on reason for discharge, episode counts, and length of stay are reviewed quarterly. Discharge data are used to look at permanency outcomes, placement in higher levels of care, and placement in other foster homes. As part of an initiative to better define and reduce disruptions and to capture all placement moves, DCF began tracking all unplanned TFC respite placements in 2016.

DCF conducts site visits for provider agencies every 2 years to examine population indicators, disruption rates, progress notes, treatment plans, and cultural diversity plans. Providers submit foster home-level statistics monthly with net gain/loss of homes, current number of homes, homes on hold awaiting placement, and respite options.

Strengths

A strength cited by DCF and DCF CBMH staff is the collaborative approach among state agencies and provider agencies. As noted above, DCF extensively interfaces with provider agencies and community mental health providers around TFC service delivery. The TFC redesign led to creation of a new process for contracting services, with providers participating in a "Request for Information" process rather than a competitive bid process.

Currently, provider agencies act as a connected network and a steering committee to discuss TFC issues. These agencies note that they benefit from a higher level of communication and partnership. DCF staff report that collaboration results a higher investment in the delivery of services by all stakeholders. One provider agency highlighted the value of TFC providers regularly sharing what they are doing, what works, and what they struggle with.

Challenges

Several challenges were noted. Unaddressed mental health issues among biological parents are increasingly contributing to children coming into TFC. Similarly, it is challenging to adequately address acute service needs among TFC children as well as adequately addressing substance use needs. Moreover, providers noted it would be helpful to have more understanding of the issue of human trafficking. Finally, increased collaboration between Probation and TFC could be improved to smooth transitions for justice-involved children (e.g., while moving from foster care to a residential facility).

Summary

TFC in Connecticut is unusual in that the state agency for mental health services for children is located within DCF. In addition to TFC, Connecticut offers FCTFC, which provides a higher level of clinical care and greater flexibility in preserving placement, and serves as a step down from congregate care. Connecticut has undergone a relatively recent transformation in the structure and provision of TFC services, following a needs assessment conducted in 2009 and subsequent creation of the Connecticut Behavioral Health Partnership Oversight Council. DCF has also been charged by the state legislature to create a statewide behavioral health plan for children, a process supported through this public-private partnership that includes DCF and several Connecticut foundations. DCF hopes to establish regional Alternative Behavioral Health Assessment Centers, an emerging best practice for conducting assessments with children while avoiding trauma associated with an emergency department visit. This would complement their existing mobile crisis team and current arrangement with local crisis providers as first responders.

TREATMENT FOSTER CARE STATE PROFILE: ILLINOIS

Overview of State Program

In the late 1990s, Illinois began offering SFC to children in foster care with significant medical or behavioral health needs. The Illinois DCFS is solely responsible for the

State term for TFC: Specialized foster care (SFC)

Number of children served: 2,200 annually

Child welfare custody required: No; Office of Medicaid Behavioral Health and Care Coordination may place children into TFC services.

Program model: Program characteristics include intensive case management (e.g., requirement of three monthly visits with one visit in the home), a limit of two or three children in the SFC home, and a requirement that one SFC parent work outside the home no more than 20 hours per week. Additionally, providers must offer 24-hour on-call support and respite to SFC homes. No specific national model is used.

How services are provided: Contracted by DCFS through providers that recruit and train parents.

Financing: SFC is financed in Illinois through a combination of DCFS and Medicaid funding. DCFS sets a single rate for all providers. Qualified providers who provide behavioral health services directly to children receiving SFC services provide DCFS with encounter data, and DCFS, in turn, submits claims to Medicaid.

management and oversight of SFC. DCFS staff reported that the SFC program serves approximately 2,200 children, out of a total foster care population of 6,150¹⁹. DCFS contracts with foster care agencies to provide SFC services, assesses children's eligibility for SFC, refers children to provider agencies for treatment, and monitors provider agencies' quality and compliance.

SFC is categorized as a community mental health service under the state Medicaid plan, although it is not defined in the

plan. State regulation defines SFC as a behavioral health service and specifies administrative requirements and guidelines for assessment and treatment.

DCFS uses its system of SFC contracts to customize the program to address the specific needs of its children. Children with significant medical needs (e.g., suffering from a chronic illness or requiring a medical device) or developmental delays who have not reached adolescence are served under the Medical Foster Care contract. All adolescents receiving

Illinois Administrative Code Definition of SFC

"Specialized foster care is a foster or adoptive home in which specialized services are provided to meet the emotional, behavioral, developmental or medical needs of a child placed in the home. Children in specialized foster care may require a wheel chair or a feeding tube, have a severe visual or speech impairment, or have disorders such as compulsive behaviors, mental retardation, substance abuse problems or a mental illness."

Source: Administrative Code Title 89: Social Services, III.A.302.90: Behavioral Health Services (<ftp://www.ilga.gov/JCAR/AdminCode/089/089003020C03900R.html>)

¹⁹ End of Fiscal Year 2016 data for foster care population from <https://www.illinois.gov/dcfs/aboutus/newsandreports/Documents/ExecStat.pdf>

SFC are served under the Adolescent Foster Care contract, which was developed to address their more-complex needs and potential dual involvement with the juvenile justice system.

DCFS does not characterize SFC as *truly* TFC because program models are not necessarily evidence-based. Illinois is in the process of launching a pilot TFC program in which each provider agency is required to adopt an evidence-based model; this program is described later in this profile.

Program Models

SFC differs from traditional foster care in several ways. Children in SFC receive more-intensive case management than those in traditional foster care. In SFC, children are visited three times a month, with one of those visits required to occur in the foster home²⁰. Children served under medical foster care have a nurse as part of their case management team. SFC caseworkers also have a reduced case load. By comparison, children in traditional foster care homes receive case management visits once a month, and children fostered by unlicensed kin receive visits twice a month.

Case managers in SFC provider agencies have smaller caseloads to accommodate this level of care. One provider stated that their SFC case workers have a caseload of 8 to 10 children, as opposed to 15 for traditional foster care. SFC case workers often have mixed caseloads because of a state initiative to ensure that every family only has one case worker.

SFC foster homes care for fewer children than traditional ones, although some flexibility remains. Agency-wide, foster homes can be licensed for up to six children²¹; each SFC placement is counted as two placements. As a best practice, SFC provider agencies will only place two SFC children in a home. A provider agency can request a waiver to exceed the placement maximums to keep a sibling group intact. DCFS reports that Adolescent Foster Care homes are limited to two children in the home. To respond to a child's needs, one foster parent must work no more than 20 hours per week (i.e., in a two-parent home, one foster parent may work full time and one part-time; in a single-parent home, that foster parent can only work part-time). SFC parents participate in the treatment planning meetings with caseworkers and therapists. The service plan for each child specifies community activities (e.g., tutoring or social, recreational, or enrichment activities), therapeutic supports (typically weekly), and respite plans. Provider agencies also provide SFC foster parents with respite services. Providers will train and contract with individuals identified by the foster parents, usually family members, to provide respite for a specified

²⁰ Illinois DCFS case management requirements (p. 24)
https://www.illinois.gov/dcf/aboutus/notices/Documents/rules_301.pdf

²¹ Number of Children in a Foster Family Home (p. 46)
https://www.illinois.gov/dcf/aboutus/notices/documents/procedures_402.pdf

number of hours per month. In addition, SFC provider agencies must have 24-hour on-call support available to all foster families.

Licensure and Training

The state relicenses foster parents every 3 years, but conducts a licensing evaluation annually. To be licensed, SFC parents must undergo a general foster parent training through DCFS and 12 additional hours of training using the PRIDE (Parent Resources for Information, Development, and Education) model.²² SFC parents also receive more-extensive training through their provider agencies, including training on trauma-informed care. SFC parents may be required to participate in specific training to meet the needs of a child placed in their home.

Illinois requires all case workers to have a child welfare license. Provider agency case workers with SFC caseloads are required to have a bachelor's degree and 2 years of prior experience in child welfare. The 2-year requirement poses a workforce challenge for provider agencies because it can be difficult to recruit and retain case workers for the time necessary to become eligible for a SFC caseload.

Child Entry and Exit

DCFS determines children's eligibility for SFC using the Child and Adolescent Needs and Strengths assessment tool, the assessment of the Children and Youth Investment Team, and the determination of investigation staff at the child's entry to SFC. Most children enter SFC as a step up from traditional foster care, although children can be placed in SFC directly based on their assessed needs. When children in a traditional foster care home are stepped up to SFC and their current foster care agency provides SFC services, the agency will first try to step up the home rather than placing a child in a new home. The current foster parent(s) will be offered training to provide higher levels of care and compensation at the higher SFC rate. If the child's current provider agency does not offer SFC services, the child will be reassigned to a new provider agency.

Children can also enter SFC as a step down from residential care. Only children in DCFS custody can access SFC services. DCFS also offers "intact family" programs for families with children who are at risk for out of home placement. Provider agencies can also offer children a less-intensive array of in-home services once they have reunified.

One interviewee noted that the average length of stay is relatively long²³ and attributed it to the fact that children often step up to SFC after lengthy foster care stays during which their trauma and behavioral disruptions have intensified; these children take longer to

²² PRIDE Model of Practice: <http://www.cwla.org/pride-training/>

²³ The exact length of stay was not available.

stabilize and achieve their permanency goal. One provider agency stated that the majority of their SFC children, 72%, achieve permanency through adoption by their SFC parents, rather than through reunification with their biological parents. Children in the medical foster care contract often remain in SFC until they are 18 years old because of chronic conditions that require long-term treatment.

Recruitment and Placement

Provider agencies are solely responsible for the recruitment of their SFC parents. Most homes enter SFC either because of traditional foster care homes being stepped up or because of relatives and fictive kin²⁴ being recruited into the program. For the last several years, DCFS has emphasized licensing relatives to serve as foster parents, which some providers feel has limited their capacity to conduct recruitment. It is also often difficult to license kin, who may be willing to care for the displaced child but not to complete the licensure process.

Interviewees agreed that the supply of SFC homes in Illinois is inadequate, particularly in the southern portion of the state. Provider agencies find that few potential foster parents are willing to foster children with the behavioral or medical needs of SFC children. In addition, many families foster with the goal of adopting and are less open to working with biological parents toward reunification rather than adoption. The most difficult children to place are adolescents, children with aggressive or other problematic behaviors, children or adolescents with a history of inappropriate sexual behavior, and children in need of Spanish-speaking foster parents.

Behavioral Health Services

Accessing behavioral health services for children receiving SFC is challenging throughout Illinois, but the western and southern regions of the state have a greater provider shortage. Most SFC provider agencies have behavioral health professionals on their staff, although

Medicaid Community Mental Health Services Fiscal Year 2016 (FY16) Billing^a

Program payments for SFC:

- ❖ Specialized and Adolescent Foster Care programs designated for Medicaid billed a total of \$1,537,377 in Medicaid Community Mental Health Services, comprising approximately 1.6% of the total amount spent on these contracts in FY16.
- ❖ Of the 3,062 unique clients served in these programs, 1,019 (33%) received at least one Medicaid mental health service, in addition to behavioral health services that constitute SFC.
- ❖ Eligible clients in these programs received 19,695 hours of service over the course of FY16.
- ❖ Medicaid Community Mental Health service types were billed as follows:
 - 14% evaluation services
 - 78% treatment services
 - 8% case management services

Source: Office of Medicaid Behavioral Health and Care Coordination

^aDoes not include IV-E claims

²⁴ Fictive kin are close relationships that are not defined by blood or marriage.

some use other community-based providers. For medication management, agencies refer to community psychiatrists or contract with a psychiatrist practice. Children in traditional foster care can access the same level of Medicaid-eligible mental health services as SFC children. The state established a centralized medication consent process for all children engaged with DCFS services to guard against overuse of psychotropic medications.

