Vermont Agency of Human Services

Analysis of Children's Residential System of Care

PUBLIC CONSULTING GROUP

October 16, 2020

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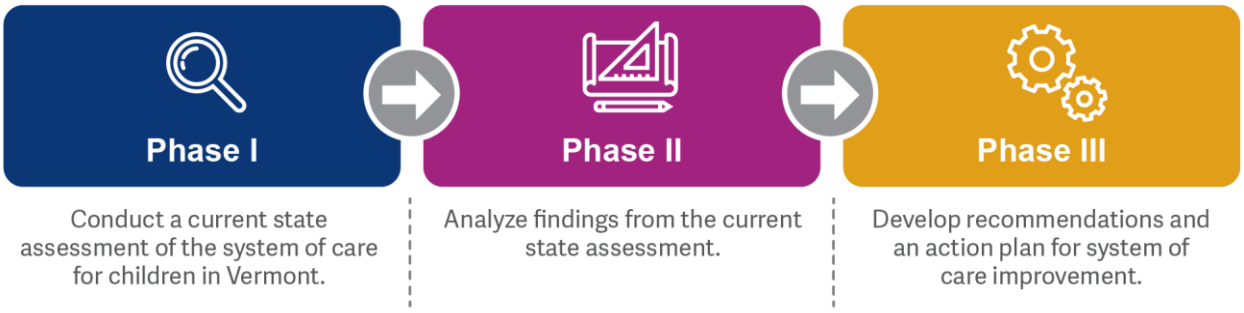
I. EXECUTIVE SUMMARY

The Vermont Agency of Human Services (AHS) contracted with Public Consulting Group, Inc. (PCG) to conduct an analysis of the children's residential system of care in Vermont in order to identify the incremental steps Vermont can take beginning in fiscal year 2021 to:

- increase community-based supports and services;
- increase the ability of families to care for their children while they receive the necessary therapeutic treatment;
- provide necessary treatment within family like settings, thus decreasing the need to receive that treatment within a residential setting; and
- assure youth only reside within residential settings when treatment provided is necessary and prescribed and only for the duration of that need.

The AHS Analysis of the Residential System of Care consisted of three main phases:



PCG conducted an assessment of the current system of care through qualitative data collected from document reviews and extensive interviews with state personnel from six different departments, regional service providers, and regional family organizations, as well as an analysis of de-identified quantitative data sets received from the State Interagency Team (SIT) Case Review Committee (CRC). Throughout this engagement, PCG regularly met with the analysis leadership team, the AHS Steering Committee, to plan next steps. PCG also met with a core group of stakeholders to review findings and recommendations, including the AHS Commissioners, Family Services Management Team, and SIT.

After analyzing findings from the current state assessment, PCG developed key findings and corresponding recommendations in six areas[1]:

[1] Note that throughout the report, all tables are labeled above, and figures are labeled below.

Table 1: Summary of PCG's Major Findings & Recommendations

A. The Continuum of Care

Summary of Finding A

Care often comes too late. The current child and family continuum of care and service array is not structured to operate as an integrated system of care, but rather as separate systems with their own rules, regulations, funding requirements, and service types. Different department missions and their associated funding limitations and restrictions can make it difficult for children and youth to access the right service at the right time.

Summary of Recommendation A

- Explore the creation of a "Single Point of Access" through a lead agency or department or through regional hubs to oversee, manage, and accept financial risk and Continuous Quality Improvement (CQI) for residential treatment, crisis services, and a continuum of community-based services and supports for children, youth, and families.

B. Funding

Summary of Finding B

Funding for services is limited and siloed, and payment structures are problematic.

Summary of Recommendation B

- Conduct a comprehensive analysis of existing funding mechanisms and service rates to learn about pain points in the system before proceeding with payment reforms
  - Examine the rate methodology for residential placements to allow for more flexible funding to stabilize the provider pool
  - Align the rates for residential care to the Qualified Residential Treatment Program (QRTP) requirements and other requirements for specialized settings under the Family First Preservation Services Act
  - Examine the payment structures in place for children's services
  - Create budgetary flexibility to reinvest savings into preventative services

C. Data Collection

Summary of Finding C

The system lacks a single data system with common client identifier and integrated data warehousing between agencies to create a holistic view of the children, youth, and families served, which results in difficultly tracking youth across departments and regions.

Summary of Recommendation C

- Invest in a centralized system for data collection to allow for a comprehensive view of children and families and for cross-agency case planning and coordination, with departments entering all data into one database
- Explore procuring services to build a live data dashboard
- Consider holding a Children's System of Care Data Summit
- Collect data on how state and federal funding is being spent at the program and individual level
- Collect data on race and ethnicity for children and families receiving services, including CRC
- Standardize geographic service regions to allow for consistent comparative analysis between departments and across services

D. Family Empowerment and Support

Summary of Finding D

Insufficient supports at home and in the community leaves caretakers without needed care and skills. Additionally, the system does not adequately integrate family partnership in service planning and delivery.

Summary of Recommendation D

- Prioritize investment in family empowerment by augmenting current efforts
- Focus on support and engagement of adoptive parents
- Review foster care rates, ensuring that tiers for children who need more support and supervision are adequate, and revise as needed
- Expand natural/informal and community/peer support networks, to empower families and communities to care for children
- Consider creating a system for community volunteers to build community capacity and provide support services
- Include family voices in the service planning process consistently and measure family satisfaction at regular intervals

E. Service Quality

Summary of Finding E

Service provision and quality vary across the system by agency, placement type, and provider. The system lacks a robust, state-level continuous quality improvement (CQI) process for residential programs to complement and strengthen ongoing quality assurance (QA) efforts.

Summary of Recommendation E

- Bolster early intervention, emergency support, crisis care, and crisis management capacity
- Align residential models to QRTP requirements, revise contracts, and monitor contract performance and improve transition planning efforts at residential programs
- Encourage transition planning to begin earlier which will help secure appropriate placement options in the community as needed for children after they exit residential care
- Conduct an inventory of where and to what degree evidence-based practices are in use and consider scaling them in regions that need them most
- Take inventory of DMH-funded Intensive Service Coordinator positions in the state, examine best practices, and consider adding the position to regions where needed
- Expand quality assurance oversight efforts in DAs and DCF-FSD Residential Licensing and Special Investigations Unit to include continuous quality improvement (CQI), where needed
- Inventory expected inputs, processes, outputs, and outcomes to align performance standards to the results-based accountability framework in Vermont's Act 186.
- Implement performance-based contracting for all service providers, using uniform outcome metrics for reporting and/or standard scorecards to assess efficacy of programs
- Amend policy to require and fund transportation for residential visits for all departments and families to children in placement every 30 days
- Consider requiring increased communications between Local Education Agencies (LEA) and children placed in residential programs

F. Workforce

Summary of Finding F

Workforce shortages and turnover affect nearly all aspects of the current system and impact the capacity, quality, and accessibility of services.

Summary of Recommendation F

- Continue to work towards implementing an integrated system of care
- Conduct turnover analysis within AHS departments that focus on the children's system of care (DCF-FSD, DMH, DAIL-DDSD) and implement strategies to reduce staff turnover
- Continue to cultivate and expand partnerships with local universities and high schools to develop academic pipelines into the human services workforce

Other findings from PCG's Quantitative Data Analysis

- There has been an overall decrease of **19%** in the number of **admissions** in residential care from 2016–2019.

- The largest age group is **14 to 17 years of age**, but there is still a large population of children **(43%)** in residential that are **ages 13 and under** and trending upward.

- There are **more cisgender males** than cisgender females consistently, and the gender gap is **widening.**

- A majority of children exhibit conduct **with aggression (77%)** and conduct **without aggression (77%).** Of those children who reported conduct with aggression, **74% were male,** and of those who reported conduct without aggression, **72% were male.**

- Self-harm, suicidal ideation, suicide attempt, and substance use have all been **increasing** in 2020.

- Autism spectrum disorder and intellectual disability continue to **increase** yearly, while borderline functional impairment and borderline intellectual disability have **decreased.**

- The majority of the cases in residential are **referred from DCF (68%).**

- There are **in-state options** available for just over half of all children **(54%)** and **67%** of the children had **no prior residential placement.**

- A child utilizes the system on average **1.17 times,** with **28%** utilizing the system **2–4 times.**

- **Five of the twelve** DO regions had children stay in residential care **longer** than the overall average of **204 days.**

- From 2016–2019, **5%** of total children in residential had both **above average LOS of 204 days** and utilization of **2–4 times** for 2016–2019.

II. PROJECT OVERVIEW

This section provides an overview of the project, scope and methods used for qualitative data collection and analysis.

A. PROJECT BACKGROUND

In June 2015, the Agency for Human Services (AHS), in collaboration with the Agency of Education (AOE), held a dialogue to discuss the increased concern about the number of children and youth in residential placements.

Three main points were agreed upon during this meeting:

1. **There is a shared concern about the increasing number of Vermont children and youth who are placed in residential programs, including out-of-state placements.**
2. **A problem was identified that needs resolution: Vermont's trendlines for residential and out-of-state residential are going in the wrong direction.**
3. **There is a commitment to create more community-based treatment options.**

Since that meeting, AHS, AOE, and the Turn the Curve Interagency Advisory Committee have worked to further the goal of the Turn the Curve Initiative: increase the number of children raised in safe and supportive homes by integrating systems and collaborating with community partners to strengthen and support families with complex needs.[2] Increasing community-based supports for children and youth has been the focus of AHS and is demonstrated in the following vision, mission, and guiding principles.

[2] Compilation of themes from *Turn the Curve* focus groups, prepared by the Turn the Curve Advisory Committee, November 2017.

In the past five years, numerous steps have been taken to achieve the Turn the Curve vison and a few are highlighted below:

- In September 2016, a workgroup co-chaired by Integrating Family Services (IFS) and Vermont Federation of Families for Children's Mental Health was launched to define the state's approach to family and youth engagement and create a plan for how to sustain it. The workgroup developed a framework based on the philosophy and values of family and youth partnership, language that identifies the commitments agencies have made to family and youth partnership, and identified outcomes for ensuring there is a consistent approach and performance measures to ensure continuous quality improvement.
- Permanency Roundtables were implemented in 2016 to achieve permanency for children and families with complex needs by breaking through systemic barriers to expedited permanency.
- Implementation of the Child and Adolescent Needs and Strengths (CANS) Assessment within DMH's Designated Agencies (DAs) began in 2017 (2015 with the two Designated Agencies who are part of IFS) to provide uniform assessment of children and youth and aid in measuring progress and outcomes for individuals accessing the children's system of care.[3]
- In 2019, the 2020-2024 Diligent Recruitment Plan was developed which aims to effectively identify, develop, and support kin or fictive kin placement resources and connections for children who are not able to safely remain at home.
- A Mobile Response Stabilization Service (MRSS) pilot program was proposed in early 2020 to provide mobile face-to-face response, support, and intervention during a family-defined crisis for a child or youth and their family, before emotional and behavioral difficulties escalate. This proposal was under review in the legislature but was put on hold due to the COVID-19 pandemic.

In 2019, AHS issued a Request for Proposal (RFP) to hire a consultant to further analyze Vermont's residential system of care and expand upon the work that has been done since 2015.

B. SCOPE OF WORK

Public Consulting Group, Inc. (PCG) was contracted by AHS to complete a formal assessment of the children's residential system of care in Vermont that identifies and examines:

- the existing residential system of care and its strengths;
- gaps in services for children, youth, and families; and
- best practices in residential care for children and youth.

The assessment also includes the development of a high-level, five-year action plan to guide implementing best practices and addresses the following:

- What planning steps Vermont can take beginning FY21, in an incremental manner, over the next five years to:
    - Increase community-based supports and services, such as wraparound supports for children in their biological or foster home, mobile response, and therapeutic foster homes;
    - Increase the ability of families to care for their children while they receive the necessary therapeutic treatment;

[3] https://legislature.vermont.gov/assets/Legislative-Reports/Combined-Act-85-E.317-Use-of-Residential-Care-Facilities-Report-11.13.17.pdf

- Provide necessary treatment within family-like settings, thus decreasing the need to receive that treatment within a residential setting; and
- Ensure youth reside within residential settings when treatment provided is necessary and prescribed and only for the duration of that need.

C. METHODOLOGY

Data and Materials Review

De-identified quantitative data was received from the State Interagency Team (SIT) Case Review Committee (CRC) and qualitative data was collected through document reviews and extensive stakeholder interviews and focus groups. The data collected were analyzed and validated through a series of working sessions with project stakeholders. The findings and recommendations in this report have been developed through the lens of compliance with the Family First Prevention Services Act (FFPSA), best practices in residential treatment, and system of care principles such as serving children and youth in the least restrictive, most appropriate settings.

Because AHS and the departments involved in this review have been systematically working towards right-sizing congregate care, significant stakeholder engagement had already occurred, and records were available for the PCG team to review. PCG reviewed of a wide variety of documents, so that stakeholder engagement could be focused on better understanding and building on the existing work. A full list of documents reviewed can be found in Appendix A.

Stakeholder Engagement

A broad range of participants were engaged to provide insight and recommendations. The table below provides more details about the types of stakeholders who participated.

Table 2: Stakeholder Engagements

Type of Engagement	Participant/s	Date
Kickoff and Steering Committee Status Meetings	AHS Steering Committee	May 19, 2020 – Sept. 30, 2020
Focus Group	Case Review Committee (CRC)	May 20, 2020
Interview	Ken Schatz, Commissioner of the Department for Children and Families (DCF), Sean Brown, incoming Commissioner of DCF	June 19, 2020
Focus Group	State Interagency Team (SIT)	June 25, 2020
Focus Group	Family Services Specialized Services Team	July 6, 2020
Interview	Sarah Squirrell, Commissioner of the Department of Mental Health (DMH) and Monica Hutt, Commissioner of the Department of Disabilities, Aging, and Independent Living (DAIL)	July 7, 2020
Focus Group	Family Services Management Team (FSMT)	July 7, 2020
Focus Group	Act 264 Board	July 8, 2020

Type of Engagement	Participant/s	Date
Focus Group	Vermont Federation of Families	July 9, 2020
Focus Group	Children's Mental Health Directors and Vermont Care Partners	July 10, 2020
Focus Group	DCF Family Services Division (FSD) Regulation and Licensing	July 14, 2020
Interview	Former Residential Youth through Youth Development Program (YDP)	July 14, 2020
Focus Group	DAIL	July 15, 2020
Focus Group	DMH Care Management Team	July 16, 2020
Focus Group	Permanency Round Table Team Project	July 16, 2020
Focus Group	Local Interagency Team (LIT) Coordinators	July 20, 2020
Focus Group	Agency of Education (AOE)	July 22, 2020
Focus Group	Regional Cross-Sector Group – Burlington	July 22, 2020
Focus Group	Vermont Coalition of Residential Programs (VCORP)	July 23, 2020
Focus Group	Regional Cross-Sector Group – Rutland	July 29, 2020

III. CURRENT STATE ASSESSMENT

A. SYSTEM OVERVIEW

Children may enter Vermont's residential system of care from one of three departments under AHS:[4]

The Department of Disabilities, Aging, and Independent Living

Within DAIL, DDSD plans, coordinates, administers, monitors, and evaluates state and federally funded services for people with developmental disabilities and their families.[5] Children and youth with developmental disabilities—defined as having a diagnosis of intellectual disability or an autism spectrum disorder and significant deficits in adaptive functioning, and onset of the disability prior to age 18—and the most intensive needs may qualify for Home and Community Based Services (HCBS), which are provided by District Agencies (DAs) and Specialized Service Agencies (SSAs).

The Department for Children and Families

DCF's mission is to foster the healthy development, safety, well-being, and self-sufficiency of Vermonters.[6] Within DCF, FSD works in partnership with families, communities, and others to make sure children and youth are safe from abuse, their basic needs are met, and youth are free from delinquent behavior.[7] A local Family Service District Office (DO) supports the work of FSD in each of the 12 FSD DO catchment areas.[8] FSD serves at-risk children; youth and families; children and youth in the care and custody of the state; youth on juvenile probation; and foster, respite, and adoptive parents. Within FSD, the Special Services Unit oversees the high end of the system of care including Residential Treatment and Wraparound level services. Also, within DCF-FSD the Residential Licensing & Special Investigations Unit provides regulatory oversight and licensure of Vermont-based residential treatment programs.

[4] Children may also be placed through the Agency of Education, but this assessment only focuses on departments within the Agency of Human Services.
[5] https://ddsd.vermont.gov/services-providers/services
[6] https://dcf.vermont.gov/about-dcf
[7] https://dcf.vermont.gov/sites/dcf/files/FSD/pubs/CFSP2020-2024.pdf
[8] https://dcf.vermont.gov/fsd/contact-us/districts

The Department of Mental Health

The mission of DMH is to promote and improve the health of Vermonters.[9] The department's vision is to provide Vermonters with access to effective prevention, early intervention, and mental health treatment and supports as needed to live, work, learn, and participate fully in their communities. DMH coordinates mental health programs for adults and children through one District Agency (DA) in each of the 10 DA catchment areas.[10] DAs are statutorily mandated, private service providers responsible for meeting the mental health service needs within their region. Additionally, there is one SSA which serves children. An SSA provides a distinctive approach to service delivery and coordination or provides services that meet distinctive individual needs.[11]

Collaboration between Departments

Vermont strives to coordinate services for children and families at a systems level. Several interagency teams were created for this effort under Act 264, which became law in 1988, and was later expanded in 2005.[12] Act 264 created a coordinated system of care between AHS and the Agency of Education (AOE), with greater involvement from parents in order to ensure better outcomes for children and families.

State Interagency Team

Established under Act 264, the mission of the SIT is to identify systems issues so supports for children and families can be provided as flexibly as possible.[13] SIT meets monthly to be a resource to Local Interagency Teams and make recommendations to the Secretaries of AHS and AOE about needed programs, supports, or services.

Membership of SIT

- **Vermont Federation of Families for Children's Mental Health (VFFCMH)**
- **Vermont Family Network (VFN)**
- **Department for Children and Families, Family Services Division (DCF-FSD)**
- **Department for Children and Families, Child Development Division (DCF-CDD)**
- **Department of Mental Health (DMH), Child, Adolescent and Family Unit (CAFU) and Commissioner's Office**
- **Department of Disabilities, Aging and Independent Living, Developmental Disabilities Services Division (DAIL-DDSD)**
- **Department of Health, Children with Special Health Needs**
- **Agency of Education (AOE)**
- **Department of Health, Alcohol and Drug Abuse Programs (ADAP)**
- **Agency of Human Services, Field Director Unit**
- **Department of Vermont Health Access (DVHA)**

[9] https://mentalhealth.vermont.gov/about-us
[10] https://mentalhealth.vermont.gov/sites/dmh/files/documents/Providers/DA/Designated%20Agency%20Geographical%20Catchment%20Areas.pdf
[11] https://mentalhealth.vermont.gov/individuals-and-families/designated-and-specialized-service-agencies
[12] https://ifs.vermont.gov/docs/sit
[13] Overview of the State Interagency Team (SIT) shared by AHS with PCG

Local Interagency Team

Act 264 established Local Interagency Teams (LIT) to support the creation of a local System of Care in Vermont.[14] Responsibilities of LIT include coordinating and implementing Coordinated Services Plans (CSPs); creating a forum for identifying, assessing, and addressing service system needs at the local level; dispute resolution for families; and assuring that community partners and core agency staff are trained and supporting and creating CSPs.

Membership of LITs

- **Parent representatives**
- **Local Special Education Administrator**
- **Local community Mental Health Children's Director**
- **AHS Field Director**
- **Developmental Disability services representative**
- **Substance abuse specialist**
- **Vocational Rehabilitation representative**

Others, as determined locally, may include representatives from:

- **Adult agency providers (Mental Health, Substance Abuse, Disabilities Services)**
- **Department of Labor**
- **Department of Corrections**
- **Child Development Division**
- **Adoption Consortium**

Case Review Committee

SIT established the Case Review Committee (CRC) to work with local teams to develop appropriate Coordinated Service Plans (CSPs) for children.[15] CRC is dedicated to serving children and adolescents with severe emotional disturbances and other disabilities in the least restrictive setting appropriate to their needs. It is tasked with reviewing the request for residential placement to determine whether a child's needs meet the criteria for this level of care and approving referrals to programs that match the child's individualized needs.[16]

[14] https://ifs.vermont.gov/sites/ifs/files/LIT%20Practice%20Guidance.pdf
[15] Case Review Committee Guidelines and Procedures for Residential Placement of Children and Adolescents, January 2020
[16] https://www.vermontfamilynetwork.org/wp-content/uploads/2019/05/SIT-Overview-1.pdf

Membership of CRC — Representatives from:

- **AOE**
- **DCF FSD**
- **DMH**
- **DAIL DDSD**
- **A parent representative**
- **Representatives from other groups including the Department of Health's Division of Alcohol and Drug Abuse Prevention, Vocational Rehabilitation, and the Department of Corrections participate as appropriate.**

Multi-Disciplinary Teams

When a child in DCF custody needs local team support, they may require multiple departments or service providers to meet and share confidential information over a long or short-term period. These ad-hoc teams meet to coordinate and strengthen a local community's response to concerns regarding the child's well-being. Typically, these multi-disciplinary teams are used specifically during the beginning of an intervention to help form a plan of care for a child/youth. In these cases, the DCF Commissioner or DCF-FSD District Directors can authorize these individuals to meet and discuss the child's needs under a DCF-FSD policy and statute called empanelment (Title 33 VSA§4917). This policy allows providers to meet and share information for the purpose of case review and coordination without violating a family's right to confidentiality.[17] Additionally, there are numerous other multi-disciplinary teams that provide support through varied roles within the children's system including, but not limited to:

- **Coordinated Services Plan (264) Meetings**
- **Family Safety Planning**
- **Family Group Conferencing**
- **Individualized Education Plan (IEP), 504, and Educational Support Team (EST) Meetings**
- **Treatment Team**
- **Transition Team**
- **Discharge Planning**
- **DCF-FSD Case Plan Reviews**
- **Care Conferences**
- **Permanency Round Tables**
- **Shared Parenting Meeting**

[17] https://kidsafevt.org/CPFST%20Referral%20Packet%20(current).pdf

B. QUANTITATIVE DATA ANALYSIS

PCG analyzed residential data provided by the state to better understand residential trends and to create a more detailed profile of children in care, including their needs and characteristics. The data set included information from both the CRC and from DCF-FSD for placements that do not go through CRC. For a full list of data categories examined and their definitions, please see Appendix B.

