Report to
The Vermont Legislature

Report on

The Use of Out of-State and In-State Residential Placements, including Woodside

In Accordance with [Act 85 Section E. 317/2017]

Submitted to: The report shall also be provided to the House Committees on Appropriations, on Judiciary, on Human Services, and on Corrections and Institutions and to the Senate Committees on Appropriations, on Judiciary, on Health and Welfare, and on Institutions.

Submitted by: **Ken Schatz, Commissioner**
Department for Children and Families

Prepared by: **The Turn the Curve Advisory Committee**

Report Date: **Thursday, November 9, 2017**

VERMONT
AGENCY OF HUMAN SERVICES
Department for Children and Families

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I. Introduction

This report is submitted in response to the following 2017 legislative session request:

At the November 2017 scheduled meeting of the Joint Justice Oversight Committee, the Commissioner for Children and Families with the assistance of the Departments of Mental Health, and of Disabilities, Aging and Independent Living, and the Agency of Education shall present a report on the use of out of-state and in-state residential placements, including Woodside. The report shall include the following:

(1) Utilization for fiscal years 2015, 2016, and 2017 including the number and age of children placed by facility and the total bed days utilized.

(2) For each facility, the average daily costs for specific levels of service or treatment acuity in fiscal years 2015, 2016, and 2017 and the total amount paid to each facility by department and by funding source in fiscal years 2015, 2016 and 2017.

(3) Measures used by the Department to determine outcomes for the children placed in these facilities and the cost effectiveness of these facilities, including length of stay, intensity of services provided, reunification of children with their family or home community, or both, relapse or readmittance rates, or subsequent involvement with the criminal justice system or both.

(4) The specific steps taken over the past three years by the Departments and the Agency to increase community-based supports for youths in custody while reducing use of residential care.

Please note: Information related to the Woodside Juvenile Rehabilitation Center will be included in the Facilities Report as directed by Act 84.

Background

Since 1990, KIDS COUNT (Annie E. Casey Foundation) has ranked states annually on overall child well-being, using an index of key indicators. The KIDS COUNT index uses four domains to capture what children need most to thrive: (1) Economic Well-Being, (2) Education, (3) Health and (4) Family and Community. Each domain includes four indicators, for a total of 16. These indicators represent the best available data to measure the status of child well-being at the state and national levels.

For 2017, Vermont ranked number three of all states for overall child well-being and number one for family and community, which is described as children who live in nurturing families and are part of supportive communities. Despite these encouraging findings we also know there are children and youth who are unable to safely live at home. The Agency of Human Services (AHS) and its partner agencies are committed to increasing supports and services in the community to ensure all children/youth can be in family-like settings whenever possible and to support families in parenting their children.

In June 2015, the Agency of Human Services held a dialogue to discuss the increased concern about the number of children and youth in residential placements. During this meeting, the group reviewed the trend lines for residential placements, looked at the current system of care in Vermont and held small group discussions to understand opportunities to turn the curve by addressing the issue at all levels in the system of care. This report and the work being undertaken by AHS is focused on children in the custody of the Department for Children and Families (DCF) and those children placed in residential care by the Department of Mental Health (DMH) and the Department of Aging and Independent Living.

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: our trend lines for residential and out-of-state residential are going in the wrong direction.
3. There is commitment to create more community-based treatment options.

Since that meeting, an AHS and Agency of Education (AOE) interagency team was created to move forward with the goal of increasing the number of children, youth and families served in community settings by transferring resources from residential settings and investing in local regions. This interagency team (Turn the Curve Advisory Team) is comprised of staff from the Department for Children and Families, the Department of Mental Health, the Department of Aging and Independent Living, and the Agency of Education. The list of members is in Appendix A.

To embark on this work, the Turn the Curve Advisory Team obtained consultation from Casey Family Programs and reviewed research about the use of residential care. One such document was the Elements of Effective Practice for Children and Youth Served by Therapeutic Residential Care (March 2016) which speaks to the importance of residential treatment with the "right size" lengths of stay, involving family members more extensively in treatment, helping youth learn skills for managing their emotions and behaviors that they can use in the community, and conducting more extensive evaluation studies. The Turn the Curve Interagency Team has been looking at the number of children/youth in residential care and the lengths of stay they are there.

Context for the use of out of-state and in-state residential placements

There has been a significant decrease (302 to 161) in the number of licensed residential beds available to children/youth in Vermont since 2010. This is due to many factors (financial difficulties of programs, closure of programs) and has impacted the ability to serve children/youth in Vermont. It is also important to note that for some children/youth they need specialized treatment that is not available in Vermont, so they are placed in the most appropriate clinical setting out of state. In addition, from 2016 to 2017 there has been a decrease in the number of days children/youth are at residential programs and the number of children who have accessed this higher level of care.

As the data demonstrates, Vermont uses in-state and out-of-state placements for youth needing residential care. This comes with advantages and disadvantages for youth, their families, and the system of care. Regardless of where the child is placed, their care is monitored by the AHS placing department and the respective state licensing entity. Vermont's size itself creates challenges for setting up additional in-state programs. Vermont does not always have enough youth with the same presenting issues to achieve an economy of scale to sustain programming. It is not practical to build a treatment program without a sustainable population as staffing a program for one or two youth is very expensive.