Financing

The SFC program is supported by Title IV-E and Medicaid funding. DCFS pays provider agencies a SFC daily administrative rate,²⁵ and the agencies also in turn pay SFC parents a daily rate. DCFS sets a rate for the whole sector rather than negotiating with each individual SFC provider. One provider noted that the administrative rate has not increased in almost a decade.

Although providers are certified to provide Medicaid-reimbursable behavioral health services, they do not bill Medicaid directly. DCFS collects encounter data from providers and submits claims to Medicaid, which are paid back to DCFS. However, the provider agency's daily rate is on a per diem basis and unaffected by the volume of Medicaid-reimbursable services provided.

Monitoring and Quality Improvement/Assurance

SFC services are monitored by both the DCFS and provider agencies. SFC provider agencies are required to enter data into the Children and Youth Foster Care Information System, which DCFS uses to generate monthly performance dashboards. The dashboards assess SFC agencies on several process and outcome measures, including encounter data, permanency, malnutrition, and children returning to foster care following reunification. The dashboard allows providers to view their data at various levels, including the individual staff level. Providers can also view composite performance scores of other agencies.

The DCFS performance team meets with providers monthly to discuss areas for improvement. Agencies with significant areas for improvement will be placed on a performance improvement plan, which the department will assess on a trimester basis. The state Medicaid office also evaluates agencies on an annual basis to assess Medicaid services provided and verify claims against medical records. Providers reapply for Medicaid recertification every 3 years. Agencies are also accredited by the Council on Accreditation and reapply for reaccreditation every 4 years.

Providers are responsible for the monitoring and evaluation of SFC homes. However, DCFS licenses homes on the basis of the recommendation of the provider agency. In addition to

²⁵ The exact administrative rate was not available.

the DCFS monthly dashboard, providers conduct internal outcome and process assessments.

TFC Pilot

In 2017, Illinois launched a 5-year TFC pilot program designed to divert foster care children from residential care settings by providing a higher level of behavioral health intervention within a home setting. The pilot will serve 50 children in its first year and grow to 100 children in its second year. There are three target populations for the pilot:

1. Children who are entering DCFS care with a significant trauma history
2. Children who are in residential care and have been prepared for discharge for more than 1 year
3. Children with high levels of need who can be diverted from congregate care as they enter DCFS care or who have been in the foster care system and require a high level of care comparable to congregate care

Similar to SFC, all children in the TFC pilot will be in DCFS custody. The department is still finalizing the eligibility determination process, but currently plans to screen children into the pilot on the basis of home county (only children with homes of origin in Cook, Aurora, or Rockford county are eligible), a Phase 2 residential placement status with a recommended discharge to foster care, and the results of the Child and Adolescent Service Intensity Instrument.

TFC Pilot—Program Models

DCFS has selected three provider agencies for the pilot program. A major departure from the SFC program is that providers will be required to use evidence-based treatment models. Models selected for the pilot program providers are (1) Treatment Foster Care Oregon (TFCO), (2) Together Facing the Challenge, and (3) a self-developed model based on the Foster Family Treatment Association standards and guidelines. Each provider agency will provide its foster parents with added training on managing behavior and the influence of trauma on behavior. The program is intended to address the fact that children are predominately accessing higher levels of treatment only after outstripping resources in traditional foster care placements rather than being placed directly in a treatment home.

Compared with SFC, foster parents will have a more-intensive role in the treatment planning team. In addition to the foster parent, the treatment team will comprise a senior clinician, a caseworker, and a skills coach. Each treatment team will have a maximum caseload of 10. Biological parents will participate in family therapy. Children will also participate in mentoring and extracurricular activities in the community.

The TFCO model requires that one foster parent be home full-time. The other two models do not require a parent to stay home, but do require that a backup individual trained in the

model be available. The pilot limits the number of foster children in the home to one, with the possibility of a second child if the second child is a sibling or if the foster parent demonstrates the ability to care for two TFC-level children.

In the pilot, agencies will be able to shift family case management responsibilities to a DCFS caseworker. This change is intended to reduce agency case workers' administrative burden and allow staff to focus on treatment for the child. Case workers in the TFC pilot will have the same qualification requirements as traditional foster care case worker: a bachelor's degree and 1 year of experience working with children and families.

Illinois plans to use the pilot to address the long lengths of stay observed in SFC. One pilot program provider agency reported that their goal was to reunify children with biological, relative, or adoptive families within 6 to 9 months. Rather than being used as a permanency option, the treatment home will be focused on working with the biological parents to facilitate reunification. Foster parents will provide parenting support and coaching to biological parents, especially regarding recognizing triggers and de-escalating situations. Re-entry rates are among the performance measures to be monitored in the pilot evaluation.

Pilot program agencies will be required to document recruitment efforts. One provider in the pilot program suggested that the TFC pilot will allow them to focus on more-targeted recruitment of foster parents and bolster their number of treatment homes. The agency will also have a dedicated recruiter and will work with their model developers to create a recruitment plan.

TFC Pilot—Financing

Funding for the pilot will come primarily from the DCFS budget. Provider agencies will receive a daily rate of up to \$92. DCFS staff reported that obtaining state approval for the higher rates was challenging. The daily rate will be unbundled, so provider agencies will be able to bill Medicaid directly for behavioral health services. Unbundling the services is expected to give the Medicaid office a better understanding of the types of services children are receiving and how services are linked to outcomes. At the time of our interviews the daily rate paid to TFC parents had not been finalized.

TFC Pilot—Monitoring and Evaluation

DCFS plans to use the same monitoring and evaluation mechanisms for the TFC pilot that it uses for SFC. The department will be evaluating providers on the basis of several unique milestones outlined in the TFC contract (e.g., recruitment and training). DCFS has contracted with Chapin Hall Center for Children to assess distal and proximal outcomes for the pilot program.

TFC Pilot—Challenges and Opportunities

One of the major challenges faced by Illinois is adding more SFC homes to meet anticipated need. Going forward, DCFS anticipates that the length of the licensing process may pose a recruiting challenge, as it currently takes up to 90 days for a home to become licensed.

The TFC pilot program is considered to be a great opportunity for the state. Overall, department staff are optimistic about the pilot because they have had buy-in from senior leadership from the beginning of the project.

TREATMENT FOSTER CARE STATE PROFILE: NEW YORK

Overview of State Program

TFC in New York is a state-supervised, locally administered service, which mirrors the state’s decentralized child welfare structure. Counties administer TFC through their departments of social services, which are responsible for taking children into custody and administering out-of-home services and care. Counties select their own TFC program models and funding mechanisms, although they receive guidance and oversight from the state.

Across all child welfare programs, New York’s Office of Children and

Family Services (OCFS) provides oversight, direction, and monitoring to counties and oversees county-level contracts. Although New York comprises 62 counties, the five New York City boroughs are consolidated under one child welfare agency, the Administration for Children’s Services (ACS); OCFS therefore oversees 58 county agencies. This profile presents state-level information from OCFS and information from two county agencies, New York City’s ACS and Erie County’s Children’s Services (CS) Division.

Currently, New York has approximately 18,000 children in foster care, with about 3,000 in TFC. More than 80% of foster care children are “agency-based” (i.e., placed by the county into private agencies), and this population comprises the largest group of children in the state that is *excluded* from managed care. Voluntary foster agencies currently depend on a Medicaid per diem to pay for certain Medicaid-eligible services, equipment, and care related

State terms for TFC: Not uniform across state and counties; terminology includes therapeutic foster boarding homes (New York State), treatment family foster care (New York City), and therapeutic foster care (Erie County).

Number of children served: 3,000

Child welfare custody required: Yes

Program model: No defined model, although there is a general state service definition.

How services are provided: Child welfare contracts with multiple private provider agencies that recruit and train TFC parents.

Financing: Medicaid funds cover clinical/therapeutic services; child welfare funds cover board care, and training and recruitment efforts of provider agencies.

New York City Treatment Family Foster Care Program Overview

“The Treatment Family Foster Care (TFC) program is designed to service children/youth up to age 21 (with a minimum IQ of 65) who have moderate to severe behavioral issues and emotional conditions and can be supported within a family setting. The children will be placed in a family setting for a short term (average 12 months) based on the severity of their emotional or behavioral condition. Foster parents will be recruited, trained, and supported to become part of the Treatment Team. The foster parents will receive pre-service training, participate in group support meetings, and have access to program staff back-up and support 24 hours a day/7 days a week. The foster parents will be contacted regularly by telephone to relay information about the child’s behavior and to discuss implementation of the treatment plan.”

Source: Personal communication with the ACS Division of Policy, Planning, and Measurement, November 2016

to physical and mental health, therapeutic needs, and nursing care. State officials are looking into how to transition all foster children into managed care, which would improve access to needed care for foster children by holding managed care organizations accountable for making services available in communities. One such example is dental care; the Medicaid fee-for-service rate structure does not provide substantial reimbursement for dental services, but a shift to managed care would enable plans to require that dental providers are available and sufficiently paid.

Program Models

As noted above, New York’s county child welfare agencies determine TFC service components and reimbursement models. Program models from New York City’s ACS and Erie County’s CS illustrate some of the dimensions on which TFC programs vary. In New York City, ACS defines key features of TFC, as shown in the box above. Key service components of TFC, as determined by ACS, include biweekly individual, family, or group therapy for a child and/or biweekly sessions with the biological parent; weekly skills training home visits for children; behavioral management trainings and support for TFC parents, including biweekly support groups and on-call 24/7 assistance; parent trainings for the biological parents; and service and discharge planning. Most of these services are covered through the room and board rate (funded through IV-E and state and city dollars), but certain trainings that are clinical in nature and focus directly on the child, such as medication management training from a licensed nurse, may be billed to Medicaid. ACS encourages placement of only one child in a TFC home, but exceptions can be made for sibling groups and children younger than 14 years of age. No more than two unrelated children under the age of 14 years receiving TFC services can be placed in the same home. TFC cannot be provided in the biological home.

TFC eligibility does not require a specific mental health diagnosis. ACS requires training in the Problem Solving Therapy–Primary Care (PST-PC) behavioral health model for all TFC parents. PST-PC is a therapy approach used to treat depression and anxiety in a primary care environment. The approach is composed of six to ten 30-minute sessions to help patients solve the “here and now” problems contributing to their mental health concerns.²⁶ TFC parents must complete a 30-hour Model Approach to Partnerships and Parenting (MAPP) training program and 12–15 additional hours of training annually. The ACS program description does not differentiate between traditional foster parents and TFC parents in their training requirements.

New York state does not require a specific TFC model, so different provider agencies may use different models, even within one county. In Erie County, CS collaborates with community agencies and service providers to support families in providing preventive and

²⁶ PST-PC <https://aims.uw.edu/evidence-based-behavioral-interventions-primary-care>

foster care services. The division places children in traditional foster care, TFC, and independent living programs. CS modifies its service contracts to the specific requirements of TFC delivery within the broad framework of state regulations. Eleven foster care agencies operate in Erie County, four of which provide TFC. These agencies collaborate to some extent, such as by organizing a coalition to identify and disseminate best practices in foster care. They also hold meetings when foster care families transfer from one provider agency to another to increase transparency and ease transfers.

Although provider agencies may choose their own model of TFC, the service is characterized by access to behavioral and medical health supports, along with more-intensive case management services than are required in traditional foster care. TFC homes require one to two case management visits per week and four contacts per month, which may include telephone calls, compared with one visit per month in traditional foster care and two visits per month in special board rate homes. The latter are homes in which TFC children may be placed as they step down to traditional foster care; they offer a higher level of care than traditional foster care, but not quite 24-hour supervision. A county CS official noted that the number of children in TFC homes typically differs from the number of children receiving TFC services, as siblings are kept together in cases when one needs TFC but others do not.

Eligibility for TFC in Erie County is established through assessment to determine whether a child has behavioral or medical conditions that require 24-hour supervision. Children with HIV/AIDS, autism, or a traumatic brain injury are automatically eligible for TFC. Children are re-evaluated every 6 months for continued eligibility.