Considerations

- Due to the timing of PCG's analysis, only data for the first six months of 2020 were captured in the CRC dataset. Data for 2020 are excluded from average count calculations to avoid skewing the data set. However, 2020 data are included where possible to demonstrate continued or new trends.
- Due to some limitations with the data, Vermont counties are used as geographic proxies for DO regions, although they do not precisely align to DO regions. Each DO region was mapped to its corresponding county according to its ZIP code, so that counties became the geographic proxy for each DO region. Because there are 14 counties and 12 DO locations, PCG worked with the AHS Steering Committee to match the two remaining counties to the appropriate DO catchment areas. As a result, Grand Isle County was combined with Franklin County to represent the St. Albans DO, and Essex County was split into upper and lower sections and combined with Orleans County and Caledonia Counties to represent the Newport and St. Johnsbury DOs, respectively. Please refer to Appendix C for a detailed explanation and table illustrating each DO location mapped to a Vermont county.
- The geographic analysis is based on a child's location of origin, meaning the analysis examines the needs associated with children's communities of origin, rather than the locations or performance of residential programs themselves.
- A lack of racial and ethnic data in the CRC data set limited the ability to examine data through lenses of racial equity and equitable resource distribution, critical viewpoints needed for a thorough examination of current practices.
- The data set provided to PCG did not include children/youth submitted to the CRC for review by DAIL. AHS removed all these children/youth from the data set because the total number was less than 11, which could therefore compromise confidentiality, a standard internal agency practice. Therefore, the data analysis excludes all children/youth referred to residential by DAIL.

Population Size

To understand the needs of children, PCG selected to analyze all first admissions to residential care per year. The aim was to understand the unmet needs that were driving children into care in the first place or for repeat treatment in different fiscal years. Through this lens, there were 702 children for examination for 2016–2020. When looking at the number of unique admissions per year, there is an overall decrease of 166 to 140, or 19%, between 2016 and 2019 (Figure 1). As mentioned in the Limitations section, 2020 data is only from the first six months of the year. If the current rate continues through the end of 2020, it is likely the total number of unique admissions will increase from 2019.

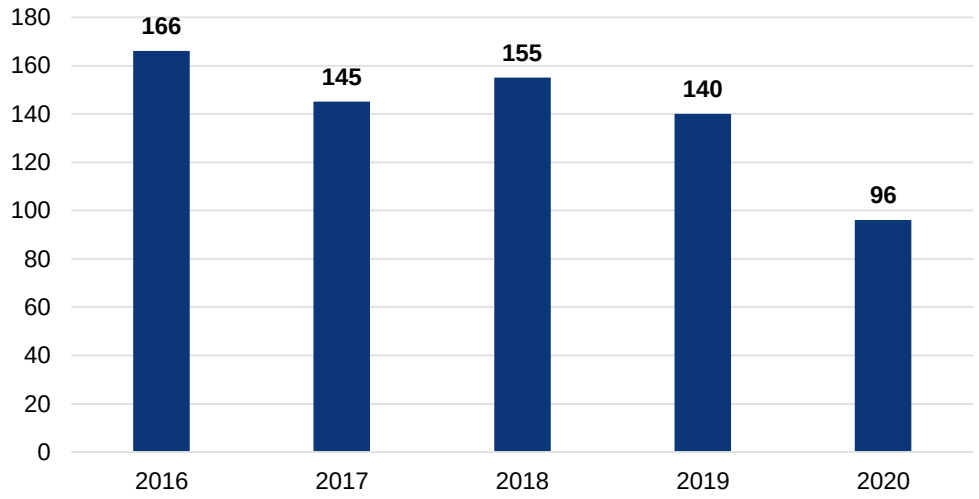


Figure 1: Number of Unique Admissions, SFY 2016-2020*

**Note that all 2020 data represents the first six months of that year only.*

As seen in Table 3 below, the proportion of referrals from DMH and DCF-FSD have remained relatively stable in relation to each other from 2016 to 2019. On average, DMH referred 32% of children, while DCF-FSD referred 68% of children. As mentioned in the Limitations section, DAIL referrals were removed by AHS because the number of DAIL referrals were less than 11.

Table 3: Number of Children/Youth Referred by Department, SFY 2016-2020*

Fiscal Year	Number of Children with Admissions	Referred by DCF-FSD	% DCF-FSD	Referred by DMH	% DMH
2016		115	69%	51	31%
2017	145	100	69%	46	32%
2018	155	102	66%	53	34%
2019	140	98	70%	42	30%
2020	96	61	64%	35	36%
Overall	**702**	**476**	68%	**227**	32%

** Note that all 2020 data represents the first six months of that year only.*

Geographic Summary of Residential Population Size

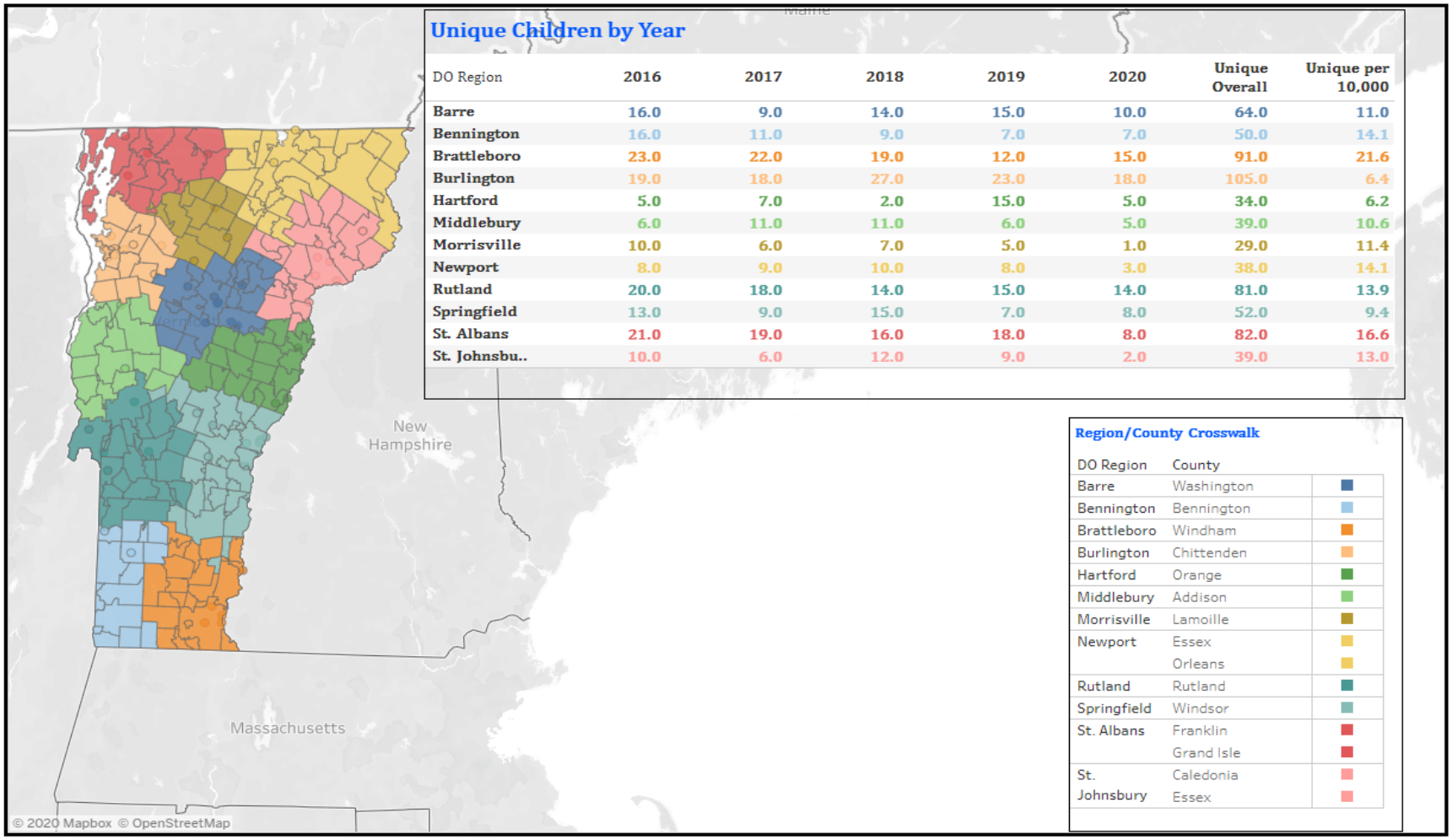
Figure 2 below shows a geographic summary of residential population size, showing unique placements per region per year, and placements per region per a standardized population of 10,000. Figure 2 is a screenshot taken from the Tableau dashboard that summarizes geographic findings and provides a platform through which readers can interact with data.[18] The regions on the map represent the DCF-FSD District Office (DO) regions of Vermont, using Vermont counties as proxies, as explained in the Limitations section above and in more detail in Appendix C. Figure 2 displays the following by DO region: the number of children in residential care by year, the overall number of children admitted, and the number of children in DO regions per a standardized population of 10,000 unique to each county. The rates of placements are standardized by county population to ensure that regions with a higher population did not appear to be admitting a higher rate of cases. For example, even though Burlington has the greatest number of children

[18] Link to interactive Tableau dashboard.

in residential care of 105 children, the region has the second to lowest rate of children placed per 10,000 at 6.4. This standardization allows for a more parallel comparison between regions.

From 2016 through the first half of 2020, the Burlington DO region had the highest number of unique children in residential care at 105, while the Morrisville DO region had the lowest at 29. When examining rates of placement, Brattleboro had the highest rate per population of 10,000 at 21.55, while Hartford had the lowest at 6.17, as shown in Figure 2 below.

All Residential Population | Residential Characteristics | Regional Outlook



DO Region	2016	2017	2018	2019	2020	Unique Overall	Unique per 10,000
Barre	16.0	9.0	14.0	15.0	10.0	64.0	11.0
Bennington	16.0	11.0	9.0	7.0	7.0	50.0	14.1
Brattleboro	23.0	22.0	19.0	12.0	15.0	91.0	21.6
Burlington	19.0	18.0	27.0	23.0	18.0	105.0	6.4
Hartford	5.0	7.0	2.0	15.0	5.0	34.0	6.2
Middlebury	6.0	11.0	11.0	6.0	5.0	39.0	10.6
Morrisville	10.0	6.0	7.0	5.0	1.0	29.0	11.4
Newport	8.0	9.0	10.0	8.0	3.0	38.0	14.1
Rutland	20.0	18.0	14.0	15.0	14.0	81.0	13.9
Springfield	13.0	9.0	15.0	7.0	8.0	52.0	9.4
St. Albans	21.0	19.0	16.0	18.0	8.0	82.0	16.6
St. Johnsbu..	10.0	6.0	12.0	9.0	2.0	39.0	13.0

DO Region	County
Barre	Washington
Bennington	Bennington
Brattleboro	Windham
Burlington	Chittenden
Hartford	Orange
Middlebury	Addison
Morrisville	Lamoille
Newport	Essex
	Orleans
Rutland	Rutland
Springfield	Windsor
St. Albans	Franklin
	Grand Isle
St. Johnsbury	Caledonia
	Essex

Figure 2. Geographic Summary of Residential Population, SFY 2016-2020*

**Note that all 2020 data represents the first six months of that year only.*

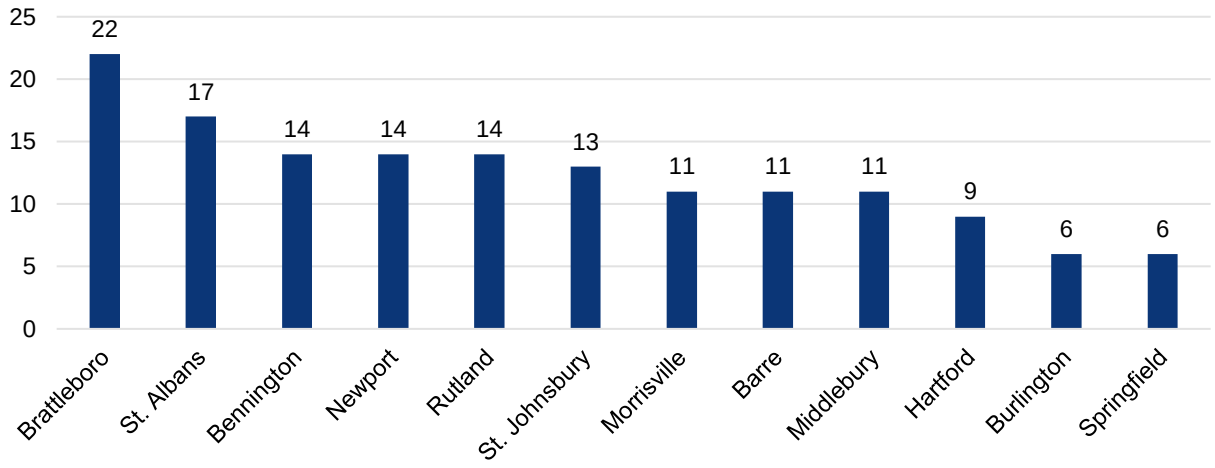


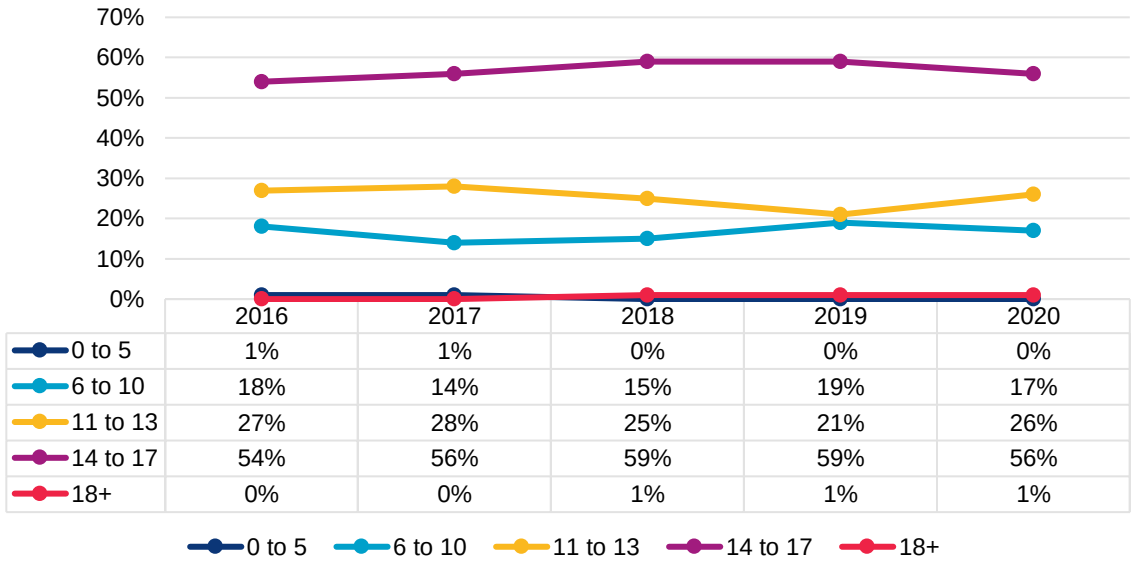
Figure 3: Children Placed in Residential Care Per 10,000 (population) by DO Region, 2016-2020*

**Note that all 2020 data represents the first six months of that year only.*

Figure 3 shows children placed in Residential Care per 10,000 population by DO Region for 2016–2020. This was calculated to give a more representative picture of the number of children placed in residential. When examining rates of placement, Brattleboro had the highest rate per 10,000 (population) at 22, while Hartford had the lowest at six, as shown in Figure 3 above.

Age and Gender Demographics

Figure 4 displays age trends for all years 2016-2020. During this time, the largest age group was 14 to 17, followed by ages 11 to 13, and ages 6 to 10. The percent of children under the age of 14 in residential care has remained relatively steady at around 40% per year. Note that in the first six months of 2020, this changes: the percent of 11 to 13-year-old children has already outpaced 2019 and will likely increase by the end of the year. This trend confirms what PCG heard from stakeholders—there have been a greater number of younger children admitted to residential care recently.

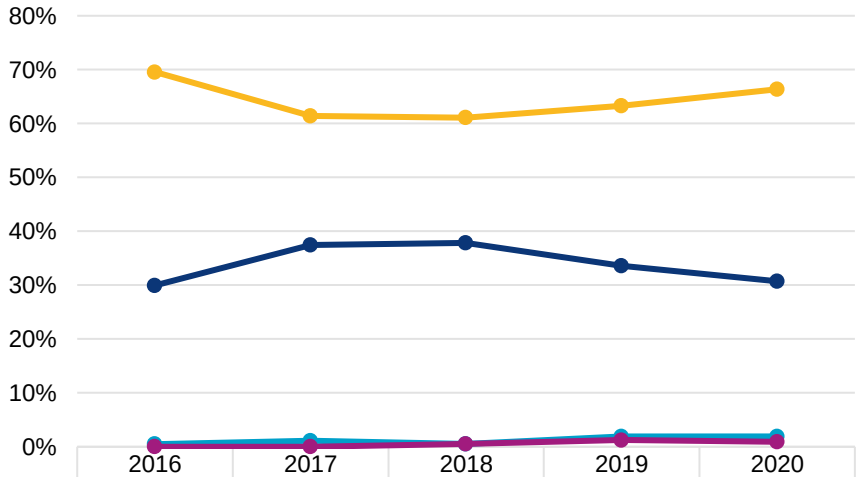


	2016	2017	2018	2019	2020
0 to 5	1%	1%	0%	0%	0%
6 to 10	18%	14%	15%	19%	17%
11 to 13	27%	28%	25%	21%	26%
14 to 17	54%	56%	59%	59%	56%
18+	0%	0%	1%	1%	1%

Figure 4: Ages of Children in Residential Care, SFY 2016-2020*

** Note that all 2020 data represents the first six months of that year only.*

Figure 5 below depicts gender trends during 2016–2020. Cisgender males represented most of the population in residential care (60-70%), followed by cisgender females (30–40%). Anecdotally, PCG heard from stakeholders that cisgender males tend to externalize emotions, aligning with two of the most prevalent characteristics, that 77% of residential placements are characterized by either conduct with aggression or conduct without aggression. The data confirms this association in Table 4, where of the total children displaying conduct with aggression or conduct without aggression, cisgender males make up the majority at 74% and 72% respectively. PCG examined "internalizing" measures such as suicidality and self-harm to understand if they may be associated with cisgender females, but the data does not support that cisgender females necessarily internalize their emotions in this way.



	2016	2017	2018	2019	2020
Cisgender Female	30%	37%	38%	34%	31%
Trans male	0%	1%	1%	2%	2%
Cisgender Male	70%	61%	61%	63%	66%
Trans Female	0%	0%	1%	1%	1%

Figure 5: Gender Identity of Children in Residential Care, SFY 2016–2020*

**Note that all 2020 data represents the first six months of that year only.*

Table 4. Characteristics by Gender Identity, SFY 2016–2020*

Category	Conduct with Aggression	Conduct without Aggression	Suicidality (ideation and attempt)	Self-Harm
Cisgender Female	25%	27%	45%	49%
Trans Female	0%	0%	1%	1%
Cisgender Male	74%	72%	52%	48%
Trans Male	1%	1%	2%	3%

** Note that all 2020 data represents the first six months of that year only.*

Characteristics

Characteristics shown below in Figure 6 illustrate one or more characteristics a child/youth may present. The most notable characteristics within Figure 6 below and from PCG's analysis are:

- Conduct with aggression[19] (77%), conduct without aggression[20] (77%), self-harm (42%) and suicide ideation (32%) are the most prevalent characteristics.
- The majority of children are in DCF custody (55%), followed by birth parents (16%), and then adoption (14%).
- In-state options were available for 54% of the children.
- 57% of the children admitted were first time admissions.
- Developmental delays are present in less than 10% of children in residential care.21
- Long term treatment referrals accounted for 62% of admissions versus assessments at 32%.

[19] Same as Conduct without Aggression (see below) including Aggression to people and animals - bullying, threatening, intimidating, fighting, cruelty to people and animals, use of a weapon and theft while confronting a victim.
[20] Repetitive and persistent pattern of behaviors that violate societal norms and the rights of other people, behavior that causes property loss or damage, deceitfulness or theft, and serious violations of rules. may also exhibit oppositional behavior and peer relationship problems.
[21] As noted above, this data set excludes DAIL-DDSD funded children/youth.