There are times that an out-of-state program is closer for a family than a similar program in Vermont. For example, a program in New Hampshire is closer to families in Northern Vermont than a similar program in Bennington, Vermont. And, for many of those youth, the proximity of the out-of-state program is relatively close to their family, community, step-down services and other supports. This means less travel for their DCF Family Services social worker (assigned when a child is in DCF custody) and it facilitates more involvement from a youth's support system with discharge planning. The child/youth's clinical needs, distance from home community and family needs are all determining factors in identifying the most appropriate residential placement.

Placing children in out-of-state placements also comes with challenges. More New England states are competing for the same beds. The impact is some youth with specialized treatment needs may have to be placed out of region (beyond New England). For example, New Hampshire is sending girls with high-end mental health needs to Missouri. Also, Vermont does not pay for unoccupied beds to secure spots for Vermont children, whereas a few other states do. Finally, the Departments are aware that other New England states who had system efforts focused on reducing residential use are now seeing an increase is residential placements again. Therefore, the Departments are interested in continuing to gain insights from the lessons learned in these other states to apply to our efforts.

II. Utilization for fiscal years 2015, 2016, and 2017 including the number and age of children placed by facility and the total bed days utilized.

It is important to note this report is only focused on children/youth placed in residential facilities by the Departments for Children and Families (DCF), Mental Health (DMH), or Disabilities, Aging and Independent Living (DAIL). When a child/youth is placed by one of these Departments, the Agency of Education is responsible for the educational costs. This report does *not* include information about children & youth placed in residential facilities through Local Education Agencies (LEAs) as they have their own residential educational placement process separate from AHS.

Due to the relatively small numbers of placements in some settings and by some Departments leading to a concern that the information in this report could be potentially identifiable of the children and youth, only the licensed age range for each program is reported rather than the specific ages of the youth in placement. Please see Appendix B for the detailed table of programs, gender, age range, location and utilization by fiscal year.

Below are figures of the aggregate utilization over the requested fiscal years (FY2015, FY2016 and FY2017).

Residential Data for Legislative Report 2017

The following charts represents the *total bed days* (Figure 1) and *total number of children placed in residential* (Figure 2) by State fiscal year. Total Bed Days is the total number of days a child/youth stays overnight in a residential program. For the Total Bed Days chart, children who were placed in more than one program during the fiscal year are represented more than once so that all bed days are calculated. For the Total Child Count in Residential by State fiscal year, the number of children is unduplicated within the fiscal year, such that if a child was placed in more than one residential program during the fiscal year, the child is only counted once.

Figure 1

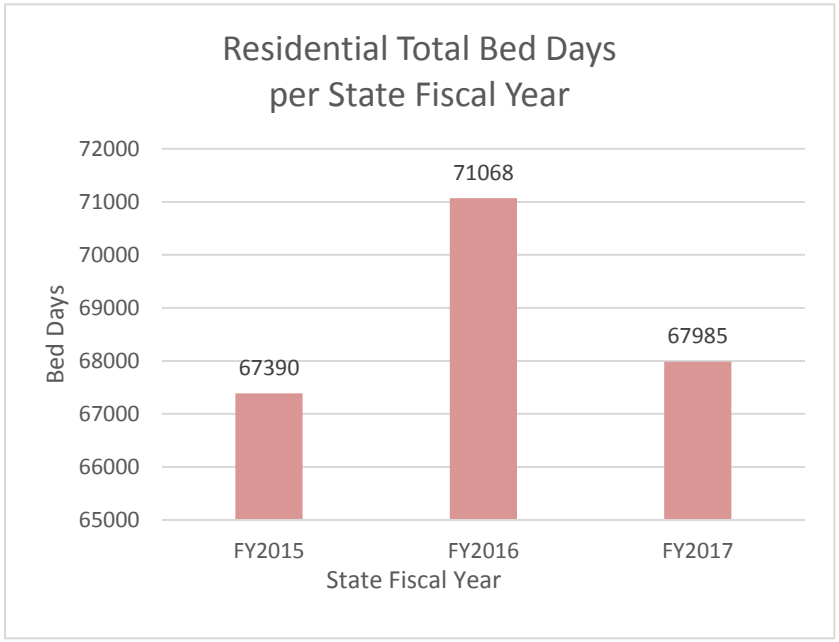
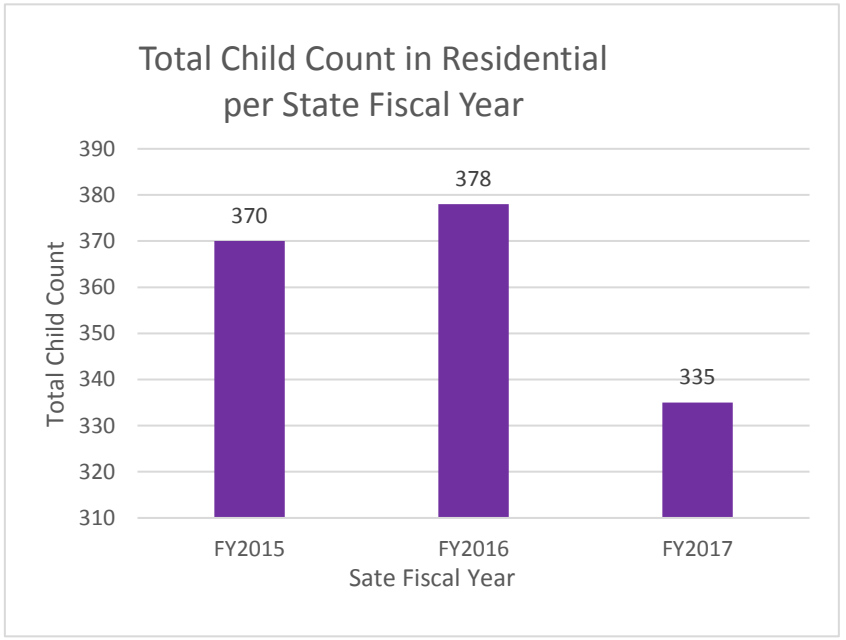