One provider agency in Erie County described their plans to expand TFC services using the Mockingbird Family Model (MFM), as outlined at right.²⁷ This model is structured around a Hub Home that serves as a support and resource to other nearby homes. At the time of our interviews (2017), three provider agencies were working together to establish two Hub Homes. In addition to providing a support network and resources for children and families, they envision that Hub Homes will be used to coordinate training for families in their MFM constellation. Their current training

Mockingbird Family Model (MFM)

MFM is a foster care service delivery model designed to improve the safety, well-being, and permanency of children, adolescents, and families in foster care. MFM is grounded in the assumption that families with access to resources and support networks are best equipped to provide a stable, loving, and culturally supportive environment for children.

It revolves around the concept of the MFM Constellation, which intentionally establishes a sense of extended family and community. In each constellation, 6 to 10 families (foster, kinship, foster-to-adopt, and/or birth families) live near a central licensed foster or respite care family (Hub Home), whose role is to provide support. The support provided through the Hub Home includes assistance in navigating systems, peer support for children and parents, impromptu and regularly scheduled social activities, planned respite nearly 24/7, and crisis respite as needed.

Source: <http://www.cebc4cw.org/program/the-mockingbird-family-model-mfm/detailed>

²⁷ MFM: <http://www.cebc4cw.org/program/the-mockingbird-family-model-mfm/detailed>

program is somewhat limited, with the provider describing use of online and paper trainings in lieu of in-person trainings. As they implement the MFM program and increase the number of TFC families, they hope to expand and strengthen training opportunities for families. TFC parents are expected to participate in monthly support groups with all foster care families, not just specific to TFC.

Another agency in Erie County described using the Coached Visitation Model, which is based on the research and publications of Marty Beyer and was originally promoted by New York City's ACS.^{28,29} As described on the next page, this model is intended to improve upon supervised visits, using them to promote engagement and strengthen communication and parenting skills. Moreover, parents are coached before and after such visits to improve the fit between their limit-setting and their child's temperament and behavior. This provider indicated that the state of New York values this model and the state has observed positive outcomes from its use. They further explained that this model is very time-consuming, as it includes pre- and post-meeting work and a lot of intensive coaching. This provider also uses the Trauma Focused Cognitive Behavioral Therapy (TF-CBT) model and directly contracts with one psychologist to ensure that children in their care are seen within 24 hours in their clinical program, after having encountered very long waiting times to access community clinicians.

Another Erie County provider conducts assessments using a posttraumatic stress disorder (PTSD) index, as well as the Adverse Childhood Experience and Strengths and Difficulties Questionnaire tools.^{30,31} Their training program is composed of a 10-week MAPP/Group Preparation and Selection training combined with a self-assessment for foster care parent readiness, complemented by an additional 2 to 4

Coached Visitation Model

Visit Coaching helps families learn how their child's behavior is shaped by the adult's words, actions, and attitudes. Families are coached to improve the fit between their limit-setting and the child's temperament and behavior. Visit Coaching is fundamentally different from supervised visits because of the focus on the strengths of the family and the needs of the children. Visit Coaching supports families to make each visit fun for their children and to meet the unique needs of each child. Visit Coaching includes the following:

- ❖ Helping parents articulate their children's needs to be met in visits
- ❖ Preparing parents for children's reactions
- ❖ Helping parents plan to give their children their full attention at each visit
- ❖ Appreciating the parent's strengths in meeting each child's needs
- ❖ Helping parents cope with their feelings so that they can visit consistently and keep their anger and sadness out of the visit

Source: <http://www.martybeyer.com/content/visit-coaching>

²⁸ Visit Coaching: <http://www.martybeyer.com/content/visit-coaching>

²⁹ Visit Coaching Manual: http://www.martybeyer.com/sites/default/files/visit_coaching_manual.pdf

³⁰ Adverse Childhood Experience: <http://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf>

³¹ Strengths and Difficulties Questionnaire: <http://www.sdqinfo.org/>

weeks of training on topics including CPR, First Aid, behavioral management, parenting, and procedures.³² County CS officials stated that an additional 5 hours of specialized training are required for foster care families to provide TFC.

Child Entry and Exit

Children enter TFC in New York through local county child welfare agencies, with staff making the determination that a child should be placed in TFC, rather than another placement setting, in collaboration with a private provider agency. OCFS allows biological families to relinquish custody to obtain TFC-level services for their child. Although uncommon, this is considered a “voluntary placement.” OCFS does not specify a statewide assessment process for TFC eligibility; instead, counties have the freedom to develop these on a local level.

OCFS does not maintain data on length of placement for children in TFC. For all out-of-home placements statewide, the average length of stay is approximately 1 year. Very young and older children tend to have longer lengths of stay. Children can exit TFC to a higher or lower placement setting, depending on their needs, but the overarching goal is to keep children in the least-restrictive setting possible. It is possible to keep a child in the same therapeutic home, yet step down the level of services to a non-therapeutic level of foster care. Children may also return to their biological families.

In New York City, ACS guidelines require that an ACS-facilitated Placement Presentation Family Team Conference determine eligibility for TFC. The team, which may include ACS staff, social workers, attorneys and biological family members, determines which placement setting is most appropriate, and is convened when a child first comes into custody and any time a change in level of care (e.g. step-down from residential care to TFC) is considered. ACS may then provide a direct referral for TFC to a provider agency. If a child comes into traditional foster care at a provider agency and the agency feels that a higher level of care is needed, they can request a “step-up” meeting with an ACS facilitator to assess the appropriate placement level.

Exit from TFC can be due to reunification with the biological family, exit to other family members, adoption, discharge to the military or college, or aging out at 20 years of age. In New York City, the TFC program design states that the average length of stay in TFC should be 12 months. However, a New York City provider agency reported that most children in their care remain in TFC until they age out of the service. This is because of the severity of their diagnoses and traumatic histories; for many, the supports that TFC offers the children and their foster parents are needed to maintain the child’s stability.

³² MAPP encourages open communication and trust among foster, adoptive and birth families and casework staff. Through role-playing, personal profiles, and other techniques, mutual decisions are made about foster parenting. Source: <http://ocfs.ny.gov/main/fostercare/requirements.asp>

In Erie County, all TFC referrals come from the CS division, which sends a referral form that includes all available information to the provider agencies. Children may be placed in TFC as a voluntary placement, in which case the parents would have to relinquish custody but not guardianship. For all children referred, each agency attempts to identify an appropriate home and provides the county with a proposed placement. A clinical specialist reviews all options and selects the best match for the child. A child then meets with a county psychologist to determine whether they need a higher level of care. In cases in which the psychologist determines that a child does need TFC, they will send a recommendation to the county, where the clinical specialist will review and approve the placement at the TFC level. One provider noted that the county conducts their own assessment, but that almost all children, even those who receive a therapeutic referral, initially come into care at the traditional foster care level.

A child may come directly into TFC if they have significant behavioral and/or medical needs that require 24-hour supervision. Alternatively, a child may be referred to TFC as a step down from a residential facility or group home if they have achieved their goals at a group home but are unable, or not quite ready, to return to their home of origin. A county CS official also noted that children may step up from TFC to a residential placement. Regardless of placement location, agencies engage with the child's family of origin, as legally mandated for all children in custody.

An Erie County provider agency stated that the typical length of stay in TFC is about 18 months, which is longer than typical traditional foster care stays, in part because it is harder for TFC children to achieve permanency. Another Erie County provider agency indicated typical length of stay as ranging from 9 to 15 months. This provider dually certifies every home for both TFC and traditional foster care, as some children start displaying behaviors that require TFC after entering traditional foster care. Dual certification prevents them from needing to change homes.

TFC Home Supply

The state reported that New York has enough TFC beds to meet the current need. However, Erie County officials stated that they see a lack of available TFC homes, which leads to many TFC-eligible children being placed in residential programs. A New York City provider agency also noted challenges in meeting the demand for TFC homes, saying, "the need for TFC is growing and so the need for homes is growing as well." According to CS officials, Erie County has the most TFC homes of any county in New York.

Recruitment and Placement

In New York City, provider agencies are primarily responsible for recruitment of TFC homes. ACS has a designated unit to support these recruitment efforts and assist agencies through technical support. A provider agency within the city described their recruitment efforts as

challenging, stating that they are “always struggling to get new homes,” especially for older adolescents and those with a history of involvement with the juvenile justice system. Within this agency, recruitment is done through their Home Finding Department and during training sessions for traditional foster care parents. Referrals from current TFC parents also assist with recruitment. The provider agency said they would like additional help with recruitment efforts. When placing children in TFC homes, the agency focuses on making a strong match between children and family based on characteristics such as age and mental health diagnoses. As an example, they noted that some foster parents work well with parenting teenage mothers who are eligible for TFC, whereas other foster parents are well-suited to parent older male teenagers. The agency struggles to recruit suitable homes and find appropriate placements for children with violent and aggressive tendencies, past gang affiliations, and particularly high-needs behavioral health challenges.

In Erie County, the CS division holds an annual recruiting event for foster care generally for all agencies. Provider agencies primarily recruit families through word of mouth from current foster care families. One provider described other recruitment strategies (e.g., community events, billboards, collaborating with police, and emergency medical technicians) but felt that word-of-mouth was the most effective recruitment approach. This provider has two staff members dedicated to recruiting, training, and retaining foster parents. Provider agency staff described difficulties around recruiting TFC families, especially for older children, stating that families are often interested in younger children who are more likely to be available for adoption. They also explained that households in which both parents work full-time often have a hard time meeting the needs of TFC children.

Behavioral Health Access

Access to behavioral health services varies across the state. A provider agency in New York City stated that waiting lists for TFC-level services are not common. However, in Erie County, CS officials indicated that TFC children have a long waiting list even for nonspecialized counseling services. For more-specialized needs, such as problematic sexual behavior, children may face wait times of a year to see a therapist, because only one specialist offers this service. One official noted that some children with autism, especially those who are nonverbal, are hard to place and remain in hospitals as a result. Officials explained that the shortage of behavioral health providers for children in TFC can have negative consequence when they age out of care, as many of these children have serious mental illness and, without appropriate treatment during and after TFC, are at risk of homelessness after exiting foster care.

NY OCFS trains county-level staff in trauma-informed practices and care, using a new initiative, the Trauma-Informed Community Initiative of Western New York, based out of the State University of New York Buffalo Center for Social Research.³³ One Erie County provider noted that they use a TF CBT model and contract directly with behavioral health clinicians who have agreed to see children within 24 hours. Previously, the provider referred children to community-based mental health services, but found it very difficult to get an appointment. Wait times were up to 2 months for an initial visit and another 2 months for a meeting with a therapist, which eventually led to a meeting with a psychologist or psychiatrist.

Financing

The state of New York funds foster care programs through a combination of state general funds, title IV-E foster care funding, and Medicaid dollars. TFC is included in the foster care funding mechanisms; there is no designated funding for TFC. The state establishes maximum state aid rates (MSARs) for agencies and foster parent stipends, which serve as the upper limit on what the county can reimburse. There is no minimum rate, however, and counties are allowed to set their own rates as long as they do not exceed the MSAR.

2015–2016 New York State Maximum State Aid Rates for Payments to Foster Parents (per day)

Regular: \$19.13–24.36 (varies by child age and location)

Special: \$42.02

Exceptional: \$63.68

Rates are calculated separately for board and care stipends for foster parents and administrative payments for foster care agencies. Foster parent stipends specify three tiers of MSARs—regular, special, and exceptional—and TFC typically falls under the exceptional rate. Local commissioners develop lists of eligibility conditions that may be covered by the special and exceptional rates, which are uniform across regions in New York.³⁴ For foster care agencies, the state determines a unique rate per provider agency based on the previous year’s spending within state established parameters.