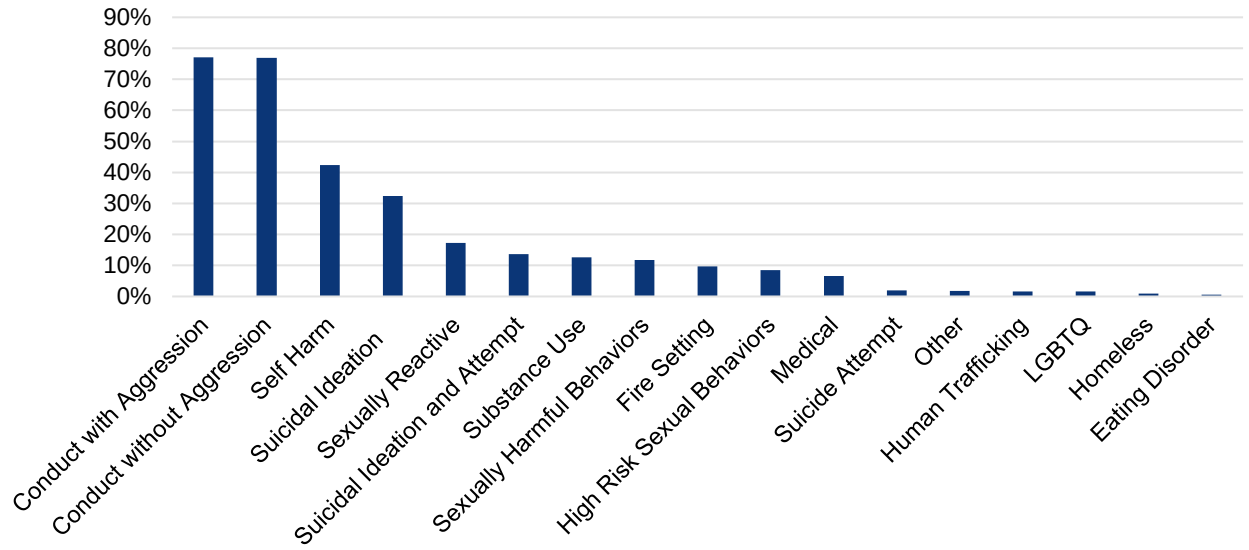
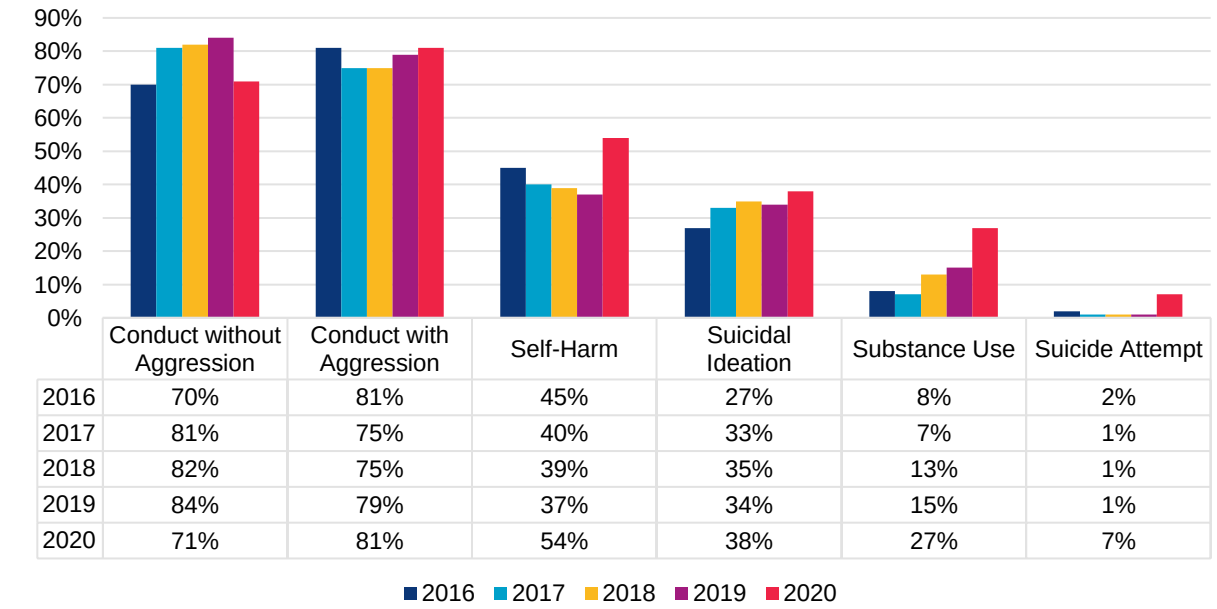


Figure 6: Characteristics of Children in Residential Care, SFY 2016-2020*

** Note that all 2020 data represents the first six months of that year only.*

Figure 7 below illustrates trends in certain characteristics in residential children. Conduct (with and without aggression) has remained relatively steady, while self-harm, suicidal ideation, suicide attempt, and substance use have all been increasing in 2020. Substance use increased from eight percent to 15 percent from 2016–2019, nearly doubling over four years, then nearly doubling again so far to 27% of residential children in 2020.



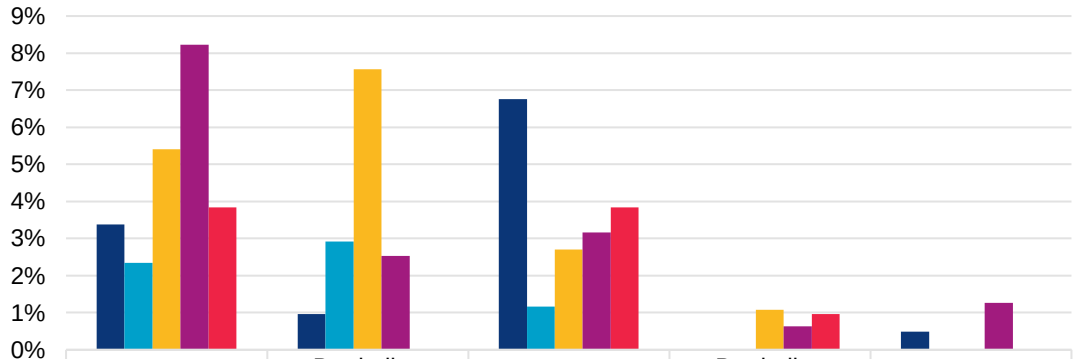
	Conduct without Aggression	Conduct with Aggression	Self-Harm	Suicidal Ideation	Substance Use	Suicide Attempt
2016	70%	81%	45%	27%	8%	2%
2017	81%	75%	40%	33%	7%	1%
2018	82%	75%	39%	35%	13%	1%
2019	84%	79%	37%	34%	15%	1%
2020	71%	81%	54%	38%	27%	7%

Figure 7: Characteristics Trends, SFY 2016-2020*

** Note that all 2020 data represents the first six months of that year only.*

Overall, the data indicates that children utilizing residential care in Vermont have significant behavioral and/or emotional needs.

Figure 8 below examines trends in intellectual disability/developmental disability (ID/DD) prevalence according to diagnosis. Note that the percent of children with ID/DD diagnoses in residential placements overall is relatively low, remaining at 9% and below per diagnosis and excludes the small number of children placed through DAIL-DDSD.



	Intellectual Disability	Borderline Intellectual Disability	Autism Spectrum Disorder	Borderline Functional Impairment	Both
2016	3%	1%	7%	0%	0.5%
2017	2%	3%	1%	0%	0%
2018	5%	8%	3%	1.1%	0%
2019	8%	3%	3%	0.6%	1.3%
2020	4%	0%	4%	1.0%	0%

Figure 8: Developmental Disabilities Prevalence Categories, Trends for SFY 2016-2020*

** Note that all 2020 data represents the first six months of that year only.*

Utilization

Utilization refers to the number of times a child enters, and has therefore utilized, residential care. For this analysis of utilization, PCG examined all 825 admitted children/youth from 2016-2020. PCG determined that during this time, children utilized the system an average of 1.17 times, then looked at how each DO Region compared against the overall average. Regions shown in red in Table 5 below indicate a higher utilization of the system than the overall average. For example, during 2016-2020, St. Johnsbury's utilization rate was 1.30 times, higher than the average of 1.17 times, and had 26 children utilize residential care 2–4 times, accounting for 40% of all residential admissions from St. Johnsbury during that time.

To identify the total percent of above average utilizers, PCG calculated how many children utilized the system two to four times, as they are above the average utilization of 1.17 times. It was determined that 28% of children utilized the system two to four times. PCG also looked at how that compared regionally. Again, those regions in red indicate a higher utilization of two to four times.

Table 5: Average Utilization by DO Region, SFY 2016-2020

DO Region	Average Utilization	Count of Children Admitted 2-4 Times	Count as Percentage of All Admissions
St Johnsbury	**1.30**	**26**	**40%**
Bennington	**1.26**	**28**	**36%**
Hartford	**1.24**	**17**	**33%**
St Albans	**1.24**	**42**	**34%**
Newport	**1.23**	**21**	**36%**

DO Region	Average Utilization	Count of Children Admitted 2-4 Times	Count as Percentage of All Admissions
Brattleboro	**1.18**	**39**	**30%**
Rutland	1.15	28	26%
Morrisville	1.15	10	26%
Springfield	1.12	14	21%
Middlebury	1.11	10	20%
Burlington	1.11	24	19%
Barre	1.06	8	11%

** Note that all 2020 data represents the first six months of that year only.*

The characteristics of children who were above average utilizers of residential services were similar to the overall population of children in residential care.

Length of Stay

Length of stay (LOS) refers to the length of a residential placement, calculated from the date of admission to the date of discharge. For this analysis of length of stay, PCG examined all 825 admitted children/youth from 2016–2020. From 2016–2019, the average length of stay for all residential placements was 204 days, in assessment placements was 166 days (Table 6) and 303 days for long term treatment placements (Table 7). 2020 data was removed to maintain a normal distribution and compare full fiscal years. Note that for the two tables below, red text indicates values above the four-year LOS average.

As shown in Table 6 below, seven of the twelve regions had a LOS longer than the overall average of 166 days for assessment placements. The regions with the highest LOS for assessment placements were Hartford, Rutland, and Springfield, while the lowest were St. Albans, Newport and Morrisville. Note that the average LOS for assessment placements is 23% below the overall average of all residential placements of 204 days.

Table 6: Average Length of Stay for Assessment Placements, 2016–2019

Placement	Hartford	Rutland	Springfield	Barre	Brattleboro	Bennington	Burlington	St. Johnsbury	Middlebury	St. Albans	Newport	Morrisville	Overall Average LOS
All Residential	**268**	173	**227**	**224**	**237**	172	171	192	194	182	177	**238**	**204**
Assessment	**247**	**237**	**228**	**211**	**212**	**185**	**178**	127	112	105	91	67	**166**

Table 7 shows long term placement LOS for 2016-2019, where five out of the twelve regions had a LOS longer than the overall average of 303 days in treatment. The regions with the highest LOS for long term treatment were Hartford, Brattleboro, and Barre, while the lowest were St. Albans, Rutland and Burlington. Note that the average LOS for long term treatment is 49% above the overall average of all residential placements of 204 days.

Table 7: Average Length of Stay for Long Term Treatment Placements, 2016–2019

Placement	Hartford	Brattleboro	Barre	Morrisville	Middlebury	Newport	Springfield	St. Johnsbury	Bennington	St. Albans	Rutland	Burlington	Overall Average LOS
All Residential	**268**	**237**	**224**	**238**	194	177	**227**	192	172	182	173	171	**204**
Long Term Treatment	**518**	**329**	**323**	**320**	**304**	302	296	284	271	259	229	208	**303**

Comparative Analysis of Key Subgroups

In the following sections, three subgroups of children in residential care are explored:

Subgroup 1: Children Ages 13 and Under: From 2016–2019, there were 299 children ages 13 and under placed in residential care, comprising 43% of first-time admissions per year (Table 8). Regionally, Middlebury, Hartford, and Springfield have the highest percentage of this age group placed in residential care. This subgroup was chosen for further review to assess opportunities for diverting these younger youth from residential care.

Table 8. Subgroup Population Size, SFY 2016–2020*

Category	Total Count	% of Total Residential Population
All Residential	702	100%
13 and Under	299	43%
Out-of-Region	55	7%
High Utilizers	42	5%

** Note that all 2020 data represents the first six months of that year only.*

Subgroup 2: High Utilizers: From 2016-2019, 42 children, or 5% of the total population, had both above average LOS of 204 days and utilization of two to four times for 2016–2019 (Figure 9). PCG defines this subgroup as "high utilizers." Regionally, St. Albans and Springfield have the highest percentage of children in residential that are high utilizers. This subgroup was examined to better understand the characteristics of children who stay in residential more often for longer LOS, and what kind of resources can be expended to support them.

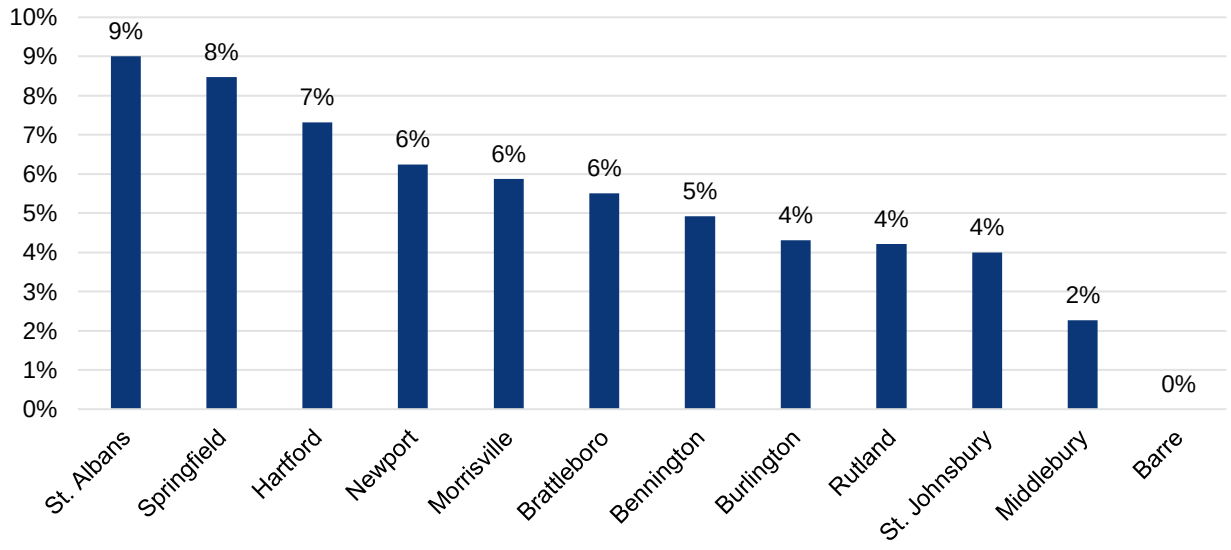


Figure 9: Percent of Children who are High Utilizers, SFY 2016-2020*

** Note that all 2020 data represents the first six months of that year only.*

Subgroup 3: Placement Out-of-Region: 55 children were placed out-of-region, defined as outside Vermont and its border states of New York, New Hampshire, and Massachusetts; a small portion of the total population overall (7%). Regionally, St. Albans, Brattleboro and Rutland place the most children out-of-region. Out-of-region placement indicates that Vermont lacks the resources to care for these children. By examining this subgroup's characteristics, Vermont can work to target resources to keep these children's treatment closer to home. Table 9 below shows placement location by region, with overall percentages shown for in state, in region and out-of-region placements. For example, out of the 7% of children placed out-of-region, 22% came from the St. Albans region.

Table 9: Placement Location by Region, SFY 2016-2020*

Category	Overall	St. Albans	Brattleboro	Rutland	Burlington	Barre	St. Johnsbury	Newport	Morrisville	Middlebury	Bennington	Springfield	Hartford
In State	56%	13%	15%	9%	15%	7%	4%	6%	3%	6%	7%	9%	6%
In Region	37%	9%	10%	15%	14%	9%	9%	6%	5%	5%	8%	5%	4%
Out-of-Region	**7%**	**22%**	**13%**	**11%**	**9%**	**9%**	**7%**	**7%**	**7%**	**7%**	**4%**	**4%**	**0%**

** Note that all 2020 data represents the first six months of that year only.*

Average Length of Stay

In Table 10 below, the overall LOS for all residential children are compared to the LOS for each of the examined subgroups. High utilizers have the largest difference compared to the "All Residential" baseline, with an average LOS of 445 days, or 241 (74%) days more than the overall average of 204 days. Children ages 13 and under stayed an average of 345 days in residential care, which is 141 (51%) more than the overall average of 204 days. Children placed out-of-region had an average stay of 287 days, 83 days (32%) more than the overall average of 204 days.

Table 10. Average LOS of Subgroup Population, SFY 2016-2020*

Category	Average LOS	LOS Difference from Overall Average (Days)	Percent Difference
All Residential	204		
High Utilizers	445	+241	+ 74%
13 and Under	345	+ 141	+ 51%
Out-of-Region	287	+ 83	+ 32%

** Note that all 2020 data represents the first six months of that year only.*

Characteristics

The characteristics captured below in Tables 11–13 compare the subgroups to the "All Residential" children baseline. Any text in red indicates a difference of at least 5 percentage points higher than the baseline of all residential children, highlighting a significantly higher need in the corresponding subgroup population relative to the general residential population. For example, 42% of all residential children displayed self-harm behavior, while that percentage was 35% of children ages 13 & under, 43% of high utilizers and 58% of children placed out of region. Because 58% is greater than 5 percentage points from the 42% baseline, it has been highlighted in red as a significant difference.

Table 11 shows that children placed out-of-region are more likely to self-harm and are more likely to exhibit suicidal ideation and attempt. High Utilizers are more likely to exhibit harmful sexual behavior, conduct with aggression and conduct without aggression. Children ages 13 and under also have a higher prevalence of conduct with aggression and conduct without aggression.

Table 11. Subgroup Characteristics Compared, Table A, SFY 2016-2020*

Group	Characteristics									
	Self-Harm	Suicidality			Sexual BX Prob		Risky Sexual Behavior		Conduct w/AGG	Conduct
	Yes	Ideation	Attempt	Both	Harmful	Reactive	High Risk	Human Trafficking	Yes	Yes
All Residential	42%	32%	2%	14%	12%	17%	8%	2%	77%	77%
Ages 13 & Under	35%	26%	3%	8%	6%	21%	3%	1%	**87%**	**84%**
High Utilizers	43%	29%	0%	17%	**21%**	21%	10%	5%	**88%**	**90%**
Placed Out-of-Region	**58%**	29%	2%	**27%**	16%	16%	9%	0%	80%	80%

** Note that all 2020 data represents the first six months of that year only.*

Table 12 below illustrates that children placed out-of-region are more likely to have special circumstances that warrant medical attention.

Table 12. Subgroup Characteristics Compared, Table B, SFY 2016-2020*

Group	Characteristics													
	Special Circumstances						Fire Set	ID/DD Prevalence						
	Eating Disorder	Homeless	LGBTQ	Medical	Other	SUD	Yes	Assmt. needed	Autism Spectrum	BDL Func. Imp	Borderline ID	Both	Early DD	Intellectual Disability
All Residential	1%	1%	2%	7%	2%	13%	10%	4%	4%	0%	3%	0%	0%	5%
Ages 13 & Under	0%	1%	0%	7%	2%	3%	11%	6%	4%	0%	4%	0%	0%	4%
High Utilizers	0%	0%	0%	5%	5%	5%	12%	5%	0%	2%	7%	0%	0%	2%
Placed Out-of-Region	0%	0%	4%	**13%**	0%	16%	11%	0%	5%	0%	4%	2%	0%	9%

** Note that all 2020 data represents the first six months of that year only.*

Table 13 below demonstrates that children ages 13 and under are more likely to have in-state options available and are more likely to be referred to the CRC for assessment placements. High Utilizers tend to be ages 13 and under, are less likely to have in-state options available and are typically referred to the CRC for long-term treatment. Children placed out-of-region tend to be older, have limited in-state options and 100% were referred for long-term treatment.

Table 13. Subgroup Characteristics Compared, Table C, SFY 2016-2020*

Group	Characteristics											
	In State Option		Reason for Referral					Age Group				
	Yes	No	Assessment	Discussion	Long Term Tx	Stabilization	Transition to Long Term Tx	0-5	10-Jun	13-Nov	14-17	18+
All Residential	54%	40%	32%	0%	62%	1%	5%	0%	18%	25%	56%	0%
Ages 13 & Under	**63%**	32%	**40%**	0%	54%	1%	5%	1%	**39%**	**60%**	0%	0%
High Utilizers	43%	**52%**	14%	2%	**71%**	0%	**12%**	0%	**33%**	**31%**	36%	0%
Placed Out-of-Region	2%	**93%**	0%	0%	**100%**	0%	0%	0%	5%	16%	**76%**	2%

** Note that all 2020 data represents the first six months of that year only.*

Regional Outlooks

Table 14 below is a summary of quantitative measures by region, making clear where measures are highest. Red text indicates the value is above the statewide average. For example, Brattleboro is above average for every measure, and therefore every measure is shown in red.

The regions are shown in order of their Master Ranking from 1 on the left to 12 on the right, reflecting the ranking of their weighted scores. These scores incorporate every measure shown, combining them into a regional outlook. A ranking of 1 indicates the region with the most favorable outlook, while a ranking of 12 indicates the least favorable outlook. Measures were weighted according to importance, with number of residential placements highest at 50%, and the remaining measures equally weighted. Note that Newport and Bennington regions produced an identical score. For a detailed explanation of how these scores were calculated, please see Appendix D.

Table 14. Outlooks by DO Region, SFY 2016–2020*

		Region												
Measure	**Unit**	**Average**	**Burlington**	**Middlebury**	**Springfield**	**Barre**	**Hartford**	**Morrisville**	**Rutland**	**St. Johnsbury**	**Newport**	**Bennington**	**St. Albans**	**Brattleboro**
All Residential Placements	**Children placed per 10,000**	**12**	6	11	9	11	6	11	**14**	**13**	**14**	**14**	**17**	**22**
13 & Under	**Children**	**42%**	37%	36%	**58%**	36%	**47%**	21%	36%	**44%**	39%	40%	**48%**	**56%**
High Utilizers	**Children**	**5%**	4%	2%	**8%**	0%	**7%**	**6%**	4%	4%	**6%**	5%	**9%**	**6%**
Placed Out-of-Region	**Children**	**8%**	**9%**	7%	4%	**9%**	0%	7%	**11%**	7%	7%	4%	**22%**	**13%**
Placed in Region (NY, NH, MA)	**Children**	**37%**	**14%**	5%	5%	**9%**	4%	5%	**15%**	**9%**	6%	8%	**9%**	**10%**
Average Utilization	**Admissions**	**1.17**	1.11	1.11	1.12	1.06	**1.24**	1.15	1.15	**1.30**	**1.23**	**1.26**	**1.24**	**1.18**
Above Average Utilization	**Children**	**28%**	19%	20%	21%	11%	**33%**	26%	26%	**40%**	**36%**	**36%**	**34%**	**30%**
Average Length of Stay	**Days in Tx**	**204**	174	200	**228**	**233**	**271**	**245**	179	196	180	177	186	**242**
Above Average Length of Stay	**Children**	**56%**	54%	55%	53%	**75%**	**59%**	**68%**	55%	44%	**60%**	52%	48%	**60%**
	Weighted Score		3.00	3.90	4.30	4.60	5.60	6.00	6.70	7.30	7.80	7.80	10.40	10.60
	Master Ranking		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

** Note that all 2020 data represents the first six months of that year only. Similar to LOS data explored in Tables 6 and 7, 2020 data were excluded from LOS measures.*

Figure 10 below depicts the geographical summary of the regional outlooks in Table 14, where the lightest regions have the most favorable outlook, and the darkest regions reflect least favorable outlooks. Figure 10 is a screenshot from the interactive Tableau dashboard.[22] Burlington (1), Middlebury (2) and Springfield (3) have the most favorable outlooks based on data from 2016–2020, while Bennington (10), St. Albans (11) and Brattleboro (12) have the least favorable outlooks.