Figure 2



The following charts (Figures 3-4) are duplicates of the previous two charts, broken down by funding department. As noted previously, if a child is state-placed by an AHS department in a residential program which has an affiliated school, the Agency of Education is responsible for the education costs. The charts below represent the primary placing department. If a child changed custody status within a fiscal year (i.e. child in DCF custody returned to parent's custody but remained in residential program), the child is counted under both Departments in the Total Child Count chart; the actual bed days are attributed to the respective department in Total Residential Bed Days. Due to the low number of placements by DAIL not visibly standing out in the chart, the numbers are presented in the table below the chart.

Figure 3

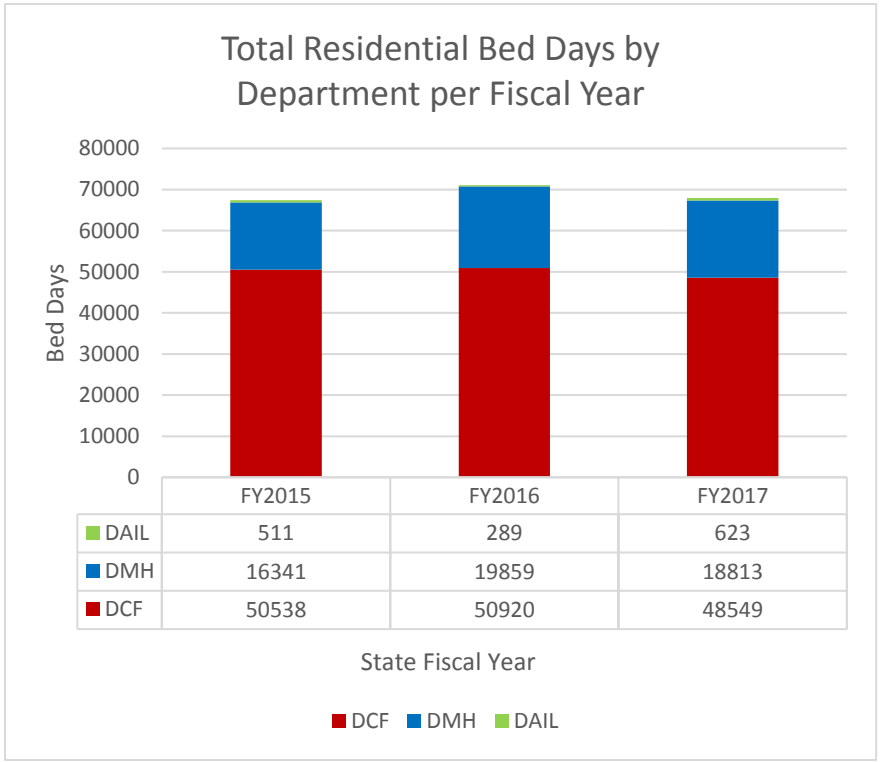
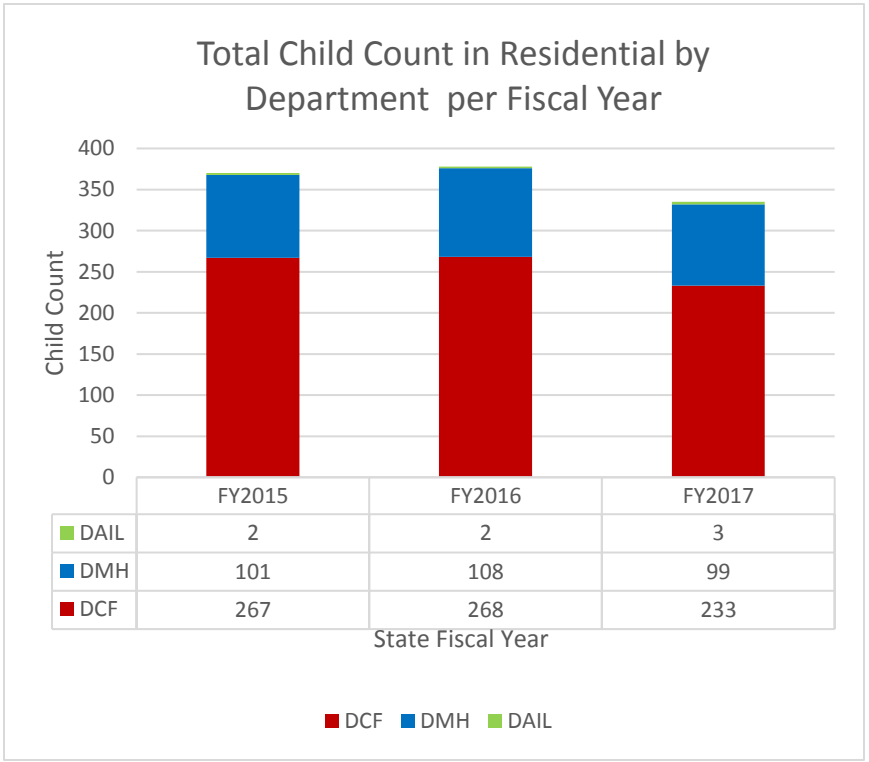


Figure 4



The following pie charts (Figures 5-7) represent the breakdown of in-state placements compared to out-of-state placements by fiscal year. If a child was placed in more than one program in a fiscal year, they are represented more than once.

