Treatment Foster Care Workgroup

Update to the Nebraska Children's Commission

November 15, 2016

The Foster Care Reimbursement Rate Committee convened the Treatment Foster Care Workgroup to research and make recommendations related to a rate structure that includes expectations regarding treatment components adequate to serve youth in out-of-home care for whom placement is problematic. The group has met nine times in 2016, and has included representation from the Department of Health and Human Services - Division of Children and Family Services, Family-Focused Treatment Association (FFTA), foster parents, KVC, Lutheran Family Services, Nebraska Appleseed, Nebraska Families Collaborative (NFC), Probation, and Voices for Children.

The group has compiled current levels of care and payment rate and intended outcomes from child welfare and juvenile justice for the Foster Care Reimbursement Rate Committee (FCRRC) to review and provide further guidance in order to create the requested rate structure. The group has created three recommendations to move the preliminary work of the group forward and the FCRRC prioritized recommendations two and three to focus the work of the Treatment Foster Care Workgroup:

1. Nebraska's existing family-like placement continuum of care should be examined to determine if placement types, requirements, definitions, and payment rates are streamlined and consistent as a first step to creating additional rate structures.
2. Nebraska's existing family-like placement continuum of care should be examined to identify which intervention components that are necessary to treat youth with high treatment needs in a family-like setting are not currently available.
3. Any new rate structure that includes treatment expectations should include and define the following non-negotiable characteristics that should be a part of treatment foster care.

Treatment Foster Care Components

1. Treatment Foster Care Intent
    a. The intent in creating a Treatment Foster Care level of care is to divert youth with high needs from congregate care and out of state placements. Youth who are child welfare involved will have their needs met in a family like setting that supports reunification or the timely achievement of permanency. Youth who are juvenile justice involved will have their needs met in a family like setting that prevents recidivism, promotes youth returning to their families, and promotes community safety.
    b. There is no one-size-fits-all model to serve Nebraska's youth in the child welfare and juvenile justice systems. Treatment should focus on skill building, options for youth participation in structured groups, and providing predictability in the youth's life. The

focus of Treatment Foster Care should be on outcomes, not compliance with the components of a particular model. The model should be trauma informed and juvenile justice informed. The Department of Health and Human Services, the Administrative office of Probation, and Nebraska Families Collaborative in partnership with provider agencies determine service needs and desired outcomes, and allowing variability in how these services and outcomes will be created by the provider agencies. Assessment drives the process of determining service needs and desired outcomes.

2. Treatment Foster Care Occurs in a Family Like Setting
    a. Treatment Foster Care should serve youth in the most family like settings possible. This intervention is not meant to create "mini group homes" in the houses of foster families. The placement should be focused on maintaining a family-like milieu, even as treatment is accessed.
3. Number of Youth with Treatment Needs per Treatment Foster Home
    a. The limit for number of youth with treatment needs in the home should be one youth, with up to two with common sense considerations for sibling groups and best interest of the youth.
    b. If a home is serving a treatment foster youth, it is desirable that this youth be the only foster youth in the home, subject to the above requirements. It is not recommended that a family have a treatment foster youth and one or more unrelated foster youths in the home, however the foster parents may have their own biological or adoptive children, or children over whom they have guardianship.
4. Treatment Component
    a. The treatment component means that a licensed clinician provides treatment in the home. The licensed clinician may have a provisional license.
    b. Clinician Role
        i. The preferred best practice is the agency providing the Treatment Foster Care provides the clinician, whether as an employee or through a third party contract. The agency remains responsible for the outcomes of Treatment Foster Care.
        ii.
    c. Foster Parent Role
        i. The foster parent is the primary interventionist and receives enhanced training to support this role. The foster parent is a part of the multi-disciplinary treatment team and implements the treatment plan in the home.
    d. Biological Parent Role
        i. The role of the child's biological parent may differ based on the system in which the child is involved, the child's transition plan, and the needs of the child. When youth are involved in the juvenile justice system only, the parent generally retains

legal custody of the child and plans to reintegrate the child into the home and community. When youth are child welfare system involved, the parent may not have legal custody and the child may have a permanency plan that precludes placement and reunification with the parent. The role of the biological parent(s), including involvement in treatment, and services provided to the parent(s), will be guided by the court and the multi-disciplinary treatment team.

5. Outcomes
    a. Families Experience Seamless System of Care with Braided Funding
        i. The treatment component should be seamless so that the billing is a part of the seamless system of care. Treatment Foster Care would be billed to the Department of Health and Human Services and the appropriate agencies (such as the Division of Children and Family Services, the Division of Medicaid) would remit payment.
    b. Reduced Placement Disruptions
        i. Youth in treatment foster care are not automatically moved to a different non-kinship/relative out-of-home placement after they have received treatment. While many funding sources are created in such a way that youth move once treatment is finished, placement disruption is harmful for children. Placement following completion of the course of treatment will be based on the multi-disciplinary treatment team's recommendations, and the youth's permanency goals and discharge plans.
        ii. Reducing placement disruptions and changes will also reduce the amount of court time spent on placement changes, and reduce docket congestion.
        iii. A reduction in placements and less time spent in congregate care and institution will help youth who are child welfare involved reach permanency or reunification in less time, and help youth who are juvenile justice involved return to their homes faster and in way that preserves community safety. When youth are institutionalized, it prevents permanency and can make integrating into a family unit difficult for the youth.
6. Functional Assessment and Treatment Plan of the Individual
    a. All agencies will use the same functional assessment to ensure consistency and enhance communication between agencies. The group highly encourages the use of a functional assessment in the public domain that will be at no cost to providers.
7. Reimbursement Rate Structure
    a. The reimbursement rate structure will include caregiver maintenance payments, Administrative payments to the child placing agency, and support (delivery of non-

treatment services) payments to the child placing agency, and payment for the additional cost of the treatment component.

8. Enhanced Training
    a. Foster parents are provided additional, enhanced training that is competency based, trauma informed, and adequate to give foster parents the needed skills to serve the population of youth served by Treatment Foster Care.
9. Multi-disciplinary Treatment Teams
    a. Multi-disciplinary teams support the treatment, the child, and the family unit.
    b. Treatment professionals direct the team to make decisions for the child's needs.
10. Next Steps
    a. The Committee will work to flesh out expectations of foster parents to determine the relationship between Treatment Foster Care and the NCR.
    b. The group will have further discussion on the treatment plan and who will perform the functional assessment. Further research needs to be completed to determine which functional assessment should be used.
    c. Research and compile information on current models in Nebraska (such as Nebraska Families Collaborative's Professional Foster Care, and DHHS Division of Developmental Disabilities' Extended Family Homes) and other states' models.
    d. Determine the role of the youth's parents in Treatment Foster Care, with the understanding that the parent role will be different according to the system the youth is involved in, the parents' legal status, and the best interests of the youth.