[22] Link to interactive Tableau dashboard.

This map has been overlaid with the locations of available residential resources in 2020, including crisis and stabilization, in-state PNMI and small group homes. Each solid colored circle may represent one or more resources in a zip code that can be individually distinguished when the map is enlarged on the Tableau dashboard. A multicolored circle represents the different resources available in a zip code, also distinguishable individually once enlarged in Tableau. Note that these outlooks are based on a residential child's place of origin and reflects the availability of preventative resources or systemic issues in each DO Region, rather than the performance of the residential resources themselves.

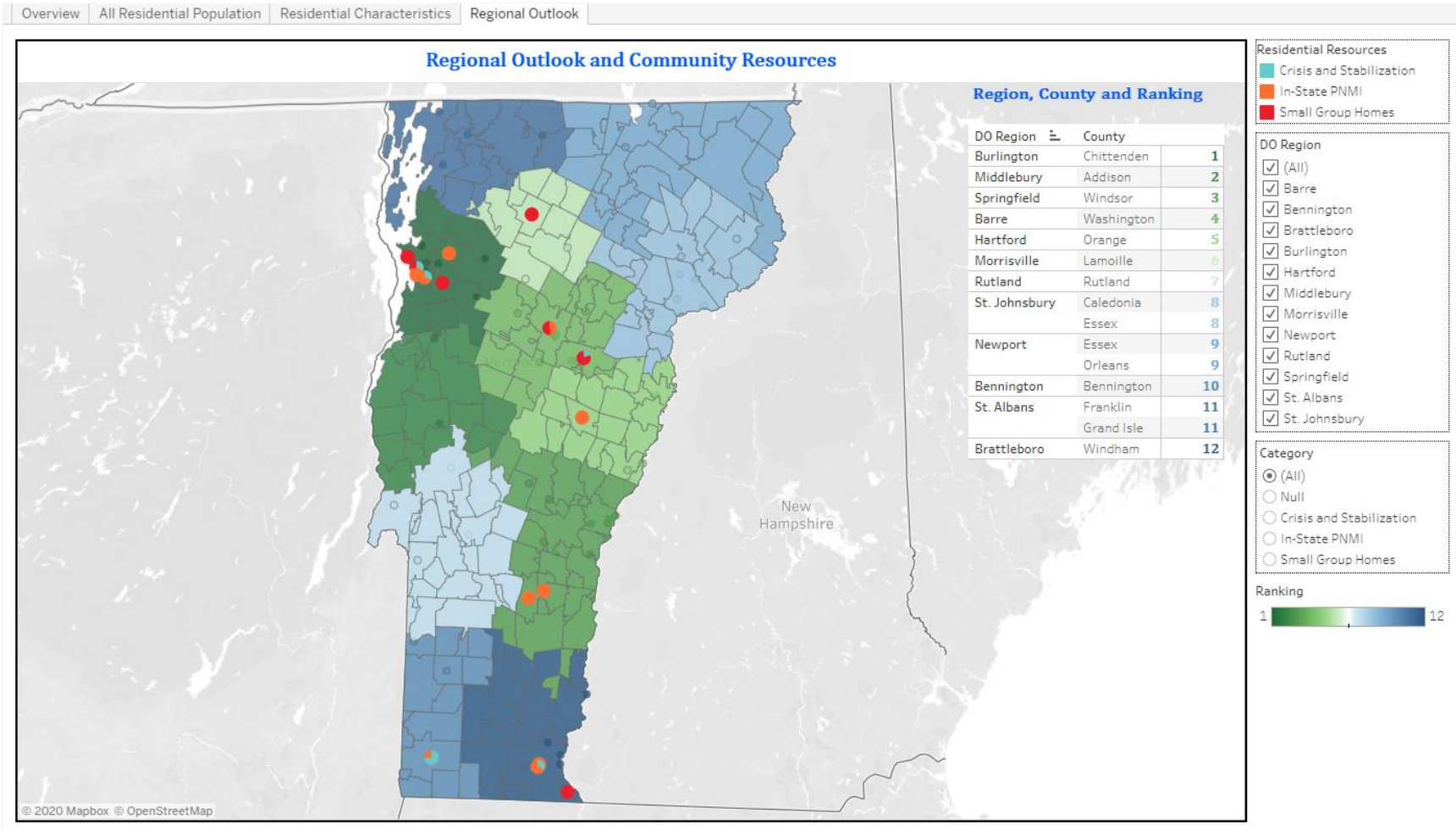


Figure 10. Geographic Summary of Regional Outlooks and Residential Resources, SFY 2016-2020*

** Note that all 2020 data represents the first six months of that year only.*

Resource Allocation Recommendations for Prevention

Using the quantitative data above, PCG recommends that Vermont AHS consider targeting investments in prevention using the following strategies to reduce utilization of residential care. These investment recommendations may additionally help AHS take regional and individual population needs into account when implementing action items in the Action Plan explored in Section V.

- **Target the most prevalent subgroup in the state: children ages 13 and under** (Table 8). Long term connections with consistent caregivers are especially important for young children, making them a high priority for serving in family-based settings. Using Table 14, AHS can see that this subgroup is most present in the Springfield, Brattleboro, and St. Albans DO regions. Using Tables 11–13, AHS could focus on creating more capacity in these regions to address the needs of children 13 & under who tend to display more conduct with and without aggression.
- **Target children placed out-of-region to keep children closer to home.** Using Table 14, the regions where most children are placed out-of-region are Rutland, Brattleboro, and St. Albans. Using Tables 11–13, AHS could focus on creating more capacity in these regions to address the needs of these children who are more likely to self-harm, display both suicide ideation and attempt, and have special circumstances that warrant medical attention.
- **Target the subgroup in residential care the longest: high utilizers** (Table 10). Using Table 16, resources can be targeted to regions where this subgroup is most prevalent, in the Hartford, Springfield and St. Albans DO regions. Using Tables 11–13, AHS can determine which characteristics of high utilizer children to address, such as harmful sexual behaviors, and higher rates of conduct with and without aggression.
- **Target regions that are placing the most children in residential care.** Using Table 14, these DO regions are Bennington, St. Albans, and Brattleboro. Using Tables 11–13, AHS may consider increasing capacity in these regions to address most prevalent characteristics of all residential children, such as incidences of conduct with aggression, conduct without aggression, and self-harm.

Vermont AHS may also consider the following additional strategies for resource allocation:

- **Target resources to mitigate growing substance use disorder** (Figure 9). Using Tables 11–13, substance use disorder is most prevalent in the out-of-region subgroup. Using Table 14, these subgroups are most present in the St. Albans, Rutland, and Brattleboro DO regions. Substance use disorder resources can therefore be targeted to these regions.
- **Target resources to subgroups in regions with the least favorable outlooks.** For this strategy, resources would be prioritized for the Newport, Bennington, St. Albans, and Brattleboro DO regions. Then, using Tables 11–13, AHS can determine which characteristics of subgroups they want to target in those regions. For example, AHS may determine that because the two out of the three subgroups tend to display higher rates of conduct with and without aggression, that investments in minimizing conduct issues may be a priority investment that resources in may greatly help these children. AHS can follow this same process for targeting resources to regions with the highest average utilization or highest length of stay.

C. QUALITATIVE DATA ANALYSIS

Strengths

The state of Vermont has many strengths in its current residential system of care for children. Critically, AHS departments are committed to improving services and reducing the utilization of residential placements for children. There is clear interest and ambition from AHS to identify challenges and solve issues in the

delivery of care, with significant work completed in recent years toward those aims. AHS has been closely monitoring the shifting patterns in the use of residential care by departments as well as metrics and characteristics of children in residential care. In 2015, AHS began the Turning the Curve (TTC) initiative to investigate the issue of increasing placements of children and youth in residential programs and develop strategies for reversing this trend.[23] Since then, AHS and the Residential Turn the Curve Advisory Committee release reports that monitor regional and state-level data that include total bed days, monthly counts, placement locations, demographics, and diagnoses. As shown in the Vermont System of Care Report 2020 submitted by SIT, Vermont has seen an overall decrease in the number of children in residential care between 2016 and 2019. PCG's quantitative data analysis also supports this pattern, as shown in Figure 1, although FY20 was trending potentially higher. PCG's quantitative analysis also supports that residential services are being provided to children with significant behavioral and emotional needs.

Because of ongoing efforts focused on improving outcomes for children and families, Vermont has laid a strong foundation on which to build future reforms. The Mobile Response Stabilization Service (MRSS) proposal, initiated in 2019, aims to prevent the need for higher levels of care by providing in-person support to families during a crisis, and by doing so, helping to prevent the escalation of behavioral and emotional difficulties of a child or young adult.[24]

Every child-serving department within AHS also actively supports and cultivates family engagement through efforts such as family and youth interviews and/or satisfaction surveys that are administered annually to gauge client satisfaction with services. In a survey conducted by Vermont Family Partners, 93% of survey respondents indicated that they received the help they needed from the DAs and SSAs.[25] Additionally, family satisfaction surveys are used in quality reviews of AHS itself. Furthermore, AHS and its child-serving departments also include family representation in state program standing committees and local standing groups, creating additional avenues for receiving input from families that can inform state and local planning efforts.

Within AHS, there are also efforts to improve the quality of services for children by creating flexible funding mechanisms for programs. In 2008, AHS began Integrating Family Services (IFS), a service delivery and payment reform initiative aimed at promoting investment in upstream, preventative services by combining funding streams at AHS.[26] IFS consolidated over 30 state and federal streams into a single case rate.[27] The goals of IFS were to be accomplished by:[28]

- **Providing flexible funding that allows service providers to meet family needs as they become known;**
- **Bringing children's, youth and family services together in an integrated and seamless continuum;**
- **Offering families supports and services based on need rather than program eligibility criteria; and**
- **Shifting the focus from counting clients and service units to measuring the impact of those services.**

[23] Presentation on Turning the Curve, Residential Placements for Children and Youth in Vermont, June 24, 2015
[24] Presentation on The Need for Mobile Response and Stabilization Services (MRSS) in Vermont: From Reactive to Responsive, February 12, 2020
[25] Vermont Care Partners, FY2018 Outcomes and Data Report
[26] Implementation of IFS and Rate Change document shared by AHS with PCG
[27] https://ifs.vermont.gov/
[28] https://ifs.vermont.gov/

The extent to which IFS has been successful in meeting its objectives remains to be determined, but this effort reflects AHS's commitment to adapting to better meet the needs of children and families.

DMH has also focused on improving service delivery at the DAs through payment reform. In 2019, DMH transitioned into a new mental health payment model for services provided to children and adults.[29] DMH payment reform allows for greater flexibility in funding, more adaptability in programming and changing yearly caseloads, and ties payment to outcomes by adding value-based payments.[30] These efforts simplified the baseline payment structures and updated the monthly care rate for mental health services, implementing one monthly prospective payment for all services covered under the case rate.

In addition, Vermont has numerous standing organizational vehicles for collaboration. State agencies and departments within AHS partner to seek and implement solutions to challenges. SIT, LIT, CRC and Multi-Disciplinary Teams are examples of ongoing efforts to coordinate care for Vermont's children and youth. The existing infrastructure and culture of inter-agency collaboration works well and could be leveraged to implement the recommendations in this report. Throughout this project, the inter-agency teams displayed effective team dynamics, respectfully challenging and questioning each other. These inter-agency collaborations may be especially effective in Vermont, where children and families seeking services may be well known to agencies, particularly if their needs are complex, allowing for focused discussion and solutions.

Furthermore, Vermont has successful programs which could be modeled or scaled up to provide services to more families in-state going forward. While the PCG team did not obtain data on the effectiveness of these programs, stakeholders identified the following as effective programs:

Staffed Living for Children and Youth/Residential Treatment Programs, formerly known as micro-residential programs, are licensed, small scale community-based residential treatment programs for children with significant mental health/behavioral needs.[31] This program offers shared living for 3–4 children who are at risk of institutional care, transitioning to home from psychiatric inpatient or intensive residential treatment, and/or transitioning to adulthood and have significant mental health needs. Funding for these programs comes from both Medicaid and Title IV-E. There was broad support from stakeholders for the Staffed Living for Children and Youth program, especially since as a community-based program, they allow for more family work.

Becket Family of Services provides a variety of services in the State of Vermont including support and stabilization services to families when there is a risk of removal to avoid a higher-level placement. These services are also offered to help support placement when a child or youth is stepping down from a higher level of placement back to their community. Depending on the needs of the youth and family, the Family Services Workers can choose from different levels of services or ask to develop a more tailored support wraparound service which could include case management, in-home supports, therapy, community skill development, and respite. Services are typically 90 days in length and include coordinating a community meeting to bridge service delivery with the local DA.[32]

[29] https://mentalhealth.vermont.gov/about-us/department-initiatives/payment-reform
[30] https://mentalhealth.vermont.gov/sites/mhnew/files/documents/AboutUs/PR/New_payment_model_and_billing_changes.pdf
[31] https://vermontcarepartners.org/wp-content/uploads/2019/06/Mental_Health_Provider_Manual_-062619.pdf
[32] https://dcf.vermont.gov/sites/dcf/files/FSD/pubs/CFSP2020-2024.pdf

Accessing Resources from Children (ARCh), located in Chittenden County, is a program for children and youth ages 22 and below who have an intellectual disability, autism spectrum disorder, or an emotional or behavioral challenge.[33] ARCh provides supports for families in areas such as coordinating services, family support, specialized behavior consultation, and family respite. This program is only available from one Designated Agency in one county and stakeholders expressed that it is a great model that they would like to see expanded.

Psychiatric Urgent Care for Kids (PUCK), located in Bennington, VT offers an alternative crisis intervention site through the local Designated Agency for children who are in mental or psychological distress at school to keep them out of the emergency department. United Counseling Service (UCS) established an outpatient walk-in Psychiatric Urgent Care for Kids (PUCK) in August 2019 to provide emergency assessments and brief treatment to children ages 3–22. PUCK is designed to lower the number of pediatric admissions to the emergency room and reduce the stress and sterility children experience in that setting. Upon entry, clinical staff assess the presenting problem and triage how to address ongoing behavioral dysregulation and psychiatric conditions. A series of stress-reducing activities and resources are available for children to use to learn how to change their physiologic level of arousal. Resource and referral to local sources of supports and services are initiated or strengthened. PUCK. is based upon the model of F. R. Stricker, et al and adapted to address challenges of a small town (rural) environment. A collaborative team from UCS and Southwestern Vermont Medical Center Emergency Department designed this pilot to decrease ED behavioral health visits and decrease length of stay.[34]

Laraway Substitute Care includes a therapeutic foster care program that offers support and crisis services 24 hours a day, 365 days a year.

Key Findings

Overall, despite many efforts and significant collaboration between departments, the system of care for children in Vermont is not as integrated, comprehensive, or accessible as it needs to be to adequately meet the needs of children. While many children are served effectively, for many others, care comes too late, when children's needs have escalated resulting in a strained residential system and frustration and unmet needs for children and families. Below are some of the key root causes.

A	**The Continuum of Care**
B	**Funding**
C	**Data Collection**
D	**Family Empowerment and Support**
E	**Service Quality**
F	**Workforce**

[33] https://howardcenter.org/all-programs/
[34] https://www.ucsvt.org/puck-a-game-changer-for-youth-mental-health/#

Finding A: The Continuum of Care

> ***"Each of the departments at AHS that place children in residential have different mandates, cultures and philosophies. All share one thing in common, however, which is to decrease the use of residential and to utilize residential only when necessary for children and youth." – 2019 Agency-Wide Analysis: Residential System of Care for Children & Youth in Vermont***

In Vermont, like many other states, the current child and family continuum of care and service array is not structured to operate as a single system, but rather as separate systems with their own rules, regulations, funding requirements, and service types. For example, the multiple waivers available for services are managed by different departments with different eligibility requirements and can be confusing for parents to navigate. While the inter-agency teams try to address these limitations to meet the needs of children and families, the system itself is not cohesive or integrated resulting in service gaps and fragmented services for children and families, particularly for children with intermediate or complex needs.

Concerns from the 2017 Turning the Curve Survey of Parents of Children in Residential Treatment were echoed in this assessment, chiefly that:

> ***A "lack of availability to local services and supports, a lack of high-quality services locally, and help coming too late were big factors in why…children reached the level of residential treatment."[35]***

Table 15. Select Findings from the Turning the Curve Survey of Parents of Children in Residential Treatment

Why was your child placed in a residential placement?	There are not enough supports at the community level to manage the behaviors, to keep everyone safe, or to meet the mental health needs. Some kids are in residential because they are not getting their needs met in the home and community.
What would have helped to keep your child at home and in the community?	Families agree that more services, better quality services, more support for the family, and help much sooner could have helped to keep their children at home. They have used community services, but the child needs are higher than the community can provide.
Describe the process that led to your child's placement.	Parents did not feel there were enough comprehensive services, and were quoted as saying they tried everything that was offered. Parents' experiences were a mixture of positive and negative with a higher level of care, in state and out of state. Of note, only one respondent mentioned that they had a mental health waiver, which should be part of the process.
Thinking of your child now, how is/was planning for your child coming home?	...There was a clear message that there were no services available when child came home...

[35] Parents of Children in Residential Treatment Survey Results for Turn the Curve Project, 2017

Parents in the TTC Survey also reported that children did not receive comprehensive services when they transitioned from residential placements back into the community. Challenges and deficiencies with transition planning were also expressed in PCG's focus groups broadly, specifically that:

- **Transition planning often happens late generally and specifically in coordinating a return to the community with Local Education Agencies (LEAs).**
- **Workers are encouraged to move children out of residential care, sometimes to reduce the cost of treatment, but services are not available in the community.**
- **There are limited options for transition placements; often family-based settings are not available.**
- **Program staff could use training on how to provide effective transition planning.**

Vermont is a rural state, with limited resources for children's services. The ability to meet the unique and specific needs of children and families across the state requires integration and flexibility at the local level. Efforts have been made through the implementation of the DA's, DMH payment reform, and programs like IFS to create this local flexibility, but barriers still exist.

The ability to meet the unique and specific needs of children and families across the state requires integration and flexibility at the local level.

Finding B: Funding Limitations and Silos

Limited funding was cited as a root cause of several challenges in Vermont's system of care, with these challenges growing due to more strain on the system from the COVID-19 global pandemic. When it comes to lobbying the legislature or the federal government for funding or policy changes, AHS departments advocate for their priorities separately, and not as a single unit representing Vermont's system of care for children collectively.

Comprehensive funding for children's services through DAIL is available for children through Medicaid DS HCBS (home and community based services, formerly known as the "DS waiver"), but only for children (under age 18) at risk of hospitalization or institutionalization. Insufficient service capacity for children with intermediate or complex needs, especially children with developmental disabilities (inclusive of intellectual disabilities/developmental disability or ID/DD and/or ASD), may lead to unnecessary residential placements.

DAIL offers several less-intensive services for children with ID/DD such as Bridge case management, Flexible Family Funding, and Family Managed Respite (FMR). DAIL also makes FMR available for youth with co-occurring mental health, or mental health diagnoses only, who are served by DAs. Families with children of varying diagnoses may access clinical services through the Medicaid state plan at their DAs. Many families throughout the state utilize Children's Personal Care Services, an EPSDT service offered by the Vermont Department of Health. Other than the funding DAIL has allocated to the ARCh program, there are no mid-level services offered.

Regarding Medicaid funded DS HCBS, the Vermont State System of Care Plan for Developmental Disabilities Services requires that individuals with ID/DD in Vermont meet a "funding priority" in order to be supported via the highest level of service, Home and Community Based Services (HCBS) "waiver". There

are two funding priorities for children to qualify for HCBS and require a high threshold of need, they are listed below.

- **Preventing Institutionalization** – Nursing Facilities: Ongoing, direct supports and/or supervision needed to prevent or end institutionalization in nursing facilities when deemed appropriate by Pre-Admission Screening and Resident Review (PASRR). Services are legally mandated. [Priority is for children and adults.]
- **Preventing Institutionalization** – Psychiatric Hospitals and ICF/DD: Ongoing, direct supports and/or supervision needed to prevent, or end stays in inpatient public or private psychiatric hospitals or end institutionalization in an ICF/DD. [Priority is for children and adults.]