Financing is administered at the county level, and counties have the discretion to develop their own funding strategies. In Erie County, the CS Division oversees and distributes funding to provider agencies. One provider agency noted that children are evaluated every 6 months and if the severity of needs decreases, the TFC home is no longer eligible for the “exceptional” rate. This is frustrating for parents, who feel they are penalized for working

³³ Trauma-Informed Community Initiative of Western New York: <http://ticiwNY.com/>
ITTIC: <https://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/community-partnerships-initiatives/trauma-informed-community-initiative.html>

³⁴ New York OCFS Standards of Payment for Foster Care of Children Program Manual: <http://ocfs.ny.gov/main/Rates/FosterCare/Manual/SOP-ProgramManual.pdf>

hard to reduce the severity of needs. Provider agencies cited several sources of funding, including community partners, grants, an endowment, and a holiday donation program. New York City also uses funds from a city tax levy. ACS oversees all funding except for Medicaid, which is part of New York City's Human Resource Administration's budget. Medicaid funding is used to pay for therapeutic services such as counseling and crisis behavioral health, and other funding supports room and board stipends and administrative costs.

As discussed earlier, the state of New York is working to transition all foster care children away from Medicaid fee-for-service and into managed care. They are also exploring how to bring current TFC services that are non-encounter-based, such as social work services and nursing services, into managed care. The state is generating six new plan services, consolidating 1915c state waivers into a bundle, and creating 12 additional Home and Community Based Services (HCBS) to promote a healthier trajectory for children in care. The goal is to reduce the need for foster care, hold managed care organizations accountable for providing comprehensive care for children in child welfare custody, and provide children with an effective array of services that promote reunification with biological families. All managed care transition work is ongoing.

Monitoring and Quality Improvement/Assurance

Monitoring is conducted on the state, county, and provider agency levels. NY OCFS licenses TFC provider agencies and audits agencies every 3 years. This process involves interviewing children, foster parents, and biological parents and reviewing agency records to assess quality, outcomes, and areas for improvement. OCFS also monitors county child welfare departments, although details of this process were not made available. With the planned transition of the foster care population into managed care, OCFS will monitor the effect of this change on TFC-specific indicators such as rate of out-of-state placements and length of stay.

At the county level, ACS in New York City conducts ongoing monitoring of contract agencies through their Division of Policy, Planning, and Measurement. The division reviews contracts, visits TFC homes, and tracks whether children are receiving necessary services. Erie County also conducts ongoing monitoring of provider agencies. Data are collected by the county through a dashboard system. Neither New York City nor Erie County reported an emphasis on cost monitoring.

Multiple providers we spoke to reported accreditation from the Council on Accreditation and the Sanctuary Institute. Provider agencies license and supervise their contracted foster care homes, although the extent of monitoring appeared to vary. One Erie County provider agency has a Quality Improvement team that holds an internal quarterly review focused on

quality, quantity, discharges, lengths of stay, and follow-ups. Data are used to inform recruiting efforts, establish length of stay benchmarks, and track critical incidents.

Strengths and Challenges

State officials and provider agencies identified strategies and strengths within their agencies that supported effective provision of TFC. In New York City, officials noted the value of holding quarterly meetings for provider agencies. These meetings are an opportunity to review data trends and patterns, discuss how ACS can better support the agencies, and work together to tailor services to meet the needs of TFC children. In Erie County, officials described the large county as having the feel of a small town because providers know each other and work together. Additionally, Erie collaborates with Niagara County, a neighboring county with a shared media market, and hopes to increase collaboration with other counties. Erie County officials felt that they were good at identifying, monitoring, and supporting provider agencies.

Provider agencies noted that knowing families well allows them to make good placement matches. Providers cited their partnerships with the school district, outside mental health service providers, and food and housing supports in the community as a strength, as well as their commitment to keeping child in their community of origin. Several agencies highlighted the quality of their relationship with the families they work with and TFC children, conveying that families and children feel supported by staff and come to them regularly for advice and support.

Recruiting and retaining good families is a challenge across the state, and providers expressed that they do not have the resources to identify such families. Providers also described challenges in placing large sibling groups (e.g., three to four children), especially with fewer stay-at-home parents who can care for multiple children. Sibling groups may be split up because of this, although the county and agency work together to coordinate weekly sibling visits.

One New York City provider expressed a need for better coordination between the child welfare system and mental health system; they feel there may be duplication of services under the current system. The state Medicaid agency ensures that children in care do not receive duplicative services through use of case managers, who coordinate care on an individual level and implement strategies to meet the child's need without duplication. The state also highlighted the use of Family Assessment Services plans that lay out the child's needs and services and allow all professionals involved in the child's care to see what services they have received.

State officials identified lack of appropriate administrative funding to fully support TFC programs as the primary barrier to optimal TFC functioning in New York. Lack of funding presents challenges in obtaining appropriate levels of supervisory staffing at TFC agencies

and recruiting TFC parents. Erie County officials described high turnover among child welfare staff and indicated that there are some negative perceptions about foster care in the community.

Summary

The provision of TFC in New York is unusual in that it is a state-supervised, locally administered service, mirroring the state's decentralized child welfare structure. The five New York City boroughs are consolidated under one child welfare agency, the ACS. New York provider agencies currently depend upon a Medicaid per diem to pay for care related to physical and mental health. In New York City, ACS also receives funds from a city tax levy. State officials are currently considering transitioning all foster children into managed care, which would improve access by holding managed care organizations accountable for making services available in communities. At the county level, some provider agencies are taking innovative approaches to expand TFC services and support TFC homes.

TREATMENT FOSTER CARE STATE PROFILE: NORTH CAROLINA

Overview of State Program

North Carolina supports a robust TFC program in which multiple child-serving agencies collaborate to provide children with intensive treatment services for complex behavioral health needs in the least restrictive setting. TFC services are funded primarily through Medicaid, with oversight provided by various agencies within the NC Department of Health and Human Services, including the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; its Medicaid agency, the Division of Medical Assistance; and the child welfare agency, the Division of Social Services (DSS).

TFC services for children in North Carolina are also supported by the Department of Public Safety through the Commission of Juvenile Justice as a part of a court diversion program. The NC juvenile justice system works collaboratively with the public behavioral health system to fund TFC services for children who meet eligibility requirements.

The NC public behavioral health system is unique in that publicly funded behavioral health services, including TFC, are managed and monitored through seven regionally based local management entities/managed care organizations (LME-MCOs) that provide a comprehensive behavioral health services plan under the NC 1915(b)(c) Medicaid Waiver for people in need of mental health, developmental disability, or substance use services. TFC services are managed by LME-MCOs that contract with multiple network providers that hire, train and supervise therapeutic foster parents.

State terms for TFC: Therapeutic foster care (TFC), intensive alternative family treatment (IAFT)

Number of children served: 28 children receiving Level I TFC, 1,885 children receiving Level II TFC, and 102 children receiving IAFT

Child welfare custody required: No; behavioral health managed care organizations (LME-MCOs) or juvenile justice agencies may place children into TFC services.

Program model: North Carolina does not require a specific model for Level I or II TFC, and recommends use of one of four models:

- ❖ Treatment Foster Care Oregon, formerly known as Multidisciplinary Treatment Foster Care,
- ❖ Together Facing the Challenge,
- ❖ Teaching-Family Model, and
- ❖ Pressley Ridge Treatment Foster Care.

IAFT providers are required to adopt one of the four models.

How services are provided: For services funded by Medicaid, behavioral health MCOs contract with providers, who recruit and train TFC parents. For services funded by the NC Department of Public Safety, Juvenile Justice Section, this state agency contracts with providers to recruit and train TFC parents.

Financing: TFC is primarily financed through a 1915 (b)(c) Medicaid waiver. IAFT is funded through Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) funds. For children in child welfare custody, room and board costs within both TFC and IAFT are covered by child welfare funds. For youth served through the Department of Public Safety, Juvenile Justice Section, the regional Juvenile Crime Prevention Council (JCPC) provides funding.

TFC services in North Carolina are also supported by a strong network of TFC providers. The NC Chapter of the Family Focused Treatment Association (FFTA) was formed in 1997 and offers advocacy, training, and support to providers.

Program Models

TFC is one component of an array of behavioral health services available for children up to 21 years of age. Because TFC is conceptualized as a behavioral health treatment service in North Carolina, there is *no* requirement that a child be in the custody of the child welfare agency to access TFC services.

TFC services in North Carolina are defined in the TFC Medicaid service definition as Child Residential Level I and Level II—Family Type. The service definition characterizes Level II TFC as a 24-hour service in which the provider provides intensive, individualized supervision and structure. Activities included are rehabilitative in nature and include development or maintenance of daily living skills, anger management, social skills, and crisis management and support. The Level I TFC service definition requires a low to moderate level of structure and supervision. Activities are similar, but of lower intensity. State officials and providers voiced a desire to revise current service definitions to provide more specificity and better distinguish among the service levels.

North Carolina also supports a Medicaid behavioral health service known as IAFT, with approximately 10 providers currently providing this service. IAFT is an intensive form of TFC, with a separate Medicaid service definition and more-intensive training requirements.

IAFT is highly supervised, with daily clinical and administrative supervision and weekly face-to-face supervision for IAFT parent(s), staff and supervisors.

IAFT is family focused, with family members or other designated support persons involved throughout the entire treatment process. Weekly therapy is provided to children and their families. Shared parenting is highly recommended between the family of permanence and the IAFT treatment parent, to promote success in transition to home or to a lower level of care. IAFT involves rigorous clinical outcomes measurement, which occurs during treatment and after discharge.

Several provider and state agency representatives discussed how the flexibility of the Medicaid managed care waiver allowed the LME-MCO to create TFC services tailored specifically for special populations. In addition to the existing Level I and II TFC and IAFT

Key Elements of IAFT

- ❖ One child placed in a home
- ❖ Daily contact with a care coordinator
- ❖ Weekly team meetings with treatment parent and agency professionals
- ❖ Psychiatric oversight
- ❖ 24/7 crisis support
- ❖ Proactive, teaching-oriented behavioral interventions
- ❖ Respite services
- ❖ Implementation of one of North Carolina's four approved training models
- ❖ Weekly engagement with biological family
- ❖ Integration of model fidelity
- ❖ Outcome reporting during and after treatment

Source: <http://ncrapidresource.org/Home.aspx>

services, some LME-MCOs are working with providers to develop specialized TFC homes for children with mental health diagnoses and co-occurring substance use disorders, as well as specialized TFC homes for children with co-occurring intellectual or developmental disabilities.

In an effort to disseminate information regarding evidence-based services, the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services supports the NC Practice Improvement Collaborative (NC PIC), which reviews and promotes evidence-based behavioral health treatment. State agency representatives estimate that about 50% of TFC providers have adopted one of the endorsed evidence-based practices. Such models are recommended by the state, but not required for Level I and II provider reimbursement. IAFT service providers are required to adopt one of the four evidence-based services.

Eligibility for TFC is determined by LME-MCOs, which authorize care based on an assessment by a provider agency. A licensed clinician typically conducts a clinical assessment, including behavioral health diagnosis, and submits the assessment for authorization. The LME-MCO reviews this request to ensure it meets medical necessity. Although there are required elements for assessments, each of the LME-MCOs uses their own assessment tool. The state is considering adopting the Child and Adolescent Needs and Strengths Comprehensive Assessment for statewide use to standardize and improve the assessment process.

Licensure and Training

DSS conducts licensure of TFC provider agencies; TFC homes are individually licensed and are relicensed every 2 years. TFC parents are required to attend annual training and to undergo an additional 10 hours of training beyond the training required for all foster parents. Provider agencies offer more-extensive training, which may be specific to a TFC program model. One provider reported using the Together Facing the Challenge training curriculum, which includes a module on trauma-informed care. LME-MCOs may impose additional training requirements. A provider reported that a LME-MCO had a contractual requirement for an agency cultural competence plan, including provisions for TFC parent training.