Figure 5

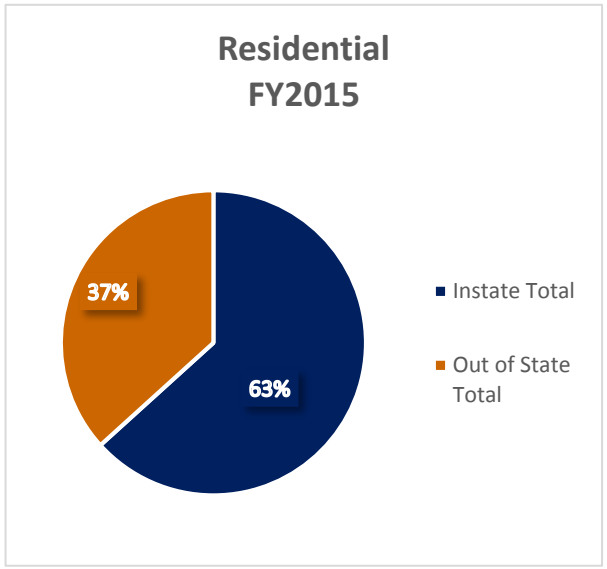


Figure 6

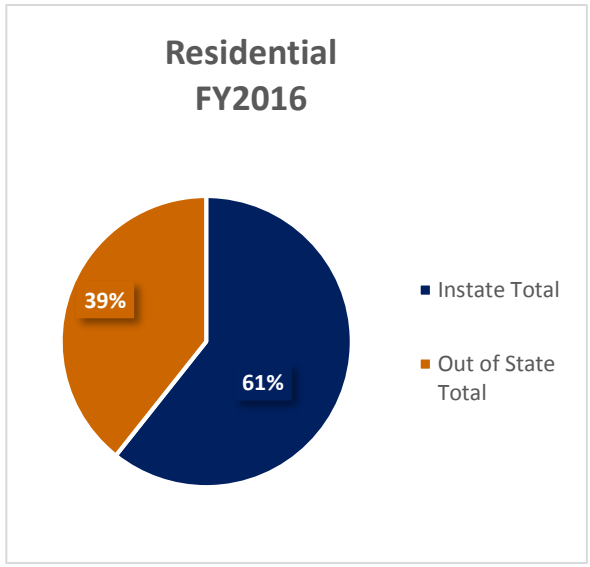
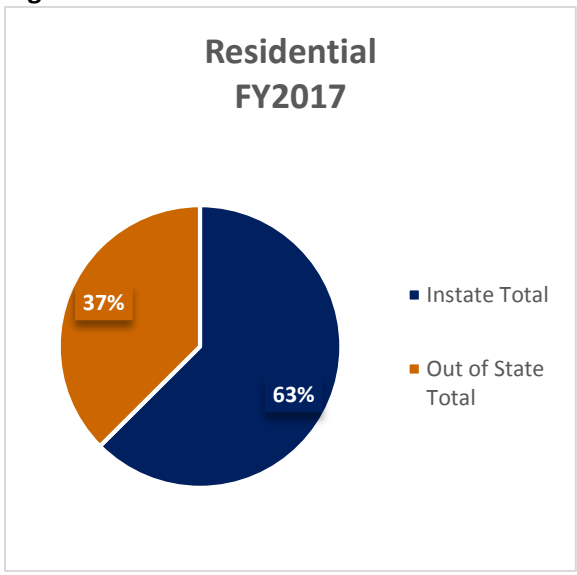
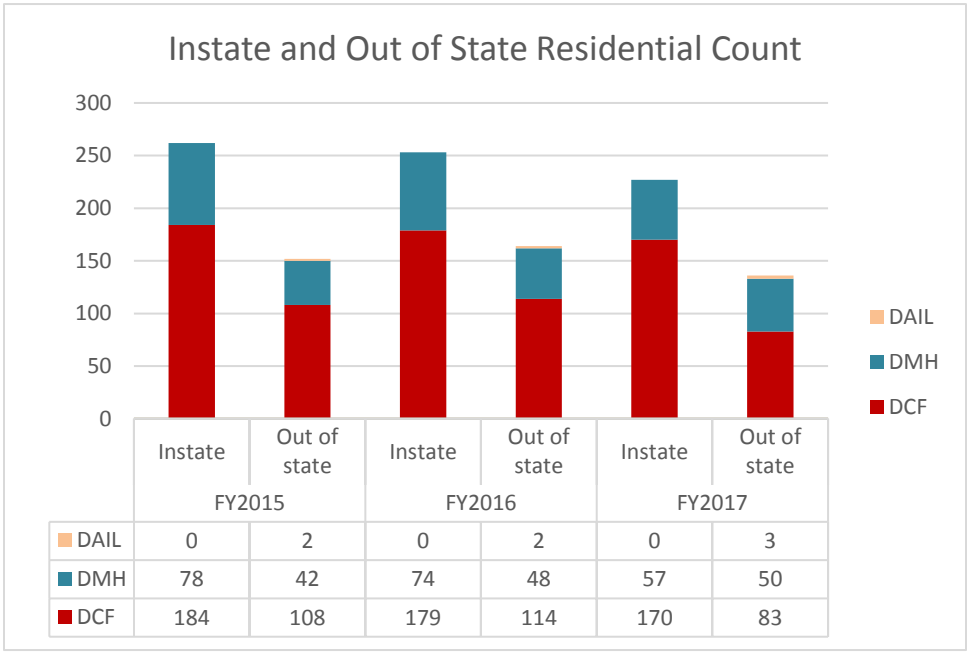