Children's services at DMH are heavily reliant on Medicaid as well. According to stakeholders during PCG's focus groups, Vermont's lack of alternative funding mechanisms for services for youth that are not Medicaid eligible leaves families feeling unsupported. Among the diagnoses that may not qualify for DMH services are conduct disorder, autism spectrum disorder, substance abuse or intellectual disability without a co-occurring mental illness diagnosis. Given that the majority of children placed in residential care present with conduct with aggression or conduct without aggression, this is significant. Families may receive services through private insurance or by paying for treatment out of pocket. However, in general, private insurance companies do not cover as many services as Medicaid does. In rare instances, this has resulted in families entering into voluntary custody agreements with DCF-FSD to obtain residential services for their children. It should never be necessary for families to relinquish custody of their children to access services. This is traumatic for children, places unnecessary pressure on DCF-FSD, and creates significant administrative burdens and costs as well (court filings, custody paperwork, etc.).[36]

Several initiatives have been implemented to improve funding flexibility to provide more preventative services with IFS and DMH payment reform being the most significant:

On January 1, 2019, DMH transitioned into a new mental health payment model for services provided to children and adults.[37] DMH payment reform allows for greater flexibility in funding, more adaptability in programming and changing yearly caseloads, and ties payment to outcomes by adding value-based payments.[38] These efforts simplified the baseline payment structures and updated the monthly care rate for mental health services, implementing one monthly prospective payment for all services covered under the case rate. Funds from the mental health (MH) waiver, formerly known as Enhanced Family Treatment (EFT), which provide families with individualized services meant to help children and families build skills needed for children to remain in their home and communities are now included in the case rate.[39] With this change, it will be important to monitor whether families are now receiving these important supports and whether they help children to remain in their communities.

Similarly, IFS was created to help Vermont improve outcomes for children and families using a pooled funding model that allowed for greater investment in preventative services. The theory behind IFS was that:

> ***"[I]f funding and expectations were integrated (documentation, outcomes, criteria), providers could spend more time on service delivery, achieve outcomes sooner, and prevent families from reaching crisis level before services could be provided".[40]***

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[36] https://dcf.vermont.gov/sites/dcf/files/FSD/Policies/81.pdf
[37] https://mentalhealth.vermont.gov/about-us/department-initiatives/payment-reform
[38] https://mentalhealth.vermont.gov/sites/mhnew/files/documents/AboutUs/PR/New_payment_model_and_billing_changes.pdf
[39] https://howardcenter.org/mental-health/counseling/enhanced-family-treatment-and-foster-care-programs/
[40] Implementation of IFS and Rate Change document shared by AHS with PCG

However, in engagements with stakeholders, PCG heard that even with the IFS funding model, there is generally a choice between providing services to youth with high-end needs—which quickly uses up the funding—or distributing funding across more youth, which results in children with greater needs being underserved. Often, little funding is available for intermediary services. Furthermore, stakeholders reported that some children receiving services through DCF-FSD—those with the highest needs—fall outside of the IFS case rate. DCF-FSD thus pays into the service bundle and sometimes must still find additional funding to provide services to children with the greatest needs, often having to go to providers with higher rates for those services. More data is needed to determine whether IFS policy and outcome goals are being met, but stakeholder feedback suggests challenges with the IFS pooled funding model.

Issues with rates for Private Nonmedical Institutions (PNMI) were raised by multiple sources in PCG's analysis. In fact, there is strong consensus that PNMI rates must be altered or dismantled altogether. The PNMI rate for residential services switched from a budget-based model to a cost-based model in 2015. Cost and occupancy data from a base year two years prior are used to calculate a per diem rate; rates are rebased yearly.[41] VT sets a cap on the amount that a provider's rate can increase from one year to another.[42]

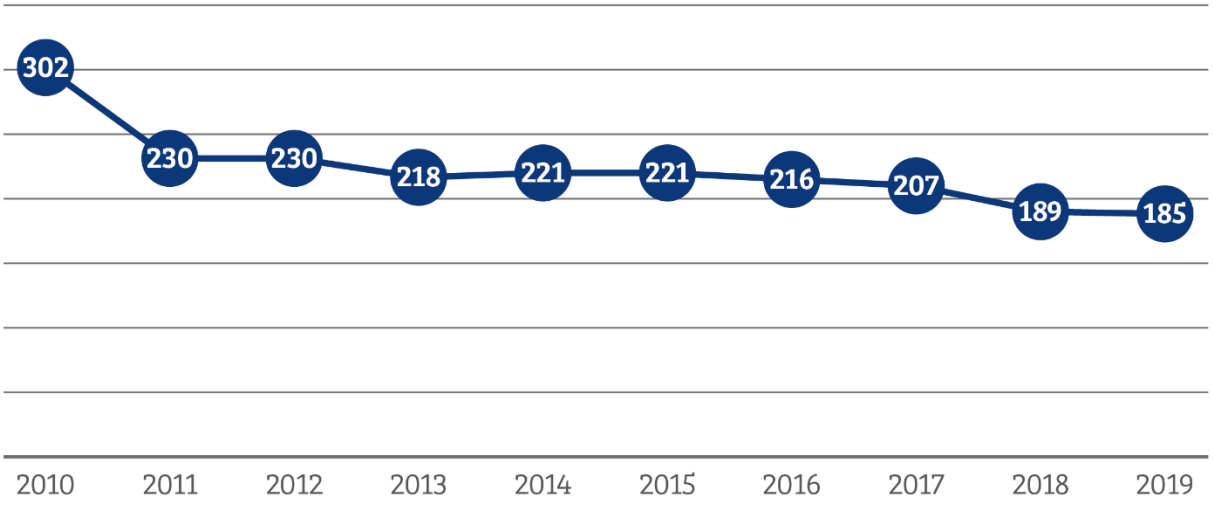
When Vermont switched from a budget-based to a cost-based PNMI rate, it led to challenges for many providers. The rates are built from cost and occupancy data from two years prior and thus do not reflect the present needs of providers. Some providers seek Emergency Funding Relief (EFR), which is an administrative burden and is subject to availability of legislative funding and approval by the Placement Authorizing Departments (in 2020, no EFR was approved). Other programs do not seek EFR and do not recoup needed dollars, while some do not contract for PNMI services at all due to low rates, further contributing to issues with capacity. PNMI also restricts providers from offering specialized treatment and does not cover post-discharge services, which contradicts requirements for Qualified Residential Treatment Programs (QRTPs) under the Family First Prevention Services Act (Family First).

As cited in the 2019 Agency-Wide Analysis: Residential System of Care for Children & Youth in Vermont, the number of residential beds available to children and youth has decreased from 302 in 2010 to 185 in 2019 (Figure 11).

[41] Report to the Vermont Legislature on The Use of Out of-State and In-State Residential Placements, including Woodside, November 9, 2017

[42] https://dvha.vermont.gov/sites/dvha/files/documents/providers/Rate_Setting/PNMI%20Rate%20Setting%20Presentation%20-%20VCORP.pdf

FIGURE 11: THE NUMBER OF LICENSED RESIDENTIAL BEDS AVAILABLE TO CHILDREN/YOUTH IN VERMONT SINCE 2010



Families must sometimes seek care out of state or out-of-region due to limited residential programs and a lack of programs that meet the needs of children within Vermont. According to PCG's analysis, between 2016 and 2020:

- **56% of children received residential care in-state**
- **37% received residential care in-region, described as states bordering Vermont (Massachusetts, New Hampshire, and New York)**
- **7% of children are placed in residential programs out of state and out of region**

PCG's analysis, as shown in Tables 11–13, indicates that out-of-region placements were generally associated with the following treatment needs:

- **58% of children displayed self-harm, compared to 42% of all residential children**
- **27% of children had both suicidal ideation and attempted suicide, compared to 14% of all residential children**
- **13% of children needed medical attention, compared to 7% of all residential children**

When services are not available in the region, children are sent to residential programs in places as far away as Florida, Michigan, Missouri, Texas, and Colorado.[43] Receiving care out-of-region makes it harder for children to transition back into their communities and often delays timely reunification.

As Vermont considers making system-wide improvements to the care provided to children, there is overwhelming consensus among various stakeholders that additional payment reform should be a top

[43] Presentation on Turning the Curve, Residential Placements for Children and Youth in Vermont, June 24, 2015

priority. Many stakeholders also feel that Vermont's funding challenges are significant enough that AHS should reimagine how services for children are funded, versus making incremental changes to existing payment structures.

Finding C: Data Collection

Vermont's system of care for children does not have a single data system with common client identifier and integrated data warehouse between departments to create a holistic view of the children, youth, and families it serves, which results in difficultly tracking youth across departments and regions. The lack of a central database came up consistently in PCG's analysis as a top priority for Vermont to resolve. In the 2017 Report to the Vermont Legislature on The Use of Out of-State and In-State Residential Placements, including Woodside, the TTC Advisory Committee cites the following:

> ***"The State lacks a database across AHS to track placements and long-term progress outcomes such as recidivism. Currently AHS staff maintain spreadsheets of placements; payments are tracked in other systems specific to each Department/Agency. Spreadsheets and data maintained in distinctly different systems poses significant limitations for this type of analysis."***

PCG was able to obtain significant data on the children referred to residential treatment from the CRC, however, because the CRC tracks all referrals via spreadsheets, this is a time-consuming process for those who maintain it. The lack of a centralized data system has also been a hindrance to determining the success of inter-departmental pilots such as IFS. In the absence of this data, it is not possible to make informed judgements about successes and challenges of these initiatives. In a similar vein, the CRC does not collect data on race and ethnicity, which is necessary for AHS to be able to examine the system of care through a racial equity lens.

Anecdotally, the acuity level of children has increased in recent years, resulting in children requiring more attention and care than in the past. However, in the absence of data to support this hypothesis, it is difficult to apply to policy making and resource allocation.

Finding D: Family Empowerment and Support

Families, including biological families, adoptive families, foster families, and fictive kin are asked to do a lot to support the children in their care, especially children with complex needs, and they are often not adequately supported. At the core of this issue is a deficiency in at-home supports and skill-building for families with children with intermediate and complex needs. Additionally, the system does not adequately integrate family partnerships in service planning and delivery.

In the 2017 TTC Parent Survey, families expressed desire for:

- ***"more supports, including peer supports and in-home behavioral supports, better communication across the board;***
- ***"more work to build skills in the whole family is needed when a child is in residential care; and***
- ***"[b]etter communication that includes the parent in decision making instead of letting them know of decisions especially while the child is in residential care".***

PCG heard this echoed in focus groups that families need supports outside of traditional services. As an example, families may lack adequate childcare, so they do not have the capacity to work with their children who have greater needs. Additionally, there was a sense of frustration that the family voice is not always heard. With the DAs, there is a misalignment of staff meeting the routine care needs of families, *e.g.,* caregivers require help in the early morning or after normal business hours, when DA staff may not be available for non-crisis work.

Furthermore, AHS has certain positions meant to advocate on behalf of families and help them better understand the system, such as the LIT Parent Representative. However, when these positions are vacant, families do not receive crucial information about their children's care, adding to what is already a stressful and complex process. In the TTC Parent Survey, only half of Parent Representative positions were filled at the time of the survey, and only 37 percent of parents were offered support from a Parent Representative on their Coordinated Service Plan (CSP).

In its focus groups, PCG heard that the current array of foster and adoptive family levels of care and reimbursement methods are not enough to incentivize success. While it is challenging to compare foster care rates across states, because there are variations in cost of living and what the rate is intended to cover, a review of Vermont's foster parent rates suggests that they are lower than rates in neighboring states. According to a rate study performed by PCG in January 2019, basic foster parent rates in New Hampshire ranged from $21.84 per day to $27.86 per day depending on the child's age. In Massachusetts, basic rates ranged from $23.21 per day to $27.47 depending on the child's age. Basic foster care rates in Vermont range from $17.16 pers day to $21.06 depending on the child's age. There is an option to provide higher rates based on tiered levels of care for those children with more acute presenting needs through Child Placing Agencies and the Caregiver Responsibilities Form (CRF) tool. This provides significantly higher reimbursement, ranging up to $75 per day, but stakeholders indicated that those slots are limited[44] and that the increased rate decreases as the child/youth's behavior improves.

Stakeholders noted that DCF-FSD has a practice of reducing or not offering enough incentives to families that play a key role in bolstering the array of care. When a child who has complex needs and/or was difficult to place with a home provider shows improvements in their behavior, DCF-FSD reduces the foster care payment rate that families receive.[45] Similarly, families are disincentivized from adopting children with a DS waiver—children who are brought into the care of foster families may remain in foster care for years because, if adopted, their parents would receive adoption assistance but lose waiver services. After adoption, the child must meet a DAIL-DDSD funding priority as is required for all children who are not in custody, to be funded for Home and Community Based Services ("waiver").

Adoptive families are of particular concern as data suggest that they may not receive sufficient support to care for their children. As shown in the CRC data, 14% of admissions for children in residential care between 2016–2020 were children who have been adopted, highlighting a need for more engagement with families prior to adoption and after an adoption, in order to help families achieve stability and avoid crisis.

In stakeholder engagements, PCG also heard that Vermont could better identify, engage, and support kin, especially for youth with complex mental health and behavioral challenges. Vermont is challenged by children with more intensive needs or who are at risk of placement in residential care. Additional training and support for kin is needed to help keep more children in their communities and avoid additional residential placements.

Finding E: Service Quality

[44] The therapeutic foster care stipend is $1,950 per month: https://www.nfivermont.org/services/therapeutic-foster-care/therapeutic-foster-care-faq/

[45] Stakeholder input during PCG focus groups

The overall quality of care that children in youth receive in Vermont varies and, in some cases, could be improved. Stakeholders reported quality issues across the system, which are hard to assess due to lack of uniform performance standards, monitoring, and accountability. AHS has implemented multiple significant initiatives but lacks monitoring to determine their effectiveness.

As one example, residential programs are supposed to provide transition planning to support children returning home from care, including coordinating with LEAs. However, there is widespread variation in the degree to which this is provided, which can delay a child's exit from care and/or create gaps in aftercare services and supports. While children may leave a program showing improvements in their behavior and/or emotional and/or psychological stability, issues may arise in the absence of family work and needed supports to build upon their successes. Residential programs are not consistently held accountable for providing these services.

Youth who have been in residential programs pointed to difficulties they faced while in congregate care. Some reported feeling like "another file in the system without 'real' support". In some residential facilities, unkempt physical spaces and an institutional culture made youth feel they were not respected or valued, this on top of some youth already feeling "different" or "less-than" because they were in foster care. Some youth expressed that a nicer or more inspiring physical space and a more home-like culture would have helped them feel better cared for, "normal", and worthy.

Similarly, stakeholders had mixed reviews of the DA's some of whom reported a need for better family engagement and a more genuine culture of treating families like partners. Additionally, lack of experienced personnel at the DAs, due to high rates of turnover, was identified as a potential deterrent to families seeking their assistance. To ensure that limited resources are going to programs offering children the best care that leads to the most positive outcomes, Vermont will need to track outcomes for children and performance measures for programs more robustly. A critical component of monitoring service quality will be working with children and families to identify and address any deficits in care.

Finding F: Workforce

Workforce challenges impact service provision throughout Vermont. In a survey of all 16 DAs and SSAs conducted by Vermont Care Partners in 2019, vacancy rates of 12% for bachelor's level clinicians, 11.3% for master's level non-licensed clinicians, and 18.6% for master's level licensed clinicians were noted.[46] DAs and SSAs reported turnover rates of 28% for developmental service positions, 26% for mental health positions, and 24% for administrative staff.[47] Staff satisfaction surveys indicate that only 44% of DA and SSA personnel believe they are paid at rates comparable to similar jobs in the non-profit sector.[48]

Similarly, in 2018, data indicated that FSD had a 25% turnover rate (although this included internal transfers and promotions).[49] This is within average for child welfare agencies, but still disruptive to care.[50] Turnover has been shown to be costly to state child welfare agencies and to have a negative impact on outcomes such as permanency.[51]

Although harder to document, workforce deficiencies at provider agencies throughout the system of care were reported to have an impact on the capacity of the system overall to service children and families in a timely way. Stakeholders reported waitlists for services due to capacity issues.

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[46] https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/WorkforceWhitePaper_2019_Final.pdf
[47] https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/WorkforceWhitePaper_2019_Final.pdf
[48] Vermont Care Partners, FY2018 Outcomes and Data Report
[49] https://dcf.vermont.gov/sites/dcf/files/FSD/pubs/CFSP2020-2024.pdf
[50] https://caseyfamilypro-wpengine.netdna-ssl.com/media/HO_Turnover-Costs_and_Retention_Strategies-1.pdf
[51] https://caseyfamilypro-wpengine.netdna-ssl.com/media/HO_Turnover-Costs_and_Retention_Strategies-1.pdf

IV. RECOMMENDATIONS

RECOMMENDATION A: THE CONTINUUM OF CARE

Summary of Finding A

Care often comes too late. The current child and family continuum of care and service array is not structured to operate as an integrated system of care, but rather as separate systems with their own rules, regulations, funding requirements, and service types. Different department missions and their associated funding limitations and restrictions can make it difficult for children and youth to access the right service at the right time.

Summary of Recommendation A

- Explore the creation of a "Single Point of Access" through a lead agency or department or through regional hubs to oversee, manage, and accept financial risk and Continuous Quality Improvement (CQI) for residential treatment, crisis services, and a continuum of community-based services and supports for children, youth and families

The system of care approach (SOC) was developed to better serve children and youth with serious mental health conditions, youth at risk of residential or juvenile justice involvement, and youth involved with multiple systems. The goal is to provide children and their families with the services they need in their homes and communities to avoid the need for inpatient and residential treatment. The purpose of the SOC approach corresponds to AHS' vision, mission, and guiding principles as well as the Turn the Curve goal to increase community-based supports for children and youth thereby decreasing the need for residential placement. The data show that children admitted to residential settings in Vermont are experiencing significant issues such as aggression, self-harm, substance use disorder, or suicidality.

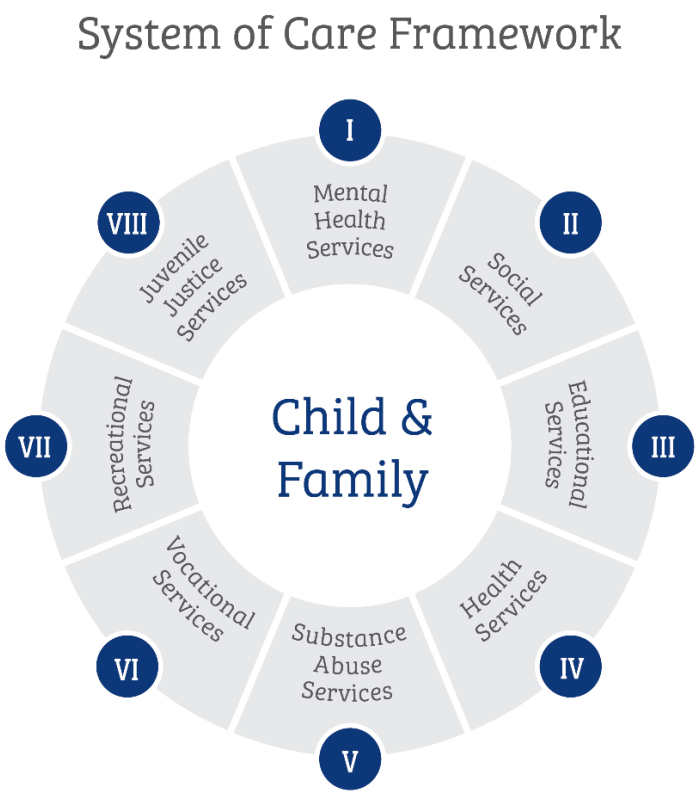
A system of care is not a specific type of program; rather, it is an approach that combines a broad array of services and supports with a set of guiding principles and core values. Services and supports are provided within the context of the core values: services should be community-based, family driven, youth-guided, and culturally and linguistically competent. Most important, services and supports are individualized to address the unique strengths and needs of each child and family. Each system of care develops its own guiding principles, but they should be aligned with these core values.[52]

[52] https://www.casey.org/can-you-tell-us-about-a-few-agencies-that-have-systems-of-care/

A **single point of access** to a comprehensive array of mental health and supportive services, supported by pooled and flexible funding, across child serving systems is a hallmark of successful systems of care across the country.

These systems of care are often managed and overseen by **care management entities or regional lead agencies or "hubs"** that also provide or arrange for intensive care coordination for children with complex needs; allowing them and their families to more seamlessly access mental health and supportive services by reducing administrative and funding boundaries between agencies and departments.

Through implementation of efforts such as inter-agency teams, payment reform and IFS, AHS has already placed an emphasis on shifting toward a more flexible, integrated, and locally responsive system of care consistent with the core values of the children's systems of care approach including:



From Stroul, B. & Friedman, R. (1986 rev ed). *A system of care for children and youth with severe emotional disturbances* (rev. ed., p. 30). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

- **Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.**
- **Community based, with the locus of services, as well as system management, resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.**
- **Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports.[53]**

[53] Stroul, B., Blau, G., & Friedman, R. (2010). *Updating the system of care concept and philosophy.* Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Other themes of a successful SOC include:

- **Core Principles** – While principles may vary from state to state, they all emphasize youth and family voice, as well as providing individualized services and supports. Establishing a common set of principles for all to work from is critical to success. *See Recommendation D for more details and discussion on how to enhance family empowerment in Vermont.*
- **Community Engagement** – Keeping children in their communities and serving them through local providers is a focus of every children's SOC. Communities play critical roles within the systems of care framework and must be viewed and valued as equal partners on the team. *See Recommendation D for more details and discussion on increasing community engagement and harnessing natural supports.*
- **Collaboration** – Communication must include all relevant stakeholders. Collaboration is necessary at all levels – individuals, system, local, and state. *See Recommendation E for more detail and discussion on collaboration, communication and service quality.*
- **Data** – Data is a powerful tool at all stages of SOC implementation: in engaging stakeholders and creating buy-in; in identifying needs and re-allocating resources; and in tracking outcomes. *See Recommendation C for more detail and discussion on how data can be more effectively leveraged to support Vermont and a future SOC.*
- **Pooled Funding** – Critical to the children's system of care approach is pooled or "blended" funding. Achieving a successful pooled funding stream requires the **creation of mechanisms for pooling funds and reinvestment of savings from reduced need for institutional care.** *See Recommendation B for more details and discussion of funding.*

Support and evidence for the SOC approach is well known and accepted throughout the child welfare world. Both the Substance Abuse and Mental Health Services Administration (SAMHSA)[54] and the Children's Bureau[55] have funded evaluations of systems of care, and a synthesis[56] of these along with other evaluations, have found that systems of care are associated with a range of positive outcomes such as:

- More stable living situations for children and youth including **fewer out of home placements** and fewer placement changes.
- Increased use of evidence-based practices and **expanded array of home- and community-based services and supports**.
- **Decreased inpatient residential stays**, suicide rates, substance use, and juvenile justice involvement.
- **Increased family and youth involvement in services**.
- Improved family functioning and reduced caregiver stress.
- Improved school attendance and grades.
- **Increased cross-system collaboration** and improved use of Medicaid and other resources.