TFC Models Supported by North Carolina

The NC PIC, which is funded in part by SAMHSA, reviews evidence-based and promising practices and has endorsed the following TFC models for use in North Carolina:

- ❖ Treatment Foster Care Oregon, formerly known as Multidisciplinary Treatment Foster Care
- ❖ Together Facing the Challenge
- ❖ Teaching-Family Model
- ❖ Pressley Ridge Treatment Foster Care.

Source: <http://ncpic.net/endorsed-practices/mental-health-practices/>

A private organization, Rapid Resource for Families, contracts with the state to provide credentialing for IAFT service agencies. The IAFT model requires parents to undergo intensive, ongoing training provided through the organization.

Child Entry and Exit

As outlined above, eligibility for TFC requires proof of medical necessity, which is determined through a multistage process. Typically, DSS conducts an initial assessment for a youth in care, followed by a more-comprehensive clinical assessment by a mental health provider. An LME-MCO makes the final determination as to whether a youth is eligible for TFC placement. Biological families do *not* need to relinquish custody to obtain TFC services.

For youth with juvenile justice involvement, a juvenile court counselor conducts a risk and needs assessment upon system entry. Next, a mental health provider is brought in to conduct an assessment via the Global Appraisal of Individual Needs–Short Screener and possibly, a full comprehensive mental health assessment. If the provider determines that TFC is appropriate based on medical necessity, the recommendation will be shared with the judge for consideration. Although approximately one-third of juvenile justice cases are diverted from court, TFC is often recommended for youth who have gone to court, based on higher risk and needs.

Regardless of adjudication status, all youth (justice-involved and non-justice-involved) can be placed directly into a TFC home following the assessment processes described above. They do not need to “fail out” of a lower level of service. However, some youth do enter from a regular family foster care placement after a higher level of care is determined to be necessary.

When youth are placed into a TFC home, a matching process is used to optimize the placement stability for both the youth and the family. This process uses the Every Child a Priority software system, a placement stability system used to refine matches between foster children and families by taking into account a number of key child characteristics and how those characteristics have affected past placement successes and failures.³⁵ LME-MCOs discussed difficulties associated with finding appropriate matches for youth, including geographic disparities in availability of TFC homes, and matching based on race/ethnicity, behaviors, language, and gender identity.

Exit from TFC may take many paths. Although no data were available on placements following TFC, state informants explained that youth can be reunited with their biological family; placed in a standard family foster care home; or placed into a higher level of service, such as a psychiatric residential treatment facility. Juvenile justice-involved youth

³⁵ Foster Care Technologies, <http://fostercaretech.com/>

in TFC may remain in the same home setting, but funding may shift from the juvenile justice system to the child welfare system as juvenile justice supervision ends.

TFC Home Supply

North Carolina is unique in its large number of TFC homes, with more than twice as many licensed homes as children being served at any given time. A state DSS agency representative reported that 4,833 TFC beds were licensed as of fall 2016. An additional 69 applications were reported to be pending for licensure review. A TFC consultant to LME-MCOs indicated the high number of TFC homes was likely because of low barriers to entry. Any TFC provider can bill for TFC by becoming a licensed provider and following the Medicaid service definition. However, the consultant noted that many TFC providers may close or may be acquired by other providers.

Despite the number of available licensed TFC beds, there is an overabundance of TFC homes in some areas and an insufficient number in others. The state continues to face challenges in meeting the need for TFC in rural areas and for children in the juvenile justice system. Specifically, there were insufficient homes to meet the needs of children with inappropriate sexual behaviors, those whose primary language is Spanish, and those who are part of sibling groups in which one child requires a higher level of care. Although North Carolina has a waiver option for sibling groups in TFC, it is not automatic and does not happen often. North Carolina limits TFC homes to no more than four children overall including no more than two foster children.

Recruitment and Placement

Provider agencies have primary responsibility for recruitment of TFC parents. One provider agency stated that their organization relied on word of mouth from current TFC parents as the most effective recruitment strategy. They also use recruitment strategies that focus on marketing in the community, including community fairs, provider fairs, and family nights with arts and crafts for kids. One innovative strategy included Google advertising, which increased interest to the point that the agency had to hire staff to handle 50 screen-in calls per week; however, many do not actually result in viable families. JCPCs may also use their funding to supplement TFC parent recruitment.

Behavioral Health Access

Although TFC is primarily delivered through the behavioral health service system, several stakeholders reported challenges accessing case management services and additional needed behavioral health services. The requirement for LME-MCO authorizations for additional behavioral health services was viewed by some as too restrictive. Before implementing behavioral health managed care, case management was a separate Medicaid-billable service. Case management funding was rolled into the LME-MCO budget as a part of

their administrative funding and not included in the TFC rates. This can make it difficult for provider agencies to provide adequate case management services for children in TFC. The juvenile justice state agency representative indicated that the agency was reinstating case management as a separately billed service for juvenile justice-funded mental health providers. The agency will use state funding to pilot case management services in a few counties. Funding will be targeted for children with more-intensive problems, such as those who are assessed to have more intensive mental health needs along with developmental or intellectual disabilities. An additional challenge is limited provider availability for behavioral health services in rural areas.

Financing

TFC in North Carolina is a Medicaid service, with all treatment costs covered by Medicaid. TFC rates range from \$49.75 a day for Level I, to \$88.58 for Level II, and to \$214.00 per day for intensive services such as IAFT and for children with co-occurring substance use disorders. Some LME-MCOs provide a higher rate than the established state rate as a performance incentive. For example, one LME-MCO received permission from the state to pay an enhanced rate if a provider agency provides required data. One provider reported that TFC parents in some geographic areas receiving a higher than average daily payment because of local economic forces.

For children in child welfare custody, the title IV-E foster care program pays board and care. TFC parents typically receive all room and board funding. For eligible children served by the juvenile justice system, room and board is covered by JCPC funds. For children who are not in child welfare custody, custodial parents are responsible for room and board costs. However, nonprofit provider agencies may cover these costs through donations or other fundraising efforts.

The NC Department of Public Safety provides approximately \$23 million annually to county-based JCPCs to develop and fund community-based diversionary programs. The JCPCs are composed of representatives from county departments of health, LME-MCOs, school superintendents, and district judges and determine how funding will be allocated at the county level. Some TFC programs are funded through the JCPC dollars, and these councils may fund initiatives to support TFC, such as recruiting TFC parents through ads on the radio or in newspapers. IAFT is funded differently, through Medicaid EPSDT funds, separate from the 1915 Waiver funds managed by the LME-MCOs.

Monitoring and Quality Improvement/Assurance

TFC monitoring is conducted by child welfare, juvenile justice, LME-MCOs, and provider agencies. DSS licenses TFC provider agencies and foster parent homes, and is responsible for monitoring and evaluation. Monitoring focuses on service definitions and administrative rules and requirements, rather than outcomes. For agencies licensed since September 2011,

North Carolina requires accreditation from one of four bodies: the Council on Accreditation, CARF International, the Joint Commission, and the Council on Quality and Leadership.

TFC services are included in the NC Treatment Outcomes and Program Performance System (NC-TOPPS), which is a Web-based system for gathering performance and outcome data for behavioral health services.³⁶ Consumers can use the system dashboard to create and download reports comparing outcomes for specific services, including Level II TFC.

Outcomes can be compared by provider agency and by LME-MCOs. Outcome measures include mental health and physical symptoms, client self-report on helpfulness of program, emergency department use, and school functioning, among others. The state is working with LME-MCOs to obtain full participation in NC-TOPPS from all providers.

Juvenile Justice conducts extensive monitoring of TFC as well. For youth with juvenile justice system involvement, TFC is often funded through the JCPCs. All JCPC programs are evaluated using five criteria: intervention, quality of service (i.e., fidelity to approach), duration standards, dosage of program, and risk level (i.e., matching youth with the appropriate type of services). Juvenile Justice consultants monitor JCPC programs, including TFC, using these criteria. TFC providers also report yearly to JCPCs on six outcome measures, three of which are determined by the state and three of which they select from a list.

MCOs in the state conduct monitoring and evaluation around outcomes and clinical aspects of care. Upcoming state contracts will require mandatory reporting on outcomes for all providers, although specific outcomes have not yet been determined. MCOs are discussing incorporation of Healthcare Effectiveness Data and Information Set (HEDIS) measures. Provider agencies focus on outcomes as well, particularly around the number of moves for every youth in care. They track nights in care, number of new families brought on, and reasons for leaving. One agency expressed that these types of data allow them to observe trends over time and take note of emerging patterns

Strengths

Strengths of the NC TFC system include a substantial supply of TFC homes and the NC PIC's endorsement of evidence-based models of care. Additionally, youth can enter TFC through both the behavioral health and juvenile justice systems, which allows for greater accessibility to TFC for a diverse range of youth. Juvenile justice officials cited a 79% reduction in institutional placements in the past decade for justice-involved youth, and a growing emphasis on providing services to all youth in a community setting. One official

³⁶ NC Treatment Outcomes and Program Performance System, <https://www.ncdhhs.gov/providers/provider-info/mental-health/nc-treatment-outcomes-and-program-performance-system>

explained, “The more options we have to get kids into community settings and involved with other community partners, closer to home, etc., the better.”

A provider agency cited very low staff turnover rate as an organizational strength that facilitated staff’s knowledge of their TFC families. They also emphasized that their data-driven approach was unique in the field and allowed them to provide better services. This focus on data allows providers to effectively target resources and improve youth outcomes.

An additional strength mentioned by all stakeholders is the TFC Collaborative. TFC providers began meeting with LME-MCO representatives in June of 2013 with the initial goal of improving outcomes for children in TFC service, including decreasing length of stay and reducing placement disruptions. The group has since grown to include representatives from local DSS agencies, universities, and state and national FFTA representatives. The collaborative meets monthly and offers training and information sharing. Goals focus on supporting training on trauma-informed care, increased use of evidence-based models, and improving child-centered services and placement stability. The collaborative is also working with a consultant to improve data collection efforts by gathering data from providers to track placements. This process has inspired one LME-MCO to expand their data collection efforts for children in TFC, increasing their provider reimbursement rate by 3% to cover costs of data collection and validation. Other LME-MCOs are considering participating in this data collection initiative

Challenges

Several informants cited limited TFC availability in rural areas as a challenge. A representative of the child welfare agency explained that because there are few TFC beds in certain areas, some children must leave their home communities to access behavioral health services. This runs counter to the goal of keeping youth close to home. Additionally, fewer TFC beds reduces the child welfare agency’s ability to make strong youth–foster parent matches. State officials also expressed concerns about the need for more engagement of biological parents in reunification activities or therapy. Current practices do not typically require a contract with biological parents for participation, and state officials felt that adoption of an evidenced-based model could promote stronger parental engagement.

Juvenile justice–involved youth face delays in assessment and placement into TFC homes. Currently, 30% of youth in juvenile detention facilities are awaiting mental health assessments. Because Medicaid does not cover services for youth in detention facilities, funding for these assessments comes from other federal and state dollars. Some JCPCs have begun funding TFC placements using their own funds while waiting for assessments and placements to occur.

Summary

The provision of TFC in North Carolina is unique in that TFC is conceptualized as behavioral health treatment, and therefore, there is *no* requirement that a child be in the custody of child welfare to access services. North Carolina also supports a Medicaid behavioral health service known as IAFT, an intensive form of TFC, with rigorous clinical outcomes measurement. The flexibility of a Medicaid waiver has allowed for LME-MCOs to tailor services, such as specialized TFC homes for children with mental health diagnoses and co-occurring substance use disorders. North Carolina benefits from the NC PIC, which reviews and promotes evidence-based behavioral health treatment for adoption by providers. There is also a TFC Collaborative, which includes representatives from local DSS agencies, universities, LME-MCOs, and the state and national FFTA. The collaborative meets monthly and strives to support training on trauma-informed care, increase use of evidence-based models, and improve child-centered services and placement stability.