Figure 7



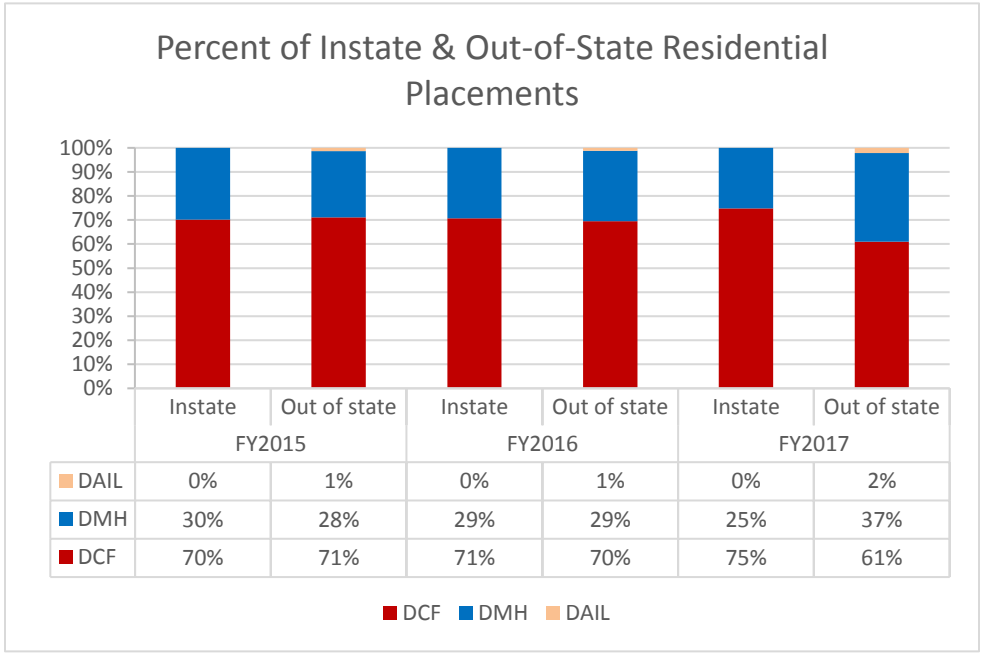
The following charts represent the *total number* and *percent of placements in-state and out-of-state* by funding department and by fiscal year. Children who were placed in more than one facility or had a custody change in a fiscal year are duplicated in the numbers below. Figure 9 provides a percentage breakdown by department of in-state and out-of-state placements in each fiscal year. Again, due to the low number of placements by DAIL not visibly standing out in the chart, the numbers are presented in the table below the chart.

Figure 8



	FY2015		FY2016		FY2017	
	Instate	Out of state	Instate	Out of state	Instate	Out of state
DAIL	0	2	0	2	0	3
DMH	78	42	74	48	57	50
DCF	184	108	179	114	170	83

Figure 9



	FY2015		FY2016		FY2017	
	Instate	Out of state	Instate	Out of state	Instate	Out of state
DAIL	0%	1%	0%	1%	0%	2%
DMH	30%	28%	29%	29%	25%	37%
DCF	70%	71%	71%	70%	75%	61%

III. For each facility, the average daily costs for specific levels of service or treatment acuity in fiscal years 2015, 2016, and 2017 and the total amount paid to each facility by department and by funding source in fiscal years 2015, 2016 and 2017.

The State of Vermont funds a network of treatment facilities for children and adolescents with emotional behavior and other challenges through Private Nonmedical Institutions (PNMI) for Residential Child Care, part of the State's Medicaid program. The daily rates for residential programs are set by the respective State's rate setting entity. In Vermont, this is the AHS Division of Rate Setting in accordance with the Private Non-Medical Institution (PNMI) rules and in coordination with the Placement Authorizing Departments of AHS and Agency of Education.

Please refer to the spreadsheet in Appendix C for the detailed listing of the average daily costs for each facility in fiscal years 2015, 2016, and 2017 and the total amount paid to each facility by department and by funding source in fiscal years 2015, 2016 and 2017.

It should be noted that the rules for the PNMI rate setting process in Vermont were revised in 2015. One significant change to the PNMI rules was the shift from a budget-based to cost-based process. This means that rates are set prospectively for each program based on the allowable operating costs in a base year. In other words, when the Division sets a rate it uses a base year, which is a year in the past. This gives the Division actual costs and audited financial statements as a basis to set the rate. For instance, the SFY 2017 rate year is based on the provider's 2015 fiscal year costs. Costs are rebased annually to a new base year. Each year the new base year establishes a per diem rate based on more current costs and occupancy.