[54] http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf
[55] http://www.centerforchildwelfare.org/kb/socsrvc/Cross-SiteEvaluationOverviewReport.pdf
[56] https://web.archive.org/web/20151216164109/https://gucchdtacenter.georgetown.edu/publications/SOC%20Results%205-7-12.pdf

Two examples of successful children's systems of care and the infrastructure models they use to support their SOCs are described below; additional state examples can be found in Appendix E:

In **Wisconsin**, the **County of Milwaukee's Department of Health and Human Services, Behavioral Health Division** created a nationally renowned, unique system of care for children with serious emotional, behavioral, and mental health needs and their families. Wraparound Milwaukee utilizes a wraparound philosophy and approach focusing on strength-based, individualized care. It was developed out of a six year, $15M federal grant that was received from the Center for Mental Health Services.

Wraparound Milwaukee is based on a "care management entity" (CME) organizational structure that is responsible for overseeing the delivery of care for youth with complex needs across child serving systems. This program blends funds across all child serving systems and oversees the management and disbursements of those funds to create a flexible and more adequate funding pool that benefits each partner department and agency. Wraparound Milwaukee also utilizes a single point of access for referrals to services for children and families that is more user friendly to the consumer and more effective and efficient from a program management perspective and from the perspective of families. In the Wraparound Milwaukee 2019 Year End Report, results of a parent satisfaction survey were reported and 90% of families indicated an overall satisfaction rating of >4.5/5.0 with the single point of access resource and referral line.[57] It is deemed an effective and efficient way to link families to individualized services which should happen at the very first contact. Indicated, as well, is the importance of brief, intensive engagement with the family through motivational interviewing, providing stress and coping support strategies and providing detailed and creatively presented support service information.

Ensuring fidelity to system of care principles and benchmarks, tracking program utilization and costs, and using outcome indicators to improve quality is also a strong part of Wraparound Milwaukee. This work is done through a Quality Assurance (QA)/Quality Improvement (QI) team. A more in-depth review of CQI is provided in *Recommendation E Service Quality*.

Outcomes of Wraparound Milwaukee:

- The average cost per month for a child in Wraparound Milwaukee is $3,700 per month versus nearly $9,000 per month in a state correctional facility, over $9,000 per month in a residential treatment center and over $10,000 for a seven-day stay in a psychiatric hospital.
- The average Milwaukee County population in a residential treatment center dropped from 375 to 90 youth; the large drop in state correctional population resulting in closure of two state facilities.
- Improved child permanency – 75% of youth were discharged to a permanent setting with parent, relative, adoptive resource or subsidized guardianship.
- School attendance for program participants increased by 60%.
- Improved functioning of youth at home and in school based on Achenbach assessment administered at enrollment and discharge from program.[58]

[57] http://wraparoundmke.com/wp-content/uploads/2013/09/WCCF-2019-Wraparound-READ-56794-1-1-to-distribute.pdf
[58] https://www.thenationalcouncil.org/webinars/wraparound-milwaukee-the-family-connection/

Wraparound Milwaukee was established through a large federal grant. Vermont can also access federal funding to build and enhance its infrastructure for a children's system of care through Substance Abuse and Mental Health Services Administration (SAMHSA) federal grants for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbance[59] (also known as System of Care Expansion and Sustainability). The purpose of the grant is to improve the mental health outcomes for children and youth, birth through age 21, with serious emotional disturbance (SED), and their families. The grant program supports the implementation, expansion, and integration of the SOC approach by creating sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children and their Families Program (also known as the Children's Mental Health Initiative or CMHI). In the last round of System of Care Expansion and Sustainability Grants awarded in May 2020, the State of Maine was awarded $8.5M to develop and expand their system of care which is intended to include the creation of a single point of access by 2025.

The **Oklahoma Department of Human Services** oversees child welfare, juvenile justice, and behavioral health services. In early 2005, the Department of Human services issued a Request for Proposals to all 77 counties to create a statewide System of Care for children with complex behavioral health needs and specifically for accredited community-based behavioral health agencies capable of providing wraparound services to the target population. Ultimately, 24 agencies were selected to cover the state with some providers covering multiple counties.

These agencies must serve children and adolescents at any level of need, but the care coordination services are targeted at the children with more complex behavioral, emotional, and mental health needs and their families. The 24 agencies are set up to provide direct outpatient, intensive in-home, case management, medication management, wraparound services, and mobile crisis services. Everything is delivered and managed at the regional or county level. There is some blending of funding at the state level with Medicaid covering most of the youth with complex behavioral needs. Oklahoma's System of Care is also funded with state funds to cover youth who are not Medicaid eligible.

Rural areas are served well by the 24 community-based providers doing wraparound care coordination across the state. All Oklahoma SOC outcomes measures continue to show substantial positive program impacts. Youth in the Oklahoma SOC show decreases in school suspensions and detentions, decreases in contacts with law enforcement, decreases in self-harm and suicide attempts, decreases in problem behaviors and clinically significant improvement in functioning.[60]

Development of a SOC in Vermont will require significant involvement and support from all levels of AHS leadership, community partners, stakeholders, and the families and youth that the SOC is designed to serve. Additionally, it will be critical to **advocate for future budget needs and revision of restrictive funding requirements collectively for the children's system of care to the legislature.**

[59] https://www.samhsa.gov/grants/grant-announcements/sm-20-007
[60] https://systemsofcare.ou.edu/resources/content/carousel/ok-systems-of-care-evaluation-2018.pdf

RECOMMENDATION B: FUNDING

Summary of Finding B
Funding for services is limited and siloed, and payment structures are problematic.
Summary of Recommendation B

• Conduct a comprehensive analysis of existing funding mechanisms and service rates to learn about pain points in the system before proceeding with payment reforms.
  ○ Examine the rate methodology for residential placements to allow for more flexible funding to stabilize the provider pool
  ○ Align the rates for residential care to the Qualified Residential Treatment Program (QRTP) requirements and other requirements for specialized settings under the Family First Preservation Services Act
  ○ Examine the payment structures in place for children's services
  ○ Create budgetary flexibility to reinvest savings into preventative services

There was broad support among stakeholders that payment reform should be a top priority for AHS. Changes to funding structures will have immediate and lasting impacts on the continuum of care for children. **PCG thus recommends that AHS first conduct a comprehensive analysis of existing funding mechanisms and service rates to learn about pain points in the system before proceeding with payment reforms.** Ultimately, payment reforms should continue AHS's progress towards breaking down siloes and building a single, united system of care but improve on the challenges of current bundled rate methods in VT. PCG recommends the following:

- **Examining the rate methodology for residential placements to allow for more flexible funding to stabilize the provider pool**
  - Consider dismantling the PNMI rate, using the rule change process, to start fresh with a strong methodology that benefits AHS, providers, and the children receiving care.
  - If using cost-based rates going forward, the methodology should allow for cost adjustments to the rates, including cost of living adjustments and the flexibility to make changes to meet policy and service needs.
  - If using cost-based rates going forward, consider conducting a solvency analysis on a regular interval to analyze how providers are faring.
- **Aligning the rates for residential care to the Qualified Residential Treatment Program (QRTP) requirements and other requirements for specialized settings under the Family First Preservation Services Act**
  - To take advantage of federal funding for residential placements under Title IV-E of the Social Security Act, AHS should aim to comply with program requirements under Family First and conduct a cost and revenue analysis to determine the implications for the state budget and federal funding. Aligning residential programs to QRTP may require additional investments which may have fiscal impacts throughout the system.
  - Among the QRTP requirements, the program must provide discharge planning and family-based aftercare support for at least 6 months post discharge. Better discharge planning and aftercare is needed and can be at least partially offset by Title IV-E if programs are QRTP compliant. Programs must also take into consideration QRTP nursing expectations, trauma sensitive care, and accreditation requirements.
- **Examining the payment structures in place for children's services**

- Review current IFS reporting metrics and data analysis processes and strengthen if needed. Depending on the findings, revise IFS framework or dismantle IFS in favor of another model to achieve short term goals while working toward the long-term financial solution recommended by PCG. While IFS has established some reporting metrics, stakeholders indicated that it is not clear what funding elements are working and/or what the pain points are for IFS.
- Similar to above, conduct analysis of established DMH Payment Reform reporting metrics and data analysis processes and strengthen if needed.
- Work with the legislature to explore options for creating parity with private insurance companies to cover children's needs more fully, using Vermont's mental health parity law as a model framework (8 V.S.A. § 4089b). Multiple focus groups cited that private insurers limiting coverage to a narrow spectrum of services results in an overreliance on Medicaid dollars for a broader array of care. While private insurance parity is investigated, Medicaid funding must be maximized to provide care for children where private insurance coverage falls short, as explored in the next bullet.
- Work with providers to communicate Medicaid waiver funding opportunities fully and regularly through the 1115(a) Global Commitment to Health waiver. Consider setting aside emergency funds to prevent unnecessary DCF custody of children who are not eligible for Medicaid funding. This amount could be a yearly equivalent to what DCF would pay for children who must enter custody due to not being eligible for Medicaid funds, and can be accessed by DMH and DAIL. If, after these measures, there are still children entering DCF custody to receive Medicaid funding for services, AHS may consider developing an alternative funding source for those children. For example, AHS may further expand the Global Commitment to Health waiver to meet unifying characteristics of the children in need of this funding.

- **Creating budgetary flexibility to reinvest savings into preventative services**
  - **Choose specific populations of children for whom to reduce residential placements**; this will help AHS use a targeted approach to improving outcomes and tracking the progress of certain groups over time. Residential population subgroups examined in the quantitative analysis are prime examples, including children ages 13 and under, high utilizers, and children placed out-of-region. For examples of ways AHS can target subgroups to target prevention resources, please see the Targeted Investments: Resource Allocation Strategies section.
  - By creating budgetary flexibility, AHS can focus on scaling up services that could immediately allow for these children to be served in a less restrictive setting—such as Therapeutic Foster Care, micro-residential, Specialized Service Agencies, other step-down programs—and then reinvest savings in scaling up more services. As an example, the Massachusetts Department of Children and Families has line item flexibility language included in their budget every year, allowing them to transfer funds between their placement line items and their family preservation line items so that placement savings can be reinvested.

RECOMMENDATION C: DATA COLLECTION

Summary of Finding C
The system lacks a single data system with common client identifier and integrated data warehousing between agencies to create a holistic view of the children, youth, and families served, which results in difficultly tracking youth across departments and regions.
Summary of Recommendation C
• Invest in a centralized system for data collection to allow for a comprehensive view of children and families and for cross-agency case planning and coordination, with departments entering all data into one database • Explore procuring services to build a live data dashboard • Consider holding a Children's System of Care Data Summit • Collect data on how state and federal funding is being spent at the program and individual level • Collect data on race and ethnicity for children and families receiving services, including CRC • Standardize geographic service regions to allow for consistent comparative analysis between departments and across services

PCG recommends that AHS:

- **Invest in a centralized system for data collection** to allow for a comprehensive view of children and families and for cross-agency case planning and coordination, with departments entering all data into one database. Currently, AHS collects data for residential placement primarily through a spreadsheet shared between departments that is updated by CRC members. Though there are a multitude of data points collected in this spreadsheet (see Appendix B), this manner of manual data collection across departments is outdated and cumbersome for staff. Creating a strong continuum of care for children requires centralized tools for collecting data and analyzing outcomes. This will enable data analytics to:
    - Drive root cause-based decision-making
    - Allow for predictive modeling
    - Help set priorities
    - Determine cultural competency training needs
    - Enable equitable distribution of resources
    - Streamline quality assurance agency-wide
    - Monitor continuous quality improvement
    - Help match children and caregivers across districts, aiding FSD's work on Cross Jurisdictional Placement of Children.[61]
- **Explore procuring services to build a live data dashboard** that generates visual aids through automatic integration of existing **data** using platforms such as Tableau, Microsoft Power BI, IBM Cognos, or others. That way, meetings can be informed with live CCWIS dashboards.

[61] http://fosteringchamps.org/wp-content/uploads/2020/06/Vermont-Diligent-Recruitment-Plan-FINAL.pdf

- **Consider holding a Children's System of Care Data Summit** to better understand what data departments do have that they may be able to combine for better decision-making in the short term, using SharePoint or another internal central data storage system.

- **Collect data on how state and federal funding is being spent at the program and individual level.** Multiple stakeholders expressed interest in collecting data on how funding streams are being used, for the sake of transparency as well as tracking outcomes to dollars**.** This would ideally tie into value-based payments in order to ensure that Vermont's dollars are spent on services that provide the greatest supports and lead to the most successful outcomes for children and families. As one stakeholder requested, "Make the money transparent." This data can provide a basis for a state and federal funding analysis to help AHS move forward with finding ways to braid or otherwise combine funding streams.

- **Collect data on race and ethnicity for children and families receiving services, including CRC**. This will allow AHS to examine service quality and outcomes through a racial equity perspective.

- **Standardize geographic service regions to allow for consistent comparative analysis between departments and across services.** As AHS works to understand regional needs, it can be difficult to compare metrics from multiple departments with both distinct and overlapping catchment areas. If possible, AHS may want to consider coordinating with other agencies, such as AOE, on this effort.

RECOMMENDATION D: FAMILY EMPOWERMENT AND SUPPORT

Summary of Finding D

Insufficient supports at home and in the community leaves caretakers without needed care. Additionally, the system does not adequately integrate family partnership in service planning and service delivery.

Summary of Recommendation D

- Prioritize investment in family empowerment by augmenting current efforts
- Focus on support and engagement of adoptive parents
- Review foster care rates, ensuring that tiers for children who need more support and supervision are adequate, and revise as needed
- Expand natural/informal and community/peer support networks, to empower families and communities to care for children
- Consider creating a system for community volunteers to build community capacity and provide support services
- Include family voices in the service planning process consistently and measure family satisfaction at regular intervals

PCG recommends that AHS:

- **Prioritize investment in family empowerment by augmenting the following current efforts:**
  - Evidence-based practices that train, educate, and support families, including biological, kin, foster, and adoptive families
  - Intensive Family Based Services (IFBS), provided that they follow an accepted and proven evidence-based practice model.
  - Permanency roundtables to facilitate permanent placements for the most challenging situations.
  - Diligent recruitment
  - The capacity of Therapeutic Foster Care (TFC)
  - Funding for family visits during residential placements, in particular for children who receive care out-of-region.
- **Focus on support and engagement of adoptive parents.** AHS could do so by increasing training to adoptive parents prior to adoptions and arranging for access to support services during the adoption process, making sure that adoptive parents have the information for DAs if they need it, and by checking in with adoptive parents regularly for at least a year after the adoption is finalized for certain children. Vermont has a foster care leveling system which could be used to identify families that will require periodic follow-up. Additionally, consider strengthening post-adoption supports specifically for families who adopt through foster care as a part of the existing Post Permanency Family Support system through the Vermont Consortium for Adoption and Guardianship. From 2016 through the first half of 2020, 112 children or 14% of all unique children admitted to residential care were adopted.

TABLE 16. ADOPTED CHILDREN IN RESIDENTIAL CARE BY FISCAL YEAR, 2016-2020*

Year	Children Referred by DCF-FSD	Children referred by DMH	Total Children
2016	0	24	24
2017	0	24	24
2018	3	35	38
2019	0	18	18
2020	0	8	8
Total	**3**	**109**	**112**

** Note that all 2020 data represents the first six months of that year only.*

- **Review foster care rates, ensuring that tiers for children who need more support and supervision are adequate, and revise as needed.**
    - Updating payments for families providing foster care can help to address issues of recruitment and retention of home providers in the state.
    - Families working with children with the greatest needs under the CRF should not receive reductions in foster care payments if their hard work leads to positive outcomes for children. Instead, quality care should be incentivized and rewarded.
- **Expand natural/informal and community/peer support networks, to empower families and communities to care for children.**
    - AHS should continue and augment efforts to identify extended family and fictive kin for placements and support in order to strengthen natural supports in the community. When out of home care is needed, kinship care is the preferred option because it can reduce trauma and help children maintain healthy bonds, a sense of belonging, and their identity. According to the Child Welfare Information Gateway, kinship care also benefits a child removed from their home by providing ongoing connections with their family of origin, siblings, and community which are bonds essential to well-being. Kinship placements help preserve cultural identity and it provides greater placement stability than for children in other out-of-home care arrangements.[62]
    - AHS should also consider developing specialized parent/peer supports to help families navigate the system of care. In addition, developing peer networks could include mentoring and support provided by youth coming out of care to youth currently in care, similar to the Allegheny County Youth Service Partners Model in Pennsylvania.
    - Developing peer networks could include mentoring and support provided by youth coming out of care to youth currently in care, similar to the Allegheny County Youth Service Partners Model in Pennsylvania.
- **Consider creating a system for community volunteers to provide support services**, such as Oregon's Department of Human Services (DHS) Volunteer Services program. Oregon's volunteer system is one example of how an agency can build capacity in local communities that support the agency's goals and objectives. Volunteers can often provide services that the agency otherwise may not be able to. This is done by recruiting and placing volunteers, developing new community resources and networking with community partners. In Oregon, DHS volunteers help with client transportation, support and training for families, family advocacy, tutoring and interpreting,

[62] https://www.childwelfare.gov/pubPDFs/kinship.pdf

childcare, mentoring, and technical and clerical assistance. Volunteers are screened and must complete an application to participate. Oversight of volunteers is managed by volunteer coordinators and facilitated through an online volunteer portal, managed by DHS, that organizes registration and volunteer opportunities.[63]

- **Include family voices in the service planning process consistently and measure family satisfaction at regular intervals**. The System of Care Guiding Principles from SAMHSA recommend engaging authentically with families and youth. This includes "ensur[ing] that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation."[64] One way to improve family satisfaction is to provide training and technical assistance to providers and state staff on how to meaningfully engage caretakers through a family-first approach. Training should also focus on implicit bias and increasing cultural competency.

[63] https://www.oregon.gov/dhs/PROVIDERS-PARTNERS/VOLUNTEER/Pages/Index.aspx
[64] https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

RECOMMENDATION E: SERVICE QUALITY

Summary of Finding E

Service provision and quality vary across the system by agency, placement type, and provider. The system lacks a robust, state-level continuous quality improvement (CQI) process for residential programs to complement and strengthen ongoing quality assurance (QA) efforts.

Summary of Recommendation E

- Bolster early intervention, emergency support, crisis care, and crisis management capacity
- Align residential models to QRTP requirements, revise contracts, and monitor contract performance and improve transition planning efforts at residential programs
- Encourage transition planning to begin earlier which will help secure appropriate placement options in the community as needed for children after they exit residential care
- Conduct an inventory of where and to what degree evidence-based practices are in use and consider scaling them in regions that need them most
- Take inventory of DMH-funded Intensive Service Coordinator positions in the state, examine best practices, and consider adding the position to regions where needed
- Expand quality assurance oversight efforts in DAs and DCF-FSD Residential Licensing and Special Investigations Unit to include continuous quality improvement (CQI), where needed
- Inventory expected inputs, processes, outputs, and outcomes to align performance standards to the results-based accountability framework in Vermont's Act 186.
- Implement performance-based contracting for all service providers, using uniform outcome metrics for reporting and/or standard scorecards to assess efficacy of programs
- Amend policy to require and fund transportation for residential visits for all departments and families to children in placement every 30 days
- Consider requiring increased communications between Local Education Agencies (LEA) and children placed in residential programs

PCG recommends that AHS:

- **Bolster early intervention, emergency support, crisis care, and crisis management capacity** by:
    - Integrating prevention resources and referrals into early care and early learning centers, specifically Parent Child Centers
    - Funding the Mobile Response Stabilization Service (MRSS) program
    - Increasing the number of crisis beds
    - Providing additional funds to DAs to supplement their current emergency service programming
    - Investing in de-escalation training for all non-emergency services providers
    - Enhancing capacities of providers to do family work by investing in building skills for the whole family. AHS should contract for family work/have providers offer more family work. While a child is in residential, families should receive instruction on how to support children at home and prevent the escalation of emotional or behavioral difficulties.
    - Invest in transitions back home

- **Align residential models to QRTP requirements, revise contracts, and monitor contract performance** which would require implementation of trauma-informed treatment models, aftercare support, and timely transition planning. See more on alignment with QRTPs in table below.
- **Encourage transition planning to begin earlier which will help secure appropriate placement options in the community as needed for children after they exit residential care.** Transition planning often happens too close to discharge. Staff training and consistent use of transition planning best practices will help prepare all parties with the planning and preparation process.
- **Conduct an inventory of where and to what degree evidence-based practices are in use and consider scaling them in regions that need them most.**
    - Conduct a statewide survey about what evidence-based programs (EBPs) are currently in use in VT and measure outcomes to determine effectiveness. One way in which a system of care can ensure the quality of services and impact the efficacy of what is delivered is to identify, invest in, and support the use of evidence-based practices (EBPs) in both preventative care and residential care. While the use of EBPs would not fix all of the issues in the system of care, nor should the application of EBPs be a "one size fits all" intervention, EBPs can be incredibly helpful to support providers achieve positive outcomes. Without the widespread use and support of EBPs, service providers are left to develop their own interventions and models of treatment or seek training on their own. However, without specific requirements to complete trainings or deliver EBPs with fidelity, providers are not held to a high standard of expertise.
- **Take inventory of DMH-funded Intensive Service Coordinator positions in the state, examine best practices, and consider adding the position to regions where needed.**
- **Expand quality assurance oversight efforts to include continuous quality improvement** (CQI), where needed, as required in 4.8.1 of the AHS rules of agency designation. This could include:
    - Expand existing Quality Assurance (QA) in DAs to include Continuous Quality Improvement capabilities, so that DAs have both the capability to measure performance against standards, but the capacity to analyze and make the necessary changes to improve.
    - Expand existing DCF-FSD Residential Licensing and Special Investigations Unit metrics to include the outcomes of children and youth served by residential programs, expanding beyond quality assurance to include Continuous Quality Improvement (CQI), and helping to demonstrate treatment outcomes as Vermont aligns to the Family First Prevention Services Act.
        - Build on work done in July 2019 by the Capacity Building Center and FSD Leadership to identify CQI priorities for the Dos and central office. See more on quality assurance and CQI in table below.
- **Inventory expected inputs, processes, outputs, and outcomes to align performance standards to the results-based accountability framework in Vermont's Act 186**, *An Act relating to reporting on population-level outcomes and indicators and on program-level performance measures*. See more on performance measures in table below.
- **Implement performance-based contracting for all service providers, using uniform outcome metrics for reporting and/or standard scorecards to assess efficacy of programs.** See more on performance-based contracting in table below.