TREATMENT FOSTER CARE STATE PROFILE: NORTH DAKOTA

Overview of State Program

TFC in North Dakota is administered by the Department of Human Services, Children and Family Services Division (DHS CFS) in conjunction with the Division of Juvenile Services (DJS) within the Department of Corrections and Rehabilitation. CFS has contracted with a single provider agency, PATH, to provide TFC services since 1994.

The strong partnership between CFS and PATH is reflected by CFS representation on the PATH Advisory Council. A close working relationship between the state-

administered system and a single provider agency facilitates flexibility and responsiveness in service delivery. This approach supports CFS in overcoming systemic barriers and developing innovations such as intensive wraparound care for children who are involved with the justice system.

Program Models

The foundation of out-of-home care in North Dakota is a continuum of care, a service-based approach in which children are assessed to determine the level of care required to meet their individual needs. The level of service required is assessed by an MA-level therapist and incorporates family and custodian input in overall consideration. Placement and level of treatment are ultimately determined by the CFS regional supervisor. The continuum emphasizes placement in the most-appropriate, least-restrictive community-based setting appropriate for the child's level of service. North Dakota does not mandate a specific TFC model.

North Dakota has a state-supervised, county-administered child welfare system. Regular foster care and emergency foster care placements are supervised by county child welfare agencies, which also recruit regular foster care homes. PATH provides TFC through a contract with CFS, Family Support homes, and an Independent Living Program.

State terms for TFC: Treatment foster care (TFC)

Number of children served: Approximately 250 children are in TFC placements at any point in time.

Child welfare custody required: No, but must be approved by the Department of Human Services, Children and Family Services Division (DHS CFS) and the Behavioral Health Division.

Program model: North Dakota does not require a specific model. Compared with children in regular foster care, children in TFC receive a higher level of case management, known as targeted case management. TFC homes receive more training than regular foster care homes and receive oversight and ongoing support from a dedicated caseworker who is available 24/7, along with a back-up caseworker.

How services are provided: TFC services are provided under contract with CFS, through a single provider agency, which recruits and trains TFC parents.

Financing: TFC is primarily financed through funds from CFS, Medicaid, and federal IV-E dollars. This combination of funding sources is used to cover most aspects of TFC, including board and care, case management, and some clinical and therapeutic services.

Justice-involved children may be placed in any of the four tiers along the TFC continuum of care. DJS is the administrative agency that takes custody of children committed to its care by the juvenile courts. DJS operates the North Dakota Youth Correctional Center (NDYCC) and eight regional community-based services offices. DJS Community Services staff provide comprehensive case management and community-based correctional services to children. DJS Community Services, in cooperation with the CFS, ND Association of Counties, and Department of Public Instruction, provides an array of placement options and services.

ND Medicaid Policy for Targeted Case Management for Child Welfare

Targeted case management includes the following:

- ❖ Comprehensive assessment and periodic reassessment
- ❖ Development (and periodic revision) of a specific care plan
- ❖ Referral and related activities
- ❖ Monitoring and follow-up activities
- ❖ Interactions with collateral contacts
- ❖ Care plans that are reviewed and updated at least quarterly

Because foster parents (in regular or TFC homes) are often reluctant to accept justice-involved children, such children may be placed in residential facilities rather than accessing treatment services from community placement. PATH is working with DJS, along with NDYCC and the juvenile court system, to develop a child probation reform project aimed at placing children back in the community by developing substance use, mental health, and family services under jurisdiction of the probation office. This approach is also intended to prevent loss of custody among biological families. For children who need residential services, PATH is working with state agencies to improve after-care support. DJS also places some children in regular foster care homes, works with foster care support groups, and provides training on the benefits of placing children in the community.

PATH prioritizes family and community engagement, long-term outcomes, intensive 24/7 services, and accountability to families. PATH conducts pre-placement visits and allows birth parents to look at placements. Family team meetings that engage in treatment planning are key and include families of origin, caregivers, and PATH staff. Targeted case management is a key component of TFC in North Dakota.³⁷ As defined by the state Medicaid agency, targeted case management assists individuals in accessing medical, social, educational, and other services necessary for appropriate care and treatment. Targeted case management is available for children who are Medicaid eligible and served by CFS, county child welfare agencies, DJS, or tribal agencies, as well as children identified as maltreated and in need of services.

CFS conducts placement review and treatment meetings quarterly for children in TFC, whereas regular foster care treatment meetings occur every six months. TFC homes receive

³⁷ ND Medicaid Policy for Targeted Case Management:
<https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/targeted-case-management-child%20welfare.pdf>

a higher level of case management and more training than other levels of service, with immediate agency oversight and support from PATH. Licensed PATH families receive ongoing support from a dedicated caseworker who is available 24/7, along with a back-up caseworker. A foster parent described their role in this process as meeting monthly with the biological family and, in some instances, working as an advocate with a mediator to achieve greater understanding between the child's biological family and an adoptive family. The foster parent also noted that TFC parents have greater access to case managers than in regular foster care and can call their case manager in the middle of the night as needed.

Licensure and Training

CFS requires all TFC, regular foster care, and adoptive parents to receive Parent Resources for Information, Development, and Education (PRIDE) training, a national pre-service curriculum by the University of California, Los Angeles, in addition to training on medication monitoring and fire safety. Following the preliminary PRIDE training, PATH requires 30 hours of annual training among TFC parents. Twelve hours must be composed of "share and support" groups, and the other 18 hours may be focused on topics of the family's choice. PATH additional training covers cultural competency, first aid, CPR, trauma, and de-escalation. A North Dakota TFC parent indicated the particular importance of the "share and support" groups, in which TFC parents listen to one another's challenges, offer support, and suggest appropriate responses and strategies in becoming an effective TFC foster parent.

Criteria for TFC Eligibility
To be eligible for TFC, children must
❖ be 18 years of age or younger;
❖ have a mental health diagnosis;
❖ have symptoms that are expected to last or have lasted 1 year or longer;
❖ have service needs involving two or more community agencies (e.g., child welfare, mental health, substance use, juvenile justice);
❖ have challenges doing well in school, home, or the community; and
❖ have difficulties that strongly interfere in their lives.
A third-party referral from a custodial agency is required. Custodian agencies include CFS, county child welfare agencies, tribal agencies, and DJS
Source: ND Children's Mental Health Services, Partnerships Program for Children's Mental Health

Child Entry and Exit

A comprehensive assessment is the first step in determining the appropriate level of service for children in the state's custody. The CFS assessment process includes the Comprehensive Adolescent Severity Inventory, Adverse Child Experiences Questionnaire, and the trauma symptom checklist.^{38,39} DJS Probation also assesses children and families in determining treatment and placement through use of tools such as the Youth Assessment and Screening

³⁸ Comprehensive Adolescent Severity Inventory:
<https://njsams.rutgers.edu/samsmain/casi2007download.pdf>

³⁹ Adverse Child Experience Questionnaire:
<http://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf>

Instrument (YASI).⁴⁰ Following the assessment, a family team meeting is convened to determine appropriate placement for the child. Through the process, children can be placed directly into a TFC home.

Families can access TFC services through a voluntary treatment program without having to relinquish custody. Accessing TFC services in this manner requires that the child be Medicaid enrolled or eligible. CFS finances the nonclinical costs of the placement. Such a placement must be approved by CFS and the Behavioral Health Division.⁴¹

It is possible for children over the age of 18 to return to a PATH home if they request to do so and CFS deems them to be good candidates for ongoing services and support. The care placing agency, the child, and the provider will then enter an agreement. A few TFC homes have an “adult license” to accommodate children older than 18. An adult placement could be covered by a therapeutic rate, a step-down regular foster care rate, or a county rate depending on the needs of the child. CFS officials noted that they also allow waivers on a case-by-case basis for children to return to a good placement, even if the TFC home is full. CFS’s overarching goal is to be flexible and accommodating within a structured assessment process.

PATH staff indicated that TFC services typically last 12 months. The length of stay has increased in recent years as the age of children served has decreased. CFS reported that services typically last from 6 to 18 months. The most common exit from TFC is a child reunifying with their family of origin. Children may also leave a TFC home to step down to a regular foster care placement or to step up to a group or residential setting. A child may also be adopted. In cases where reunification ceases to be the goal and adoption becomes the permanency goal, children tend to receive TFC services for the longer period of 18 months.

DJS officials noted that juvenile justice–involved children tend to be older than other TFC children, who typically range from 7 to 16 years of age and have different needs. As of late 2016, of the 171 children on the DJS caseload, only 6 (3.5%) were in TFC. Others were in their own home, the assessment phase, group homes, the PATH Independent Living Program, or behavioral health treatment programs. The duration of TFC services is shorter among the juvenile justice population than other TFC children, ranging from 6 to 9 months. Officials described the training offered by PATH as robust. DJS intentionally has recruited some foster parents residing close to the NDYCC so these parents can engage with the facility staff and thus provide a more seamless continuum of care.

⁴⁰ Youth Assessment and Screening Instrument: <http://orbispartners.com/assessment/youth-assessment-yasi/>

⁴¹ North Dakota Foster Parent Handbook: <https://www.nd.gov/dhs/info/pubs/docs/cfs/foster-parent-handbook.pdf>

TFC Home Supply

PATH currently has 368 licensed TFC homes in North Dakota. Each home is licensed for two TFC beds, but PATH may request waivers to increase the number of placements. Among these, 59 homes are designated for respite care only, as North Dakota has a statute requiring that respite care be provided in a licensed home. PATH also has 26 Family Support homes, licensed foster homes that provide mentoring, case management, and emergency leave to biological families with children at risk for removal. Such homes are intended to serve as a preventive measure but may be used for children returning home from a residential program.

PATH and state officials agreed that the current pool of TFC homes does not meet the need. PATH stated that they have 65 to 85 pending referrals daily for children for whom they do not have homes. Additional TFC homes would enable the state to move more children out of congregate care. About a third of licensed homes are not currently used because they will not accept children with the characteristics of those in need of TFC services. For instance, some homes are only willing to take female children or are waiting for a child of a certain age, and thus have no current child placement.

All interviewees identified recruitment as a challenge and expressed difficulty finding parents willing to accept older children, especially those with a history of aggressive behavior, problem sexual behaviors, or difficulty in functioning. DJS officials stated that they face additional challenges finding TFC homes for adjudicated delinquent children because of foster parents' concerns over juvenile justice records.

Recruitment and Placement

As the sole provider agency, PATH has primary responsibility for foster parent recruitment. The ND Recruitment and Retention Taskforce, funded by CFS, allocates funds to each CFS region to support recruitment and retention for foster homes. PATH participates in the Taskforce as well. The agency reports that word of mouth by current foster parents is the most effective recruitment strategy. They also use strategies that focus on churches and religious organizations, and a larger campaign that includes radio advertisements, yard signs, and social media advertisements. PATH noted that children with special needs or considerations may require more-active and targeted recruitment.

PATH described TFC families as typically having two working parents, rather than one stay-at-home parent, which limits their ability to foster TFC children. PATH and CFS reported that the recent oil boom in North Dakota brought families from other states, including some who were interested in being licensed. Although this trend temporarily bolstered the supply of homes, the number of applicants declined when the boom ended.

PATH did not identify payment levels as a barrier to TFC home recruitment. They reported that TFC foster care parents are not motivated by the per diem, and some parents even set aside the funds in a savings account for a child placed in their home. It is worth noting the distinction between adequate payment level and income replacement. PATH officials, as well as DJS and probation officials, noted that the societal trend of two working parents is a barrier to recruitment, but higher payment levels do not approximate income replacement. One foster parent indicated that satisfaction comes from hearing appreciation directly from the children fostered.