The VT PNMI payment structure for in-state programs has some challenges. With the PNMI funding structure based on the actual program utilization from previous years, this presumes that usage and need remains fairly constant; however, there is variability in our system of care from year to year. The PNMI payment structure does not support or encourage programs to diversify to meet client needs. The rate of utilization, variability in the intensity of kids, small size of programs and populations served results in a significant number of requests for rate adjustment and financial relief. This approach creates challenges in budgeting for the State and providers. Please refer to the listing of requests for rate adjustment and extraordinary financial relief to understand the number and fiscal impact over the recent fiscal years (Appendix D).

IV. Measures used by the Department to determine outcomes for the children placed in these facilities and the cost effectiveness of these facilities, including length of stay, intensity of services provided, reunification of children with their family or home community, or both, relapse or readmittance rates, or subsequent involvement with the criminal justice system or both.

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.

All contracts with residential service providers, both in and out of state, include performance measures. These measures were created collaboratively with DCF, the Department of Mental Health, and representatives from the residential programs. The measures track the effectiveness of the programs by determining how well the programs are doing and whether children and youth are better off when they leave the program. In how well the programs are doing, the contract requires that a high number of children/youth have completed an evidence-based clinical measurement tool upon admission and every six months thereafter and that every child/youth will have a discharge plan within 30 days of entry into the program. This measure ensures the residential programs are looking at how to transition the child/youth out of the program as soon as is clinically appropriate. In order to determine if the children/youth are better off, programs are measured on the percentage of children/youth who discharge to a lower level of care, and the percentage with no new admissions to another residential or inpatient hospital setting at 6-months post discharge.

In addition to the performance language in the contracts, the Family Services Division Residential Licensing and Special Investigation (RLSI) unit oversees the regulatory compliance of all residential programs. This includes quality oversight of the programs. The staff responsible for regulating the residential programs includes a Licensed Clinical Social Worker who is continually gauging the quality of the program through various means including the number of child abuse reports or incident reports from the program, the number of unanticipated discharges from the program, staff turnover, interviews with children/youth and staff, and other factors that indicate the health of a program. The licensor also reviews Plans of Care as part of the licensing process to determine if the Plans of Care are appropriate and meet expectations. While the RLSI oversight does not include the outcomes of individual children/youth served by residential programs, RLSI ensures each program as a whole is providing high quality services. This, in turn, supports achievement of positive outcomes for the children/youth served.

As well, the Turn the Curve Advisory Team has identified outcome measures for the children's system of care (see Table 1 below). The Child and Adolescent Needs and Strengths (CANS) tool is being implemented statewide for use in the child and family system of care to measure child progress and program outcomes. Different regions are in varied stages of implementation and we anticipate being able to collect and use CANS data for outcome measurement in the next fiscal year. We are in the early stages of developing protocol for how the CANS will be used with residential placements. On a child/youth level, individual progress in treatment and towards the transition plans is monitored by

representatives of the placing department. Lastly, it is difficult to know what would happen without this level of care for an individual child/family as a means to measure the effectiveness of treatment.

Table 1. Outcome Measures

1. # Children/youth in residential placement (total)
    a. Out of state
    b. In state
2. # of beds in PNMI (in-state capacity)
    a. calculate total # beds per category: Assessment, residential & secure residential
3. # of beds in non-PNMI community-based residential programs
4. # of bed days per month (in each month, how many kids were in residential placements each day in the month)
    a. Region specific (DCF/DMH)
    b. State average
    c. Lengths of stay in non-PNMI community-based residential programs
5. Discharge level of care/location
6. Improvements in behavioral/emotional needs, life domain functioning, child strengths (CANS – progress monitoring every 6 months)
7. Trends of ages, clinical/behavioral presentations, custody, etc. for Case Review Committee (CRC) cases

Cost Effectiveness

Cost effectiveness is a complex concept when applied to the care and treatment of children and youth with complex mental health and behavioral problems. We do not simply look at the daily rate for the treatment, room and board and education of the program. We must also take into consideration the ability of a program to effectively engage and address the needs of the child and family, the proximity of the program to the family and home community which may significantly impact the child's ability to make progress and transition back to the community. Length of stay impacts total cost and can be shortened or lengthened depending on factors already noted such as connection to family, appropriate clinical match of program to child and family needs. Cost effectiveness should also take into consideration the indirect costs associated with DCF Family Services Social Workers traveling to the program and the likelihood the program will effectively address the identified areas for treatment such that the child can transition to a less intensive level of care. It is important to note that the Vermont programs are a smaller scale than many out-of-state programs and thus do not benefit as much from the economy of scale of running a large 50+ bed program. Thus in-state programs often, but not always, have a higher daily rate than the out-of-state programs. More clinically intensive and highly supervised programs have higher daily rates and are necessary for children who have highly acute mental health; suicidal, homicidal or behavioral concerns; or significant non-suicidal self-injurious behaviors. These highly intensive residential programs are more cost-effective than inpatient settings and typically support youth to stabilize and transition to lower levels of intensity. Lastly, we recognize providing a highly intensive wrap of services for a child/youth in a community setting, either in their own home, a foster home or small group living program, can have a higher daily rate than many residential programs, yet allows a child/youth to remain in the community and be connected to school, peers, family. These "wraparound" approaches can be highly effective in preventing children/youth from being placed outside of their community and enables them to learn new skills to manage social, emotional and behavioral difficulties in more normalized settings as compared to being placed in a fully contained residential program.