- **Amend policy to require and fund transportation for residential visits for all departments to children in placement every 30 days, rather than "monthly."** Stakeholders informed PCG that "monthly" visits often meant staff visited on the last day of the month, followed by the next day, the first day of the month, to achieve this monthly requirement. This was primarily due to budget constraints. As a result, the child was being visited less often and left without more frequent, healthy community connections. While COVID-19 remains a challenge, consider adapting staff visits to be virtual until in-person visitation is once again safe.
- **Consider requiring increased communications between Local Education Agencies (LEA) and children placed in residential programs.** This allows for children to stay in better contact with their school communities so they can, for example, read the same book as their classmates.

More on Alignment with Qualified Residential Treatment Programs

Residential services need to be aligned to new Federal requirements for congregate care in child welfare. In February 2018, Congress passed sweeping federal child welfare financing reform with Family First Prevention Services Act (FFPSA). To draw down federal reimbursement for residential placements for children in foster care, under Title IV-E of the Social Services Act, residential programs must meet the requirements of Qualified Residential Treatment Programs (QRTP). QRTP requirements include:

- An assessment, performed by an entity other than the residential provider must be conducted and must indicate the need for residential placement;
- The program must have a trauma-informed treatment model;
- The programs must be licensed and accredited;
- If it is in the best interest of the child, the family must be involved in the child's treatment;
- The program must provide discharge planning and family-based after care support for 6 months after discharge; and
- The continued need for residential placement must be documented.

While these requirements only apply to programs for which the state is seeking Title IV-E reimbursement for children in foster care, the QRTP requirements are notably similar to the best practices identified by the Building Bridges Initiative. In particular, the requirements to utilize a trauma-informed model (however AHS wishes to define that) and six months of family-based aftercare are notable QRTP requirements that align well with overall recommendations to improve the quality of services and continuity of care along the continuum of services. AHS could develop a service definition for residential providers to provide time-limited support following discharge from residential services. Massachusetts is one state that covers community-based services to prevent congregate care placement and to support children returning to the community from residential services through the Rehabilitation Option in their Medicaid State Plan. While not every residential provider includes aftercare services, many who provide Continuum Services under the Caring Together Program can provide both residential and home- and community-based services.[65] While aftercare services were originally competitively procured in Massachusetts, under FFPSA all residential providers will be required to provide these services to be reimbursable for Title IV-E funding.

[65] http://togetherthevoice.org/sites/default/files/bbitraining/caring_together_powerpoint.pdf

More on Quality Assurance and Continuous Quality Improvement

Quality Assurance (QA) is the retrospective comparison of practice against a standard or best practice, while Continuous Quality Improvement (CQI) is evaluation of current processes for opportunities to streamline or increase effectiveness. Ideally, these processes are done in tandem where quantitative, hard numbers, are compared with qualitative and anecdotal data using a look at past performance for future planning. For children's human services QA/CQI monitoring can be categorized into five areas:[66]

- Service provision;
- Safety;
- Child outcomes;
- Child and family, staff, and community perspectives; and
- Financial impact.

The ultimate goal is better outcomes for children and families. Not only are comprehensive QA/CQI systems required for successful quality management or continuous quality improvement (CQI), but the Substance Abuse and Mental Health Association (SAMHSA) also states that continued training and supervision serve to maintain high-quality behavioral health services, which may, in-turn, decrease staff burnout and increase worker retention.[67] Therefore, QA, CQI, and ongoing training should be considered as a package deal for child-serving systems seeking to increase competency and effectiveness in keeping children and families living in their communities with access to quality, timely and comprehensive services and supports.

States have utilized various designs and methodologies to create quality management for children's behavioral/ mental health systems. Where some states have created centralized departments to handle QA/CQI statewide, others have divided duties into regions across the state. Moreover, while some states have created separate divisions for QA/CQI, others have couched services in a committee structure. How an agency builds capacity in quality improvement varies depending on organizational needs and resources, but successful state quality management systems have some commonalities:[68]

- First, the leadership and culture of the organization not only supports the mission behind quality improvement but integrates the culture into the norms and expectations of day to day work. Therefore, it is no longer the exception to the rule when services provided or contracts are reviewed, but internal and external customers expect and welcome the idea because they know that having someone review their work and offer feedback makes the whole team and system stronger.
- Second, agencies have a way to collect, store, and analyze the data needed to monitor performance. States with comprehensive systems find ways to maximize their resources (including computer software) to ensure data sets are secure, complete, and accessible so that thoughtful, strategic analysis can give the best picture of what is actually occurring in a system or process.
- Third, not only are the staff who perform QA/CQI tasks trained, but all staff is continually trained and updated on relevant quality management topics. Training staff to observe and report is only

[66] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2739613/.
[67] https://www.samhsa.gov/data/report/behavioral-health-workforce-quality-assurance-practices-mental-health-treatment-facilities.
[68] https://fcda.chapinhall.org/wp-content/uploads/2014/07/2014-07-Principles-Language-and-Shared-Meaning_Toward-a-Common-Understanding-of-CQI-in-Child-Welfare.pdf .

half of the equation. In comprehensive systems, all staff have ongoing training to inform staff of quality improvement findings and plans to move the system forward.

Fourth, agencies have created administrative structures to support quality improvement, like the routine review and updating of department policies and procedures. Not only do these agencies create systems for review and training of staff, but they also have processes to update policies and procedures so that staff are continually supported in their work by rules, statute, and mandate.

Examples of Quality Assurance by State

The **Alaskan** Division of Behavioral Health Quality Assurance, another rural state like Vermont, also divides the structure of their services into three regions to serve the state in a variety of units, including conferences, clinical information, grants, emergency planning, individual services programming, etc.[69]

Arkansas utilizes a standalone Division of Provider Services & Quality Assurance to oversee certification, licensing, and surveying functions within other divisions of Aging & Adults Services, Behavioral Health Services, Developmental Disabilities Services, Child Care and Early Childhood Education, and Medical Services. This unit is tasked with monitoring outings and compliance as well as workforce development for the state.[70]

By contrast, Wraparound **Milwaukee** has a relatively large system that outlines specific units and duties for QA/QI in the Milwaukee service area. Primary functions of this system include review of the internal handling of past and current situations, tracking client and family satisfaction, partnering with families and stakeholders around policy and program development, review of provider adherence to contract requirements and outcomes, updating program policies and procedures, management of concerns and complaints, monitoring of Medicaid contract requirements, service utilization review, and annual engagement in more general department performance improvement projects.[71]

Burlington, **New Jersey** further offers a different type of model for regional quality assurance programming. They utilize a subcommittee who oversees department compliance with philosophy, principles, policies, procedures, and standards and receives regular QA/ QI reports regarding service access, quality, and outcomes. Additionally, they perform an annual county service needs assessment to identify gaps in services, barriers to access, and recommendations for service priorities.[72]

More on Performance Measures

Currently, there are inconsistent performance measures in AHS contracts related to residential care and support services. Other state children's behavioral health systems have developed performance

69 http://dhss.alaska.gov/dbh/Pages/TreatmentRecovery/default.aspx.
70 https://humanservices.arkansas.gov/about-dhs/dpsqa
71 https://wraparoundmke.com/quality-assurance/
72 https://www.co.burlington.nj.us/442/Childrens-Inter-Agency-Coordinating-Comm.

standards and have strengthened contracts with specific process and outcome standards providers are expected to meet. To accomplish this, **AHS should inventory the expected inputs, processes, outputs, and outcomes and align performance standards to the results-based accountability framework in Vermont's Act 186,** with a particular emphasis on outcomes as well as processes that are associated with positive outcomes.

As another state example, the Kansas Mental Health Office at the Kansas Department of Social Rehabilitation contracted with the University of Kansas to develop a state-level performance management system, specifically for Psychiatric Residential Treatment Facilities (PRTFs). [73] The researchers collaborated with stakeholders to develop a PRTF program logic model. The program model outlined the inputs and resources of the system; the associated activities and processes expected of those resources; and ultimately the immediate, mid-term, and longer-term outcomes that would be anticipated. The research team ultimately developed a series of performance measures for PRTFs in three broad domains: Access, Process, and Outcomes detailed in Table 17 below.[74]

TABLE 17: PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF) KANSAS PERFORMANCE MEASURES

Domain	Indicators	Measures
Access	Access to services	Length of time from referral/acceptance to admission Length of time from screening to admission The ratio of acceptance to denial of referrals The reason of denial by agency
	Follow-up care	Percent of parent or caregiver response to consumer satisfaction survey questions about availability and acceptability of services for child/youth
	Follow-up care	Average length of time for clients between discharge and next face-to face visit at community- based services
Process	Youth and caregiver's participation in treatment	Percent of children/youth with caregivers satisfied with participation in treatment
	Treatment plan completion	Percent of children/youth with treatment plan completed at discharge Reasons for non-completion of treatment plan prior to discharge
	Serious occurrence	Total number of serious occurrences Number of deaths Number of injuries requiring medical care Number of suicide attempts

[73] https://www.kdads.ks.gov/commissions/behavioral-health/consumers-and-families/services-and-programs/prtfs
[74] Kapp, S.A, et al. (2011). Building a Performance Information System for Statewide Residential Treatment Services. Kansas Department Social Rehabilitation Services, Division of Disability and Behavioral Health Services. Routledge Taylor & Francis Group.

Domain	Indicators	Measures
	Use of restraint and seclusion	Percent of change in use of restraint, seclusion per month
	Length of stay	Length of stay by agency
Client Status Outcomes	Clients' satisfaction with services	Percent of caregivers satisfied with services measured by the Ohio scales Percent of child/youth satisfied with services measured by the Ohio scales
	Improvement in clients' functioning and symptom reduction	Two scores over a period of time (at admission and at discharge) in the Problem Severity domain in Ohio Scales Two scores over a period of time (at admission and at discharge) in the Functioning domain in Ohio Scales
	Restrictiveness of living environment	Percent of child/youth whose primary residence was listed at discharge as their own home or foster care in the FY Percent of child/youth who maintained the level of care at 90 days after discharge
	Return to PRTF	Percent of readmission to agency within 90 days

More on Performance-Based Contracting

Measurement of outcomes helps to understand if an approach or service is effective and if it has value. A well-integrated outcome measurement system will include outcomes at multiple levels including program, clinical, and across multiple child-serving systems. Medicaid has been increasingly shifting from traditional fee-for-service models to performance-based or value-based models for health care services, although this trend has been slower for behavioral health services. Aligning payment structures to better support program goals requires careful analysis, planning, and monitoring.

Vermont utilizes performance-based contracting and value-based payments for their DAs and SSAs as a result of DMH Payment Reform. IFS is also an example of a bundled rate intended to allow for more flexibility and creativity. Going forward, these payment models can help inform additional payment reform, if AHS can learn more about what is working well and what needs to be improved.

AHS has also taken strides in the direction of measuring outcomes from providers, including the use of the CANS assessment by the DAs. Some DCF-FSD providers also have performance-based contracting measures such as Becket Family of Services and Laraway.

PCG recommends that AHS continue to move towards tracking outcomes such as functioning and well-being. PCG would like to note two AHS examples of performance measures in particular that can be used as model frameworks from which to expand 1) DMH Payment Reform performance measures submitted to the Centers for Medicaid & Medicare Services (CMS) in July of 2020 and 2) contracting performance measures used in a recent Becket Family Services contract with DCF-FSD in 2019-2020. In the DMH example, measures 1-11 are outputs based, while measures 12-15 are outcomes based. In the Becket example, all contract measures are focused on outputs, which can result in a more limited understanding of the full impacts of services. Outcome-driven performance measures should be

expanded in all contracts, similar to measures in the DMH Payment Reform July 2020 report, to understand if services are effective, hold providers accountable, and incentivize good work. Ideally, every AHS provider contract would include uniform performance measures, emphasizing outcomes, to allow for easier record keeping, quality assurance, and CQI by AHS.

One challenge in implementing performance- or value-based purchasing models in behavioral health settings is that there are not as many universally recognized outcome measures for behavioral health as there are for physical health services.[75] One way to address this is to focus early on process measures that are associated with positive outcomes and gradually build up to measuring outcomes. This allows time to agree on the measures as well as the data that will be used for reporting the measures. The current performance measures, many of which are process oriented, can serve as a helpful starting point going forward.

AHS could increase public transparency on the quality of services through provider scorecards and/or public reporting dashboards, potentially expanding upon existing tools used in Vermont like the Results Based Accountability Clear Impact Scorecards in use by DMH.[76] Other health care services, public education systems, and childcare agencies all have a form of public rating systems resulting in a scorecard, "grade", or some other measure of transparent quality indicators. Although not widely used in behavioral health at this time, this type of accountability has been proposed and utilized in an inpatient setting.[77]

[75] https://www.chcs.org/media/VBP-BH-Brief-061917.pdf

[76] https://mentalhealth.vermont.gov/reports-forms-and-manuals/reports/results-based-accountability

[77] Lin, E., & Durbin, J. (2008). Adapting the balanced scorecard for mental health and addictions: An inpatient example. Healthcare Policy, 3(4), e160.

RECOMMENDATION F: WORKFORCE

Summary of Finding F
Workforce shortages and turnover affect nearly all aspects of the current system and impact the capacity, quality, and accessibility of services.
Summary of Recommendation F
• Continue to work towards implementing an integrated system of care • Conduct turnover analysis within AHS departments that focus on the children's system of care (DCF-FSD, DMH, DAIL-DDSD) and implement strategies to reduce staff turnover • Continue to cultivate and expand partnerships with local universities and high schools to develop academic pipelines into the human services workforce

PCG recommends that AHS:

- **Continue to work towards implementing an integrated system of care.** One federal DHHS study of child welfare systems of care noted that caseworker job satisfaction showed a statistically significant increase[78] post-implementation. Job satisfaction was affected both directly by agency support for systems of care principles and indirectly through perceptions of a more positive organizational climate (*i.e.,* one where agency rules and regulations increasingly promoted effective service provision) and a more positive organizational culture (*i.e.,* one in which caseworkers felt more supported and motivated in their day-to-day environment), indicating that the implementation of a SOC could potentially contribute to reduced turnover, a chronic challenge that has been found to negatively affect safety and permanency outcomes for children and youth.
- **Conduct turnover analysis within AHS departments that focus on the children's system of care (DCF-FSD, DMH, DAIL-DDSD) and implement strategies to reduce staff turnover.** If not already in place, collect data on staff turnover for FY20 and survey staff to better understand reasons for turnover. Tailor appropriate strategies to reduce turnover and for reducing service disruptions. Depending on results, actionable options may include known best practices such as:
    - **Prioritize recruitment efforts.** Inventory Vermont's current human services workforce, including its size, number of positions filled on average, number of vacant position on average, required credentials per position, hourly rates and/or salaries, and composition of race and ethnicity of human services staff. Use this information to target recruitment of the most needed positions, build racial equity in the workforce and determine if rates or salaries need revision.
    - **Supporting staff with quality supervision.** Supervisors have a significant effect on retention of staff, both negatively and positively. The more satisfied an individual is with their supervisor and the kind of supervision they receive, the less likely the individual is to leave an organization. Quality supervision helps build a positive work environment where staff feel appreciated and safe, both physically and emotionally. This is especially important in the behavioral health field where many workers experience emotional trauma on the job or may struggle with their own mental health. Model examples include:
        - Michigan State University School of Social Work, Staff Retention in Child and Family Services, The Role of Leaders Workbook[79]

[78] https://www.casey.org/can-you-tell-us-about-a-few-agencies-that-have-systems-of-care/
[79] https://ncwwi.org/files/Supervision__Perf_Management/Workbook_1_Role_of_Leaders_6-07-07.pdf

- Fordham University, The Recruitment and Retention of Child Welfare Staff by Building Management Capacity Project[80]
- Workforce Recruitment and Retention in New England, Leadership Academy for Supervisors (LAS), University of Southern Maine[81]
- National Child Welfare Workforce Institute, A National Qualitative Analysis of Child Welfare Recruitment and Retention Efforts, Turnover Intention Predictors[82]
- Annie E Casey Foundation, 5 Steps to a Stronger Child Welfare Workforce, Hiring and Retaining the Right People on the Frontline[83]

- **Ongoing education, training, and professional development opportunities.** Training increases staff confidence in their ability to provide quality services, shows that an organization is invested in the development of their staff and helps to increase staff commitment to the organization. Training also helps staff achieve core competencies key to their professional advancement. Using competency-based models to determine success helps staff visualize their upward mobility and gives them concrete goals to earn promotion. Model examples include:
  - Institute for the Advancement of Social Work Research, Factors Influencing Retention of Child Welfare Staff: A Systemic Review of Research[84]
  - Behavioral Health Education Center of Nebraska in the University of Nebraska Medical Center[85]
  - Academy for Professional Excellence Child Welfare Social Worker Recruitment and Retention: Influential Factors and Promising Practices- Review of the Research[86]
  - Nevada, Douglas County Counseling and Supportive Services Recruitment and Retention Plan[87]
- **Flexible and innovative work arrangements.** Flexible schedules benefit both employers and employees. Alternative work hours increase morale and capacity for self-care along with improved engagement and commitment to the organization. Flexible scheduling helps reduces employee turnover, absenteeism, and tardiness by allowing workers to arrange hours around home and family obligations. Advertising these options and other benefits help attract and retain new staff. This is increasingly important during and post-COVID-19 era. Model examples include:
  - Child Welfare Staff Engagement and Retention in Washington DC, Alternative Work Schedules, Telecommuting and Other Supports[88]

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80 https://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=83&articleID=1337&keywords=fordham
81 www.cwti.org/RR
82 https://ncwwi.org/files/Retention/Kim__Kao_2015.pdf
83 https://www.aecf.org/m/resourcedoc/aecf-fivestepstoastrongerchildwelfare-2018.pdf
84 https://ncwwi.org/files/Retention/Factors_in fluencing_retention_of_CW_staff.pdf
85 https://www.unmc.edu/bhecn/about/index.html
86 *https://ncwwi.org/files/Recruitment_Screening_Selection/CW_Social_Worker_Recruitment_and_Retention.pdf*
87 https://www.aecf.org/m/resourcedoc/aecf-fivestepstoastrongerchildwelfare-2018.pdf
88 https://ncwwi.org/files/CW_Staff_Engagement__Retention_1-pager.pdf

- National Child Welfare Workforce Institute, Cornerstone, Tips for Recruiting a Post-Boomer Workforce[89]

- **Realistic job interviews.** Review hiring practices to understand if employers communicate realistic expectations for the job and if new hires fully comprehend their roles. Consider implementing or emphasizing realistic interview protocols and screening applicants for "fit." The hiring processes requires precious resources, so it is important to hire staff that are the best fit. Standardizing desirable qualities and core competencies help employers in their search to fill vacancies. Applicants need clear information and realistic job expectations at the time of application and again after they are hired. Carefully crafted hiring protocols aid in employee retention. Other state models include:

  - The Child and Family Practice Model (CFPM) Recruitment and Selection Best Practices[90]
  - Michigan State University School of Social Work Recruiting and Selecting the Right Staff[91]
  - Institute for Families UNC-Chapel Hill School of Social Work: Child Welfare Staff Recruitment & Retention an Evidence-Based Training Model[92]
  - Workforce Recruitment and Retention in New England, University of Southern Maine (USM)[93]
  - Nevada, Douglas County Counseling and Supportive Services Recruitment and Retention Plan[94]

- **Continue to cultivate and expand partnerships with local universities and high schools to develop academic pipelines into the human services workforce.** Inventory education reimbursement programs currently or previously offered in Vermont, such as student loan forgiveness, and consider scaling them up to incentivize workforce retention.

  - Ongoing and previous state efforts include:

    - The Center on Disability and Community Inclusion at University of Vermont is working on building a curriculum with DAIL to identify the core skills that are necessary to support individuals with developmental delays.
    - Current Title IV-E allocated funding for education and training to support the social work education of current and future DCF employees, made possible through a contract between DCF and the University of Vermont (UVM) Department of Social Work.[95]
    - Legislative funding allocated for tuition reimbursement and loan repayment in the amount of $1.5M is currently being worked on by DMH and VDH-ADAP as this funding is for increasing retention and workforce education for mental health and substance use staff in DAs and SSAs.

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[89] https://ncwwi.org/files/Recruitment_Screening_Selection/Tips_for_Recruiting_a_Post-boomer_Workforce.pdf
[90] https://ncwwi.org/files/Recruitment_Screening_Selection/CFPM_Recruitment-Selection_Best_Practices.pdf
[91] *https://ncwwi.org/files/Recruitment_Screening_Selection/Staff_Retention_in_Child_and_Family_Services.pdf*
[92] https://ncwwi.org/files/Recruitment_Screening_Selection/Recruitment_Toolkit.pdf
[93] www.cwti.org/RR
[94] http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/PCO/Douglas_County_MHRR_Plan_FINAL%2012-18-13.pdf
[95] https://www.uvm.edu/sites/default/files/media/2018-2019_Program_bulletin_3.pdf

- DMH funding for assisting DA staff with doing graduate work in counseling. This funding has since been cut.
- Pilot program with Johnson State College that partnered with DAs to create paid undergraduate internships. This created opportunities to be hired at the DAs upon graduation, forming a workforce pipeline in community mental health. This pilot program was not able to continue due to budget cuts.