Behavioral Health Access

PATH case managers are licensed social workers and provide multiple types of targeted case management: assessment, monitoring, case planning, referral, and linkages. They refer children to community-based therapists while concurrently developing internal capacity to directly provide therapy. DJS officials reported that PATH uses the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) for behavioral health management with children in their care.⁴²

In addition to this program, PATH uses trauma-informed approaches such as Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) with children in facilities.⁴³ SPARCS is a group intervention designed to address the needs of chronically traumatized adolescents who are living with ongoing stress and are experiencing problems with self-efficacy and connecting with others. TF-CBT is designed to reduce negative emotional and behavioral responses following sexual abuse, domestic violence, traumatic loss, and other traumatic events. The treatment, based on learning and cognitive theories, provides a supportive environment in which children are encouraged to talk about their traumatic experience. TF-CBT also helps parents cope more effectively with their own emotional distress and develop skills to support their children.

CFS officials acknowledged that rural areas typically have fewer providers and longer wait times. CFS and DJS officials cited the distance of behavioral health providers in rural areas and the travel time involved as another barrier. One TFC foster care parent expressed concern about inadequate behavioral health services in the community. Such barriers to access can extend the amount of time children remain in a TFC home.

⁴² Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems: <https://www.ncbi.nlm.nih.gov/pubmed/26458917>

⁴³ Structured Psychotherapy for Adolescents Responding to Chronic Stress, <https://www.nctsn.org/interventions/structured-psychotherapy-adolescents-responding-chronic-stress>

Financing

TFC is financed in North Dakota through a combination of CFS and Medicaid funding. These funds are combined with federal IV-E funding within CFS, and are used to cover most aspects of TFC, including board and care, and some clinical and therapeutic services. CFS contracts with PATH for TFC services and pays an administrative rate through the funding stream. This rate is based on the level of service and not the setting in which the child is placed; providers therefore have a financial incentive to place a child in the least-restrictive level of care at which they can succeed. Funding for TFC for DJS consists of state funding, title IV-E, and Medicaid. DJS officials noted that juvenile justice court orders are written to comply with CFS standards for Medicaid eligibility for PATH services.

The state pays PATH a per diem maintenance rate of \$108. North Dakota unbundled its rates in 2008, which allows PATH to bill external providers, Medicaid, and private insurance for the various types of targeted case management that they provide. The rate PATH pays to TFC parents can vary depending on characteristics of the children or parents. For example, TFC families typically receive higher per diems for children with problem sexual behavior or if a TFC child gives birth while in care.

One DJS official indicated that a higher reimbursement rate could reduce barriers to recruitment if the rate enabled one parent to stay at home. A probation official stated that there needs to be increased incentive (e.g., income replacement) to expand foster care for justice-involved children.

Monitoring and Quality Improvement/Assurance

PATH is a licensed child placement agency. They license the foster care homes, and then the state approves that licensure. CFS oversees licensing of foster care and TFC homes on an annual basis, as conducted by regional CFS staff. A PATH staff member with an MSW completes the assessment, after which a regional representative of the state reviews and approves licensure. The representative also reviews each placement as part of family and team meetings. In addition to the monitoring required by the state and for accreditation, PATH conducts internal audits of targeted case management billable activities.

PATH has been accredited through the Council on Accreditation for some time, and this accreditation has recently been mandated by the state. CFS conducts an annual review of the PATH licensed child placement agency, which involves a review of homes and foster children for compliance.

Strengths

The CFS, DJS, NDYCC, and probation officials all spoke highly of their partnerships with PATH. CFS cited their organizational structure as very effective in covering all North Dakota, which allows PATH to triage issues efficiently. Advantages of a single vendor in a small state

include frequent and transparent communication and contact; the ability to build close, positive relationships; and familiarity with administrators and staff.

PATH cited their expertise and experience in successfully matching children to TFC families that support stability and permanency. The agency credited their strong partnership with the CFS and relationships with TFC parents with their success in identifying and supporting structured, supportive homes. The level of commitment among PATH staff and families was noted, such as a willingness to re-accept a child who has run away. TFC parents expressed appreciation for the training, resources, and support PATH provided.

Challenges

PATH is the only TFC provider in the state, and according to state agency officials, there has been difficulty in identifying other vendors. Data collection and reporting mechanisms are not as well developed in North Dakota as in other states. Respondents noted that efforts are underway to improve the collection and availability of data regarding TFC services. One TFC parent noted high turnover among TFC case managers, which can negatively impact children, and questioned whether compensation was an issue.

A shortage of qualified TFC homes was identified as a pressing challenge by all stakeholders. North Dakota parents are experiencing many mental health issues and substance use disorders, which seem to be driving the recent, rapid growth in the foster care population. A probation official observed that the complexity and severity of cases is presenting a barrier to placement, as prospective TFC families are reluctant to accept older children with challenging behaviors. DJS officials also noted the lack of outpatient addiction programs for children in care.

As noted earlier, juvenile justice, CFS, and PATH are developing an initiative to provide more-responsive care earlier in the process. Reconfiguring the process is intended to preserve family custody and ensure children are in the least-restrictive setting that meets their treatment needs. DJS noted that the needs of children may exceed the resources of small school districts, so TFC children sometimes need to be relocated to larger districts to be better served. A DJS official noted that school districts' zero-tolerance policies can be a barrier to placing justice-involved children.

Summary

The provision of TFC in North Dakota is unique in that there has been just one provider agency, PATH, since 1994. North Dakota is primarily rural, with fewer behavioral health providers, longer wait times, and long travel time involved. Along the TFC continuum of care, targeted case management is a key component, and is available to children who are Medicaid eligible and served by CFS, county child welfare agencies, DJS, or tribal agencies, as well as children identified as maltreated and in need of services. Families can access TFC

services through a voluntary treatment program without having to relinquish custody. Moreover, children over the age of 18 may return to a PATH home if they request to do so and CFS deems them to be good candidates for ongoing services and support. TFC services for adjudicated delinquent children are robust; however, placement and recruitment of TFC homes for such youth is difficult with respect to older children, male children, and those with a violent record or history of problem behaviors. As part of ongoing training, PATH facilitates “share and support” groups, a key resource among TFC parents.

TREATMENT FOSTER CARE STATE PROFILE: TENNESSEE

Overview of State Program

Therapeutic foster care, as it is known in Tennessee, is administered within a highly integrated and engaged state system. In 1996, the Department of Human Services and the Department of Youth Development consolidated nearly all their services within a new Department of Children’s Services (DCS) that now serves children in both child welfare and juvenile justice custody.

DCS programs in each of Tennessee’s 12 regions are

overseen by a regional administrator. This administrator is responsible for all children’s programs except active child protective services investigations; these include foster care, social services, juvenile justice, adoptions, and other child protective services. Assessment processes, placement teams, fiscal management, and data systems are shared across programs. As a result of this integration, dependent (child welfare) and delinquent (juvenile justice) youth undergo very similar processes on entering DCS custody. Nearly all DCS youth, both dependent and delinquent, can receive TFC if the assessment process identifies this as the most appropriate placement. The exception is delinquent youth placed in *hardware secure facilities*, which are the juvenile equivalent of high-security prisons.

State terms for TFC: Therapeutic foster care

Number of children served: 1,700 in fall 2016.

Child welfare custody required: No; the juvenile justice agency may also place children into TFC services.

Program model: No defined model, although there is a general state service definition. Tennessee is working to establish a state-specific TFC model.

How services are provided: Child welfare contracts with multiple private provider agencies that recruit and train TFC parents.

Financing: Child welfare funds cover board care, as well as clinical/therapeutic services not covered by Medicaid, as well as training and recruitment efforts of provider agencies. Medicaid is used for medically necessary clinical/therapeutic services included in the state’s Medicaid plan.

TFC Service Description

“Therapeutic Foster Care Services provide safe, nurturing care and guidance in private homes when children/youth are unable to receive the parental care they need in their own home. The child/youth is integrated fully into the community and provided opportunities for participation in community and extracurricular activities as well as development of talents, interests and hobbies. The placement will be in a home-like, least restrictive setting that meets the unique need of the child/youth with respect to their community/school district and placed with siblings, if possible. The foster parents receive standard foster parent training and are supervised and supported by agency staff, working together to meet the goal of permanency based on the best interest of the child. The families of children in foster care are offered support services to facilitate reunification whenever appropriate.

“The child/youth requires a higher level of clinical support, intervention and case coordination than those eligible for standard foster care. Their emotional/behavioral needs within the family are met through care by parents who have received standard foster parent training as well as specialized training to meet the higher therapeutic needs of the children/youth they serve. Moreover, the child/youth’s emotional/behavioral clinical needs are moderate and can be met through community and/or outpatient services.”

(Source: Contract Provider Manual Section 2 – Standard Foster Care Services, Tennessee Department of Children’s Services.)

In 2016, the state led a 2-day TFC learning collaborative intended to work toward a Tennessee-specific model of TFC, which both providers and state officials had identified as an important need. The collaborative brought together DCS officials, TFC parents, national leaders from the Family Focused Treatment Association and the Oregon Social Learning Center (developer of the Treatment Foster Care Oregon [TFCO] model), and provider agencies. Of the 10 applicants 6 provider teams were selected to attend; each team comprised an upper management representative, a mid-management representative, a clinician, a frontline staff member, and a foster parent. State officials stated that defining and implementing a statewide model would allow stakeholders to mutually determine the optimal level of TFC services and ensure that this level was provided across all provider agencies. Other topics covered during the learning collaborative included training and development for TFC parents and a universal TFC assessment process across all agencies. DCS officials reported that the collaborative was extremely productive, and TFC providers were receptive to the goals and activities of the meeting. They found particular value in working with other TFC providers to recognize common challenges and shared aims. In the months since the initial meeting, DCS has led smaller workgroups and organized conference calls to continue development of a statewide TFC model. Additional in-person and telephone meetings are planned.

Program Models

The foundation of out-of-home care in Tennessee is the continuum of care, a service-based approach in which children and youth are assessed to determine the level of care required to meet their individual needs. The continuum emphasizes placement in the most appropriate, least restrictive community-based setting appropriate for the child's level of service. This approach is used for all DCS youth, regardless of their adjudication status. Within the continuum, Level I is the DCS network of "traditional" foster care homes, for children and youth without enhanced service needs. Level II and III services can be delivered in either therapeutic foster care homes or group care facilities. The difference between these two service levels is largely related to the youth's intensity of behaviors and the intensity of services needed to provide care and treatment at the time of admission. (Level III children and youth require more frequent visits from providers, and more frequent medical and therapeutic interventions.) Level IV is subacute hospitalization. The level of service that a youth requires is assessed first, and the placement setting for these services is subsequently determined.

According to the Tennessee foster care contract provider manual, TFC is appropriate for children and youth who

- Are unable to receive the parental care they need in their own home.
- Appear to be capable of participating in a family unit and able to participate in family and community activities without posing a serious danger to themselves or others.

- May be of any adjudication type (i.e., may be in the custody of juvenile justice or child welfare).⁴⁴
- May have a history of moderate mental health, and behavioral concerns that require monitoring or observation to prevent an increase in severity. Youth may have current emotional or behavioral symptoms that are moderate or transiently severe in nature. These may manifest themselves in difficulty coping socially, occupationally, or in school functioning.
- Have a Child and Adolescent Needs and Strengths (CANS) recommending Level II or Level III services.