Research says the threshold for the impact of treatment is 90 days (BBI). "Residential-specific research shows improved outcomes with shorter lengths of stay, increased family involvement, and stability and support in the post-residential environment (Walters & Petr, 2008). Accordingly, a research-based synthesis is emerging, suggesting that when residential and community providers integrate or "bridge" values and practices, improved outcomes can be demonstrated." (The Building Bridges Initiative; http://www.buildingbridges4youth.org/sites/default/files/Blau%20et%20al_BuildingBridges.pdf)

V. The specific steps taken over the past three years by the Departments and the Agency to increase community-based supports for youths in custody while reducing use of residential care.

Since June 2015, the Turn the Curve interagency team in collaboration with AHS and AOE leadership has been focused on increasing community-based supports for children and youth. The TTC team created the following vision, mission and guiding principles.

- **Vision:** All children and families will live in their communities and have access to a comprehensive array of services and supports.

- **Mission:** AHS will increase the number of children, youth and families served in community settings by transferring resources from residential settings and investing in local regions.

- **Guiding Principles:**
    1. Children and youth live in their communities.
    2. Families have access to supports and services in their community.
    3. Community teams are supported with resources to assist families so children can remain in their community.
    4. Children, youth and families have access to more intensive levels of care when necessary.

The steps this group has taken to achieve the vision of Turning the Curve on the number of children and youth in residential settings includes a detailed work plan was created to address the following areas which all impact the number of children/youth in residential care:

1. **Leadership:** *Leadership in DCF, DAIL, DMH, AHS & AOE are engaged, supportive and committed to the goal of turning the curve on residential use.*
    a. Develop clear & consistent communication strategy of vision, desired outcome, current status
    b. Plan for continuity across related efforts

2. **Fiscal/Cost and Policy**: *Departmental funds that have historically been used for residential placements are considered for building the community-based services.*
    a. Contract for local intensive wrap to bring kids back from residential/ keep from going
    b. Use bed days as measure, not number of kids
    c. Determine method for identifying target # bed days
    d. Determine method for setting rates for community intensive wraps
    e. Utilization reviews contribute to identifying gaps in local systems of care

f. Use data to inform what VT needs

3. **Systems and Interventions**: *Identify and respond to needs, gaps and how to measure success*
    a. Create a common language/terms for the levels within the Vermont system of care
    b. Technical assistance (TA) from State to build capacity using current ISBs/waivers, how to partner locally, structure services/plans/staffing/referral flow to develop & sustain wrap-around
    c. Technical assistance is provided from the state on Coordinated Services Planning, Act 264 & Interagency Agreement
    d. Local community proposals to address local needs
    e. Work with state-level partners to identify key service system client populations and critical performance measures

4. **Stakeholder Engagement:** *Initiative is informed by cross-cutting feedback from a variety of stakeholders*
    a. Assess perspective and interest for reform from key stakeholders, family, providers (see Appendix E for themes that were gathered through numerous focus groups, surveys and discussions with family members)

5. **Accountability:** *We monitor outcomes for children and youth and quality of the service system across the service system – at a state and local level*
    a. Outcome measures are identified and tracked and begin with baseline data

6. **Workforce Development:** *Utilize stakeholder input to determine and execute training and support*
    a. Utilize stakeholder input to identify needs of current workforce to meet shifting approach
    b. Strengthen crisis planning strategies among providers
    c. Identify what resources currently exist, what resources could be used differently and how to align resources

In the fall of 2016, Northwestern Counseling and Support Services, with their regional partners, identified a dramatic increase in clinical acuity and need for a wider spectrum of care. This team proposed a program whose primary function would be to address the high utilization of out of community placements of children who are in DCF Custody. This team supports both children coming back from residential placements, and those with needs who, historically, prematurely accessed out of community placements. In January 2017, DMH and DCF provided funding to NCSS in a 2-year contract to support this program. The program NCSS developed can serve eight children at a time with intensive supports in an effort to keep them stable in their community.

With respect to DCF specifically, the Commissioner attended a conference hosted by the Annie E. Casey Foundation in the spring of 2015. Research was presented that indicated home-based and community based care is more effective for youth than congregate (residential) care settings. The report and research also included data which showed Vermont placed more youth in DCF custody in residential care than was considered best practice. As a result, the Commissioner proposed that within the DCF budget for FY17, the spending on residential care be reduced by $1.5M (roughly split 50/50 State General Fund/Global Commitment). In addition to reducing the budget request, DCF repurposed some of its Substitute Care funding to be invested in projects that would provide community based support to both youth at risk of being placed in residential care and youth in residential care who are

ready to return to their community. As a result, DCF invested funding into the Becket Support and Stabilization Program which augments the current system of care in regions. This support is available to children and youth involved with DCF to assist in preventing residential care and to offer supports when a child is returning to a community placement. This program offers a bridge to enable providers in the community the time to create supports and services the child/youth will need to be successful. The stabilization and support program has shown promising results and DCF was successful in reducing its spending in the FY17 budget on residential care.

Finally, a Request for Information (RFI) was released in late September 2017 to solicit input from regions seeking their creative solutions to serving children and youth in their communities. The Agency of Human Services released this RFI to hear from regions/communities about what they think is needed in their local area to build up their system of care to ensure children and youth are supported, whenever possible, in their community. Once the responses to the RFI are reviewed and analyzed, AHS anticipates issuing an RFP to further efforts to ensure that the right care is available to our youth so that they can remain in their communities. Please see Appendix F for the full RFI.