- Some other state strategies are explored in the following:
  - Michigan State University, School for Public Behavioral Health Workforce Research Center, The Behavioral Health Workforce in Rural America: Developing a National Recruitment Strategy[96]
  - University of Iowa developed and implemented a child welfare specialization for B.S.W and M.S.W. students at the university[97]
  - University of Southern Maine three-credit M.S.W. course for leaders on workforce development[98]
  - University of Colorado's Eugene S. Farley, Jr. Health Policy Center in partnership with the Oregon Health Authority[99]
  - Montana Area Health Education Center[100]

[96] http://www.behavioralhealthworkforce.org/wp-content/uploads/2020/02/Recruitment-and-Retention-of-BH-Providers-Full-Report-2.2020.pdf
[97] www.uiowa.edu/~nrcfcp/training/recruitment.shtml
[98] www.cwti.org/RR
[99] https://www.oregon.gov/oha/HPA/HP-HCW/Documents/Recruitment-Retention-Recs-%20Oregon-BH%20Workforce-April-2019.pdf
[100] http://www.scmtahec.org/post-secondary/nhsc-information/

V. ACTION PLAN

The table below outlines a broad, five-year action plan beginning in fiscal year 2021 and is designed to:

- increase community-based supports and services (wraparound supports for children in their biological or foster home, mobile response, therapeutic foster homes);
- increase the ability for families to care for their children while they receive the necessary therapeutic treatment;
- provide necessary treatment in family like settings, thus decreasing the need to receive that treatment within a residential setting; and
- ensure youth only reside within residential settings when treatment provided is necessary and prescribed and only for the duration of that need.

Ultimately, PCG recommends that Vermont work towards fully implementing Recommendation A, a "single point of entry" system with one lead entity or regional hubs. The exact form the system takes depends on what is right for Vermont and will take into consideration best practices from state models outlined, available resources, and stakeholder input. While Vermont builds towards this level of systemic change, PCG recommends that AHS take intermediate actions, described below.[101]

The Action Plan below is broken into four stages, where each stage indicates how soon AHS may start action on each item. Stage 1 suggests that AHS begin work on items within 1-6 months, while Stage 2 suggests a 7-12 month timeline, Stage 3 suggests a 13-18 month timeline and Stage 4 suggests a 19-24 month timeline. Action items are a short description of the full recommendations described above and are abridged for easier reference. For full descriptions, please refer to the associated recommendations sections indicated by each letter in the first column. For example, in Stage 1, PCG recommends collecting data on race and ethnicity. For a full description of that recommendation, please refer to the Recommendation C: Data Collection. Within each stage, action items are grouped by letter, indicating the order in which PCG recommends AHS begin work on action items. For example, in Stage 1, there are three action items labeled 1A, indicating that they can be pursued simultaneously. The tables also indicate whether the action item is considered priority or support to the overall goal of AHS implementing Recommendation A. Lastly, Tables 19-22 show whether the action's expected timeline to completion is short-term at 1-2 years or long-term at 3-5 years.

STAGE 1

Work begins in 1-6 months.

TABLE 18. STAGE 1 OF ACTION PLAN

Recommendation Category	Action Item Summary	Stage	Priority or Support	Completion Timeframe
Data Collection (C)	Collect data on race and ethnicity*	1A	Priority	1-2 Years
Service Quality (E)	Increase communications between youth in residential and LEAs*	1A	Priority	1-2 Years

[101] For further details on specific targeted investment approaches by region and population that may be useful during implementation, please refer to the Resource Allocations Recommendations section within the Quantitative Data Analysis in Section III.

Recommendation Category	Action Item Summary	Stage	Priority or Support	Completion Timeframe
Family Empowerment (D)	Include family voices in the service planning process consistently and measure family satisfaction at regular intervals	1A	Priority	3-5 Years
Service Quality (E)	Bolster early intervention, emergency support, crisis care, and crisis management capacity	1B	Priority	1-2 Years
Funding (B)	Examine the rate methodology for residential placements to allow for more flexible funding to stabilize the provider pool	1C	Priority	1-2 Years
Family Empowerment (D)	Conduct rate study of foster payments from DCF-FSD	1C	Priority	1-2 Years
Funding (B)	Examine the payment structure for children's services (IFS, Payment Reform, Medicaid, private insurance parity, etc.)	1C	Priority	1-2 Years
Family Empowerment (D)	Create budgetary flexibility to reinvest savings into preventative services	1D	Priority	3-5 Years
Funding (B)	Align the rates for residential care to the Qualified Residential Treatment Program (QRTP) requirements and other requirements for specialized settings under the Family First Preservation Services Act**	1E	Priority	1-2 Years
Service Quality (E)	Align residential models to QRTP, revise contracts, monitor contract performance**	1E	Priority	1-2 Years

**These two action items may be started and completed immediately and would be quick wins.*

*** Depending on Vermont's approach to Family First implementation, these two recommendations may be moved to a subsequent stage or eliminated.*

STAGE 2

Work begins in 7-12 months.

TABLE 19. STAGE 2 OF ACTION PLAN

Recommendation Category	Action Item Summary	Stage	Priority or Support	Completion Timeframe
Data Collection (C)	Conduct interdepartmental data summit, data feasibility	2A	Priority	1-2 Years
Data Collection (C)	Collect data on how state and federal funding is spent at the program and individual department level	2A	Priority	1-2 Years
Service Quality (E)	Conduct statewide EBP survey, considering what is in use and if they should be scaled up	2A	Priority	1-2 Years
Service Quality (E)	Amend policy to require and fund transportation for residential visits for all departments to children in placement every 30 days	2B	Priority	1-2 Years
Service Quality (E)	Encourage transition planning to begin earlier	2B	Priority	1-2 Years

Recommendation Category	Action Item Summary	Stage	Priority or Support	Completion Timeframe
Family Empowerment (D)	Focus on support and engagement of adoptive parents	2C	Priority	1-2 Years
Family Empowerment (D)	Expand support networks to empower families and communities to care for children (fictive kin, peer networks)	2C	Priority	1-2 Years
Family Empowerment (D)	Continue/strengthen family voices in planning care for their child	2D	Priority	1-2 Years
Service Quality (E)	Inventory expected inputs, processes, outputs, and outcomes to align performance standards to the results-based accountability framework in Vermont's Act 186.	2E	Priority	1-2 Years

STAGE 3

Work begins in 13-18 months.

TABLE 20. STAGE 3 OF ACTION PLAN

Recommendation Category	Action Item Summary	Stage	Priority or Support	Completion Timeframe
Data Collection (C)	Invest in central data collection system	3A	Priority	3-5 Years
Family Empowerment (D)	Prioritize investments in current efforts (EBPs, IFBS, permanency roundtables, diligent recruitment, TFC, funding for family visits, etc.)	3B	Support	1-2 Years
Service Quality (E)	Implement performance-based contracting for all service providers	3C	Support	3-5 Years
Workforce (F)	Continue to cultivate partnerships with local universities and high schools to build pipeline into human services workforce	3D	Support	3-5 Years
Service Quality (E)	Expand QA to include CQI in DAs and in DCF-FSD RLSI	3F	Support	3-5 Years
Workforce (F)	Conduct staff turnover analysis of direct care staff for children's residential system of care AHS-wide	3G	Support	1-2 Years

STAGE 4

Work begins in 19-24 months.

TABLE 21. STAGE 4 OF ACTION PLAN

Recommendation Category	Action Item Summary	Stage	Priority or Support	Completion Timeframe
Service Quality (E)	Take inventory of DMH Intensive Service Coordinator positions in the state, examine best practices, and consider	4A	Support	3-5 Years

Recommendation Category	Action Item Summary	Stage	Priority or Support	Completion Timeframe
	adding the position to regions where needed			
Family Empowerment (D)	Create system for volunteer community efforts to provide support services	4B	Support	3-5 Years
Data Collection (C)	Invest in dashboard platform	4C	Support	3-5 Years
Data Collection (C)	Standardize geographic service areas	4D	Support	3-5 Years

VI. ACKNOWLEDGEMENTS

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VII. APPENDICES

APPENDIX A: DOCUMENT REVIEW CATALOG

	Document Name
1	10K In-State Residential Qualified Residential Treatment Program (QRTP) Analysis
2	Child Protection in Vermont Report, 2018
3	Residential Payment Summary for Fiscal Year 2019 and Half of Fiscal Year 2020
4	Case Review Committee Guidelines
5	Memorandum of Understanding between Department of Disabilities, Aging and Independent Living (DAIL), Developmental Disabilities Service Division (DDSD), Department of Children and Families (DCF) Family Services Division (FSD)
6	Department of Children and Families Policy number 97, Case Review Committee Referrals Policy
7	Vermont Diligent Recruitment Plan
8	Family Services Division Residential Placements Chart
9	AHS and AOE Coordinated Service Plan, 2019
10	FSD Contract and Grant Inventory
11	Legislative Report on the Use of Out-of-State and In-State Residential Placements, including Woodside, 2017
12	Payment Reform for Human Services: Looking at Money Differently, 2015
13	Regional and State Residential Data FY 2020 Quarters 1, 2, 3
14	Agency-Wide Analysis: Residential System of Care for Children & Youth in Vermont, 2019
15	Vermont System of Care Report, 2020
16	Parents of Children in Residential Treatment Survey Results for Turn the Curve Project
17	Turning the Curve Residential Placements for Children and Youth in Vermont, 2015
18	Department of Children and Families Family First Prevention Services Act (FFPSA) Presentation
19	The Need for Mobile Response and Stabilization Services (MRSS) in Vermont: From Reactive to Responsive, 2020
20	State of Vermont DCF FSD Consultation Report Woodside De-Escalation and Restraint System Consultation Service, 2019
21	Various contracts between AHS Departments and contracted entities
22	Residential Treatment Programming Licensing Reports, 2018-2020
23	Developmental Disabilities Services Division System of Care Plan, 2017-2021
24	Changes to the Developmental Disabilities Services System of Care Plan, 2017
25	Regulations Implementing the Developmental Disabilities Act of 1996, Effective, October 1, 2017

APPENDIX B: QUANTITATIVE DATA ANALYSIS CATEGORIES AND DEFINITIONS

The data set 'Consultant CRC_Spreadsheet' was provided to PCG as a baseline for understanding the profile of children in residential care. The data contained information for every child whose case was reviewed by the CRC from 2016 through the first half of 2020. PCG analyzed the data set using categories shown in the table below.

Data Categories Used for PCG Analysis

#	Data Category	Definition	Format or Options
1	Age Category at Time of Admission or Referral	Age group	0-5, 6-10, 11-13, 14-17, 18+
2	Home Designated Agency or DCF District Office	Location where case originated	One of 10 Designated Agencies (DA) or 12 District Office (DO) locations[102]
3	Identifier	Unique number to identify each child	Five-digit identifier, XXXXX
4	Fiscal Year	Fiscal year CRC examined the case	YYYY
5	Referred By	Department that referred the case	DMH, DCF, DCF/DMH[103]
6	Gender	Gender of child	Female, Female-Male, Male, Male-Female
7	Self-Harm	A spectrum of behaviors where demonstrable injury is self-inflicted.	Yes or No
8	Suicidality	Thoughts about or an unusual preoccupation with suicide. Suicides attempt- a non-fatal self-directed potentially injurious behavior with any intent to die because of the behavior.	Suicidal Ideation, Suicide Attempt, Both, N/A
9	Sexual Behavior Problem	Sexually reactive behaviors include children and adolescents who have been exposed to, or had direct contact with, inappropriate sexual activities, sexual behaviors, or relationships, and have then begun to engage in or initiate sexual or sexualized behaviors, activities, interactions, or relationships that include excessive sexual play, inappropriate sexual comments or gestures, mutual sexual activity with others, or sexual molestation and abuse of other children.	Sexually Harmful Behaviors, Sexually Reactive, N/A

[102] DAs are contracted providers through DMH, while DOs are DCF regional office locations.
[103] Note that DAIL data was removed by AHS due to DAIL's total being less than 11 cases total for 2016-2020.

#	Data Category	Definition	Format or Options
10	Risky Sexual Behavior	High-risk sexual activity includes any behavior that would cause participants emotional or physical harm. High-risk sexual activities include unprotected sex, sex before the legal age of consent, and multiple sex partners. These activities put youth at risk for teen pregnancy, sexually transmitted diseases, and, for adolescent girls, early sexual activity may cause depression	High Risk Sexual Behaviors, Human Trafficking, N/A
11	Developmental Disability	Evidence of developmental disability. For example, Intellectual Disability, is Significantly sub-average cognitive functioning documented by a full-scale score of 70 or below on an appropriate standardized test of intelligence and resulting in substantial deficits in adaptive functioning 1) IQ testing is required. 2) Substantial deficits in adaptive behavior which occurred before age 18.	Assessment needed, Intellectual Disability, Autism Spectrum Disorder, Borderline Functional Impairment, Borderline Intellectual Disability, Both, N/A
12	Conduct with Aggression	Same as Conduct without Aggression including Aggression to people and animals - bullying, threatening, intimidating, fighting, cruelty to people and animals, use of a weapon and theft while confronting a victim.	Yes or No
13	Conduct without Aggression	Repetitive and persistent pattern of behaviors that violate societal norms and the rights of other people, behavior that causes property loss or damage, deceitfulness or theft, and serious violations of rules. may also exhibit oppositional behavior and peer relationship problems.	Yes or No
14	Custody	Type of custody	Adopted, Birth Parent(s), DCF, DCF (Adopted), DCF (Freed 4 Adopt), Guardianship
15	Special Circumstances	Evidence of special circumstances	Eating Disorder, Homeless, LGBTQ, Medical, Substance Use, Other, N/A
16	Prior Residential Placement	Only include placements that are licensed residential programs, not foster care. This does include "micro-residential" or "staffed homes"	Yes or No

#	Data Category	Definition	Format or Options
17	In-State Option Available	Available in-state options available for the child	Yes or No
18	Fire Setting	A disorder of impulse control which is characterized by a pattern of fire setting for pleasure, gratification, or relief of tension. Has deliberately engaged in fire setting with the intention of causing serious damage	Yes or No
19	Reason for Referral	Reason for referring the child into residential	Assessment, Long Term Treatment
20	Admission Date	Date the child was admitted to facility	MM/DD/YY
21	Facility Admitted To	Name and location of residential facility to distinguish in-state, in-region, and out-of-region placements.	Name of facility and associated state
22	Length of stay based on discharge	How long the child stayed in residential care, reported at the time of discharge from service	Number of days
23	Region	All DA locations standardized to DO regions	One of 12 DO regions

APPENDIX C: DISTRICT OFFICE REGIONS AND VERMONT COUNTY CROSSWALK

In the data set, a child's location of origin was listed either by DMH Designated Agency (DA) location or DCF-FSD District Office (DO) location. AHS standardized all DA origin locations to the corresponding local FSD District Office (DO). That way, all children could be uniformly identified by one geographic service area—their corresponding DO geographic service areas.

Each DO region was mapped to its corresponding county according to the headquarters' ZIP code, so that counties became the geographic proxy for each DO region. Because there are 14 counties and 12 DO locations, PCG worked with the AHS Steering Committee to match the two remaining counties to the appropriate DO catchment areas. As a result, Grand Isle County was combined with Franklin County to represent the St. Albans DO, and Essex County was split into upper and lower sections and combined with Orleans County and Caledonia Counties to represent the Newport and St. Johnsbury DOs, respectively. PCG was able to combine counties and parts of counties by breaking Vermont into every ZIP code and redrawing custom county boundaries to reflect these desired changes. Therefore, the viewer will see every zip code boundary in the state when viewing the Tableau dashboard.

DO Region	County
Barre	Washington
Bennington	Bennington
Brattleboro	Windham
Burlington	Chittenden
Hartford	Orange
Middlebury	Addison
Morrisville	Lamoille
Newport	Essex
	Orleans
Rutland	Rutland
Springfield	Windsor
St. Albans	Franklin
	Grand Isle
St. Johnsbury	Caledonia
	Essex

APPENDIX D: REGIONAL OUTLOOK CALCULATIONS

All measures in Table 14 above were standardized from their respective units into rankings of 1-12, and each region's rankings were used to generate a weighted score and Master Ranking. For example, in the "All Residential" category, measures were expressed in the unit of children per 10,000 population. Brattleboro had the highest rate of placement at 22 children per 10,000 and was therefore ranked 12th out of the 12 DCF-FSD regions. Each region was similarly ranked from 1-12 based on their totals relative to each other for rates of placement. This was repeated for every measure in Table 14, producing the table below. Once regions were ranked for each measure, meaning all units were standardized, a weighted average was calculated for each region. The rate of placement was given the largest weight of 50%, while the remaining measures were split equally. This means that the region's rate of placement of children into residential care was the largest factor in its score and therefore regional outlook. The weighted scores below then translated into a Master Ranking from 1 to 12 for each region.

Measure	Burlington	Middlebury	Springfield	Barre	Hartford	Morrisville	Rutland	St. Johnsbury	Newport	Bennington	St. Albans	Brattleboro	Weight
All Residential	2	4	1	5	3	6	8	7	9	10	11	12	50%
13 & Under	5	3	12	2	9	1	4	8	6	7	10	11	10%
High Utilizer	3	2	11	1	10	8	4	5	9	6	12	7	10%
Placed Out of Region	9	4	3	8	1	5	10	7	6	2	12	11	10%
Average Utilization	2	3	4	1	9	5	6	12	8	11	10	7	10%
Average Length of Stay	1	7	8	9	12	11	3	6	4	2	5	10	10%
Weighted Score	3	3.9	4.3	4.6	5.6	6	6.7	7.3	7.800	7.800	10.4	10.6	
Master Ranking	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	

APPENDIX E: ADDITIONAL SYSTEM OF CARE EXAMPLES

New Jersey implemented regional Care Management Organizations (CMO) as part of their children's behavioral health system of care transformation. Their system is accessed through a single statewide Contracted System Administrator (CSA), which performs the initial assessment, triage, and referral to services, including referrals to CMOs for children with moderate to complex needs. The CMOs provide care coordination and wraparound care planning for children and their families and are responsible for facilitating access to a full range of treatment and support services. They facilitate and work within child-family teams to develop individualized plans of care based on assessment. Through this model New Jersey has significantly reduced the number of children in behavioral health out of home placements and children placed out-of-state (from more than 300 to less than 5), although it is important to note that the CMOs are only one aspect of the system of care enhancements leading to improved outcomes. New Jersey has also leveraged federal System of Care grants from SAMHSA to fund infrastructure changes to its children's system of care.

Louisiana's Coordinated System of Care (CSoC) was created in 2010 and targets youth with significant behavioral issues and co-occurring disorders who are at risk of out of home placement. It offers an array of Medicaid State Plan and Home and Community-based waiver services (HCBS). Its goals are to 1) reduce residential treatment placements; 2) leverage Medicaid and other funding; 3) increase access for youth and families to a full range of community-based services; and 4) improve outcomes for youth served.

Clinical eligibility for services includes ages 5–20, a minimum score on the Child and Adolescent Needs Assessment tool (CANS), involvement in two or more child serving systems and the youth must be at risk for placement in a residential, inpatient hospital, group or foster home. Financially, youth must be Medicaid eligible.

Similar to Wraparound Milwaukee, the Department of Human Services contracts with a Pre-Paid Inpatient Health Plan referred to as the CSoC Contractor to coordinate, administer and manage the System of Care throughout Louisiana. Magellan HealthCare currently serves in that capacity. Magellan conducts the screening for eligibility across the state regions using the CANS screening tool and the face-to-face Independent Behavioral Health Assessment. It then contracts with nine or more community agencies to provide care coordination services for youth screening positive for serious behavioral health needs using the CSoC wraparound approach and model. Besides the contracts with the agencies providing wraparound care coordination, youth and families are also served by statewide Family Support Organizations (FSO) who provide a peer or family peer specialist for all enrolled families.

Besides the currently available state plan services, Louisiana created four specialized services. These include: 1) Parent Support and Training; 2) Youth support and Training; 3) Independent Living/Skill building; and 4) Short-Term Respite Services.

The newest system of care (SOC), in **New Hampshire**, was just recently enacted through SB14 on June 4, 2019. The legislation enhances the state's home and community-based service system and reduces their reliance on more expensive residential and inpatient treatment. The creation of their SOC follows the recommendations in the Adequacy and Enhancement Study of their Child Welfare and Behavioral Services conducted in 2018 by PCG and the Alliance for Families.

SB14 expands mobile crisis and stabilization services across the state and calls for the creation of home and community-based services that are family driven, youth guided, community-based and trauma informed. It models off Wraparound Milwaukee and New Jersey in creating at least one care management entity across the state to "oversee and coordinate the care for children with complex behavioral needs who are at risk for residential, hospital or corrections placement or involved in multiple child serving systems." Beginning Jan. 1, 2020, the care management entity shall coordinate the behavioral services in no less than 25% of cases involving referrals for residential treatment. In 2021 that increases to 50% of such referrals and in 2022 that coordination rises to 75% of the referrals for residential treatment.

The Act requires The Department of Health and Human Services to create and maintain a web-based informational clearinghouse for families seeking information regarding children's behavioral health services.

This is like the Wraparound Milwaukee Resource Center, a web-based system application that families can access and create a request by need, service type and location. The computer program then matches them to a provider with that service.

The Act creates an ongoing System of Care Advisory Committee with specific roles and responsibilities. The Department also establishes a Medicaid Home and Community-Based Behavioral Health Services Program for children with SED through a state plan amendment as provided under the 1915i provisions of the Social Security Act. No specific waiver is required with the 1915i. Newly created Services beyond those already covered in the NH state plan include wraparound care coordination, in-home and out of home respite, family, and youth peer support. At least 10% of state funds utilized must be used for evidence-based services for 2020 and that increases to 40% by 2022.