Tennessee does not mandate a specific TFC model, although the ongoing state collaborative aims to develop one. All provider agencies adhere to a standard scope of services that specifies the responsibilities and services of both the agency and the TFC parents. However, state officials noted that the service definition (excerpted above) is less specific than they prefer. TFC models thus vary among provider agencies and over time. For example, one agency initially used the Treatment Foster Care Oregon model (formerly called Multidimensional Treatment Foster Care), but since 2009 has operated under its own TFC model, which it felt better fit the needs of the youth in its care. This model draws on elements from TFCO, but focuses less on treatment needs specific to juvenile justice youth and more generally on trauma-driven needs of all TFC youth. Its work is grounded in the Evidentiary Family Restoration model developed by Youth Villages, which prioritizes family and community engagement, measurable long-term outcomes, intensive 24/7 services, and accountability to families and funders.⁴⁵

DCS specifies minimum requirements for TFC in its Contract Provider Manual.⁴⁶ TFC parents must complete the standard preservice foster parent trainings (23 hours) as well as an additional 15 hours of training. DCS does not have requirements as to what the additional trainings must contain. They must also complete at least 15 hours of additional training annually. Preference is given to TFC parents aged 25 years or older, but agencies can choose to accept younger parents if they can document that parents have shown the necessary maturity level. Families are limited to two TFC youth (Levels II or III) in the same house at any time; waivers may be possible when dealing with sibling groups. TFC youth typically attend public schools. Provider agencies must develop a written treatment plan within 30 days of placement. Throughout the placement, agencies provide 24/7 crisis

⁴⁴ Services provided to children in the custody of the juvenile justice system who are inmates of a public institution are not reimbursable by Medicaid. More information is available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf>

⁴⁵ More information about the Evidentiary Family Restoration Model, including the five core tenets of this approach, is available at: <http://www.youthvillages.org/how-we-succeed/evidentiary-family-restoration.aspx>

⁴⁶ Contract Provider Manual Section 2 – Standard Foster Care Services, http://tn.gov/assets/entities/dcs/attachments/Section_2-Foster_Care.pdf

response services to TFC families. Compared with traditional foster care, TFC has a more intensive scope of service, including at least one DCS visit per month and multiple clinical visits by the provider agency per week.

Child Entry and Exit

Eligibility for TFC is initially assessed for all custodial youth, regardless of adjudication status, through the CANS comprehensive assessment. Based on the results of this assessment, youth are assigned a level of service (I through IV) that corresponds with the continuum of care that has been established in Tennessee. According to the contract provider manual, a CANS score of 2 or 3 within the domain of child behavioral or emotional needs is indicative of a potential need for TFC. Following the CANS assessment, a Child and Family Team meeting (CFTM) is convened to determine the appropriate placement setting for the youth, taking into account the previously determined level of service needed. CFTMs comprise the youth and their family members (parents and/or other supportive relatives), as well as therapists, providers currently working with the youth, teachers and school counselors, social services staff members, and any other individuals who are invested in the youth and can serve as a support or a potential placement. CFTMs are convened within 7 days of the youth's coming into care, in order to determine the appropriate placement setting. Progress review meetings occur quarterly. CFTMs also take place at certain predetermined touchpoints (e.g., a step-down in levels, a placement disruption, discharge) and on an ad-hoc basis when key decisions need to be made about the youth's placement. This process is the same regardless of whether the youth is in juvenile justice or social services custody.

Through the CFTM process, youth can be placed directly into a TFC home. However, the CFTM may recommend a higher level of care first, such as residential treatment, with TFC a step-down placement following completion of treatment.

The most common exit from TFC is a return to the family of origin. Youth may also leave one TFC home for another foster home or for a group or residential setting. It is important to note that an exit from TFC does not necessarily correspond with a change in the level of care, as assigned through the CANS assessment. State officials provided an example of a youth in a TFC home who had intensifying needs and moved to a residential facility before stabilizing and returning to the same foster home. Throughout this whole process, the youth remained at the Level II setting

TFC Home Supply

Approximately 32% of the state's foster children are in TFC, and both provider agencies and state officials agreed that the current pool of TFC homes is insufficient to meet the need for the service. All interviewees identified recruitment as a challenge. A provider agency expressed difficulty in finding parents who are willing and able to meet the needs of a TFC

child, particularly those who are older or have experienced significant trauma. Highly skilled TFC parents are usually fostering the maximum number of children, or have chosen to adopt the youth and no longer have the resources or capacity to accept new foster placements as well. TFC parents also may take breaks between placements. State officials noted that they have approximately 4,000 certified foster homes (TFC and traditional), but only about half of these homes are actively accepting children. DCS officials who oversee juvenile justice programs stated that the agency faces additional challenges when seeking a TFC home for an adjudicated delinquent youth due to foster parents' concerns over their criminal background.

Recruitment and Placement

Provider agencies have the primary responsibility for foster parent recruitment. One provider agency stated that although every staff member is considered both a recruiter and a trainer, 15 designated individuals are stationed throughout the state to lead recruitment efforts. Staff receive incentives related to their recruiting efforts, as do current foster parents. This agency felt that word-of-mouth from current foster parents was the most effective recruitment strategy. It also uses recruitment strategies that focus on churches and religious organizations, and a larger social media campaign that includes radio, yard signs, and social media advertisements. The agency expressed concern that certain children with special needs or considerations may require active and targeted recruitment, although most TFC homes are not recruited with a specific child in mind. In Tennessee, agencies first look at placement options in the youth's county of origin but may place outside as needed. Kinship placements have also received increased emphasis in recent years; the state has initiated pilot programs through which provider agencies can certify kin under the TFC training and guidelines.

Behavioral Health Access

TennCare is the state Medicaid program in Tennessee. TennCare Select, the state's Medicaid managed care organization (MCO) serving children in foster care, is operated by BlueCross BlueShield of Tennessee. Because most TFC youth are insured through TennCare Select, they have access to community-based behavioral health services through the TennCare provider network. TennCare Select has a Best Practice Network of primary care, dental, and behavioral health providers who have committed to working with youth in DCS custody and have received extra training through TennCare Centers of Excellence. This includes training on trauma-informed care, trauma focused cognitive behavioral therapy, and the attachment regulation competency model. The Best Practice Network Primary Care Practitioner is responsible for providing a "medical home" for the children assigned to him/her and coordinates all physical and behavioral health care, including maintenance of all health records. Provider agencies typically assist in finding and coordinating community-based

behavioral health services, and sometimes provide services such as counseling in the foster home through their internal clinical staff.

TennCare officials did not identify significant challenges in accessing behavioral health care for TFC youth. However, DCS officials acknowledged appointment waiting lists at community mental health centers across the state. Length of wait for an office visit varies depending on geographic location; rural areas in the eastern part of Tennessee typically have fewer behavioral health providers and longer wait times. TennCare holds BlueCross accountable for length of wait through access and availability guidelines included in their contracting language with MCOs. Per this contract, MCOs must meet the specific geographic and time requirements; TennCare will “evaluate the need for further action when the above standards are not met.” MCOs may then be required to detail the adequacy of their network, considering any alternate measures, unique market conditions, and/or its plan for correction. TennCare may request periodic updates from the MCO regarding its improvement efforts.⁴⁷ TennCare MCOs are also trying to increase behavioral health provider capacity in the eastern and rural parts of Tennessee, and have promoted telehealth as an option to enhance access to care within the state.

The provider agency with whom we spoke completes a trauma assessment and works with the TFC parents to develop an individualized approach that is grounded in trauma-informed behavior management. DCS officials plan to develop a trauma toolkit training for foster parents and are considering additional trauma-focused trainings as well.

DCS officials stated that the shortage of behavioral health providers, and the subsequent appointment wait times, can have an impact on the length of a youth’s TFC placement. When youth have a harder time accessing behavioral health care in a timely manner, the delays can extend the amount of time they remain in a TFC home.

Financing

TFC is financed in Tennessee through both DCS and TennCare funds. The majority of youth entering foster care are eligible for TennCare Select, which functions as an MCO operated by BlueCross BlueShield of Tennessee, through an immediate eligibility system. TFC is not a TennCare covered benefit except under its contract with DCS; TennCare contracts with DCS to provide funding for all children in custody as well as for precustodial investigative work. DCS oversees distribution of these funds as well as federal IV-E funding; the two funding streams are used to cover distinct aspects of TFC, including clinical/therapeutic services (Medicaid) and board care and training and recruitment efforts of the provider agencies (IV-

⁴⁷ TennCare MCO Statewide Contract
<https://www.tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf>

E). Medicaid funds are used only to pay for Medicaid-covered clinical and therapeutic services.

Through DCS, Tennessee engages in performance-based contracting with all TFC providers. DCS contracts with agencies for a continuum of services and pays a predetermined rate. This rate is based on the child's level of service and not the setting in which the child is placed; providers therefore have a financial incentive to place a child in the least-restrictive level of care at which the child can succeed.

As shown in the box to the right, rates are higher in certain cases, such as youth with substance use issues or other special needs. Agencies keep some of the DCS funds internally while using the rest to pay foster parents. The rate paid to TFC parents can vary according to the characteristics of the child or parents. Providers typically do not

negotiate rates with the state, but may do so for youth with unique needs, such as complex medical conditions, that require significant additional services and costs. Provider agencies may also fundraise to acquire additional funds for services like support for youth aging out of foster care. Fundraising activities by Tennessee provider agencies include events such as races, dodgeball tournaments, and wine tastings; donation drives for backpacks and school supplies; and online promotion of planned-giving opportunities. Because of the performance-based contracting, provider agencies must undergo fiscal reconciliation at the end of every fiscal year in which they receive financial rewards or penalties based on their performance on the performance measures described below.

DCS Rates to Provider Agencies	
❖	Level II family setting
–	Standard: \$120
–	Special needs and substance use disorders: \$135–\$150
❖	Level III family setting
–	Standard: \$175
–	Special needs, substance use, sex offenders: \$200–\$300

Monitoring and Quality Improvement/Assurance

DCS is the primary agency responsible for monitoring and evaluation. With assistance from Chapin Hall, the state implemented a performance-based contracting system. The system has used three performance-based contract measures since 2006: timely exits to permanency, days spent in care, and reentries into the system. Providers are reimbursed for services at time of delivery and face fiscal reconciliation (penalties or rewards) based on their performance on these measures. Data are collected from providers monthly and provided to DCS by Chapin Hall biannually. State child welfare contacts reported satisfaction with the extent to which performance-based benchmarks are being met in Tennessee, as the net amount of provider rewards have greatly surpassed the net amount of provider penalties (through 2014). These rewards are paid for with state funds.

In addition to the monitoring required for performance-based contracting, DCS also monitors program accountability reviews, provider quality team processes, provider compliance, and provider performance.

Strengths

DCS staff cited their cooperative relationship with provider agencies and their consistent focus on process improvement as two of the agency's key strengths. The learning collaborative is one example of the proactive approach that DCS has taken in improving TFC services throughout the state and soliciting feedback from TFC providers and parents. State officials also highlighted the fact that many youth who are adjudicated delinquent are eligible for placement in TFC homes, rather than institutionalized in public facilities, which they view as a strength that sets them apart from other state systems.

The learning collaborative appears to have been well received by a variety of stakeholders, and it has been an effective means of engagement and idea-sharing. TFC providers had initial hesitation about working directly with other providers throughout the process, but DCS reported that afterward several expressed that through the collaborative they could discuss shared challenges, and that "they were all in this together."

Integration of social services and juvenile justice under the same department eliminates many of the traditional barriers that create delays and silos for interagency collaboration. Information sharing among state officials is facilitated by the fact that all DCS youth are part of the same data systems.

Challenges

A shortage of qualified TFC homes was identified as a pressing challenge by DCS officials, TennCare officials, and the provider agency. The provider agency suggested that reimbursement rates may be partly responsible for the struggle to maintain an appropriate supply of homes. DCS staff also highlighted the need for improved training for foster parents and to the frontline staff who support these parents.

Multiple interviewees felt challenged by the current lack of a standardized model for TFC. Explained one DCS official, "We want 'TFC' to mean the same thing to one provider and to another provider and to DCS." This goal was the motivation for the learning collaborative.

Summary

The provision of TFC in Tennessee is unique in that most TFC youth are insured through the state's Medicaid MCO, and thus have access to community-based behavioral health services through the provider network. Tennessee DCS and TennCare are trying to address barriers to access by holding MCOs accountable for length of wait through access and availability guidelines in their contracting language. The state recently organized a learning collaborative to solicit feedback from TFC providers and parents, to improve care. A primary goal of the learning collaborative was to implement a standardized model for TFC.

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