Challenges that Lie Ahead

Consistent with research and best practices, AHS wants to thoughtfully reduce the number of youth in residential care and serve them closer to their community. The Turn the Curve Advisory Committee will continue to provide support to achieve this goal. In addition to the challenges already highlighted in this report with respect to reliance on out-of-state placements and the PNMI funding structure, there are a couple of areas the Turn the Curve Group will also need to address:

- The number of children in DCF custody as a whole taxes the foster care system. This means there are fewer homes to place youth which is a key element to any successful initiative to reduce reliance on congregate care.
- Room and Board costs associated with residential care will no longer be eligible for Medicaid reimbursement as of January 2019. These costs will need to be back-filled with general fund dollars.

Our perspective is that to be successful, we need to be sure there are appropriate levels of community based support and services for families and foster parents including: mental health treatment, substance abuse treatment, education, support, and crisis services.

VII. Appendices

Appendix A: TTC Advisory Committee membership list
Appendix B: Utilization for fiscal years 2015, 2016, and 2017 (Age & Gender)
Appendix C: Fiscal analysis by program by FY and funding department
Appendix D: DRS rate adjustment & extraordinary financial relief requests
Appendix E: Focus Group themes
Appendix F: Request for Information

Appendix A

TTC Advisory Committee Membership List

1. Cheryle Bilodeau, DMH, Interagency Planning
2. Charlie Biss, DMH-Child, Adolescent and Family Unit
3. Diane Bugbee, DAIL, Developmental Disabilities Services Division
4. Melanie D'Amico, DCF-Family Services
5. Alicia Hanrahan, Agency of Education
6. Barb Joyal, DCF-Family Services
7. Heather McLain, DCF-Family Services
8. Laurel Omland, DMH-Child, Adolescent and Family Unit
9. Karen Vastine, DCF-Commissioner's Office

Appendix B

Utilization for fiscal years 2015, 2016, and 2017 (Age & Gender)

Utilization for fiscal years 2015, 2016, and 2017 including the number and age of children placed by facility and the total bed days utilized

Vermont Private Non-Medical Institution (PNMI) Facilities

Name of Facility	Location	Licensed Capacity	Gender	Age Range	DCF Contract	Total Number of Children in Facility FY15	FY16	FY17
Vermont Permanency Initiative dba Vermont School For Girls	Bennington	55	F	9 up to 22	45	See Bennington School	25	45
Vermont Permanency Initiative dba Newbury Campus	Newbury	8	M	17-Sep	8	See Bennington School	8	13
Bennington School (renamed 2016) shifted to Vermont Permanency Initiative on two campuses	Bennington	55	M & F			80	37	renamed
Brattleboro Retreat - Adolescent Treatment Program (Linden)	Brattleboro	19	M & F	13 up to 18	8	39	34	29
Brattleboro Retreat - Abigail Rockwell Center for Children (ARCC)	Brattleboro	11	M & F	6 up to 14	8	19	24	21
Brookhaven Home for Boys	Chelsea	8	M	6 up to 14	8	9	14	11
Community House	Brattleboro	8	M & F	6 up to 13	8	21	22	20
Howard Center, CompCare (closed 6/30/2016)	So. Burlington	12 -> 6	M & F	5 up to 14	12 -> 6	19	12	closed
Howard Center, Park Street	Rutland	10	M	12 up to 18	10	17	16	15
Howard Center, Transition House	Burlington	4	M	16 up to 22	4	3	1	4
NFI Allenbrook Homes for Youth	So. Burlington	8	M & F	12 up to 18	8	9	24	21
NFI Group Home	Burlington	6	M & F	13 up to 18	6	12	11	14
NFI Shelburne House	Williston	3	M	13 up to 18	3	4	3	4
NFI DBT house	Vernon	4	F	10 up to 18	4	4	3	7
NFI Village House	Burlington	3	M	16 up to 22	3	3	3	4
Onion River Crossroads	Montpelier	8	F	12 up to 20	8	15	13	20
Seall, Inc. "204 Depot Street"	Bennington	8	M	13 up to 18	8	95 individuals 128 episodes	97 individuals 135 episodes	90 individuals 129 episodes
Seall, Inc. Depot St (Girls Adolescent Program) Program began 9/30/2016	Bennington	4	F	13 up to 18	4	N/A	N/A	44 individuals 53 episodes
Valley Vista (Adolescent Program)	Bradford	15	M & F	13 up to 18	3	ADAP		
WCYS-Mountainside House	Ludlow	8	M	13 up to 22	7	48 individuals 58 episodes	37 individuals 46 episodes	52 individuals 60 episodes
WCYS-House at Twenty Mile Stream	Proctorsville	8	F	13 up to 22	7	44 individuals 57 episodes	46 individuals 54 episodes	42 individuals 48 episodes
Woodside Rehabilitation Center	Colchester	30	M & F	10 up to 18	16	15	9	10
TOTAL IN-STATE						**262**	**253**	**227**

Out of State PNMI Facilities				Total Number of Children in Facility		
Name of Facility	**Location**	**Gender**	**Age Range**	**FY15**	**FY16**	**FY17**
American School for the Deaf	CT	M + F	3 up to 21	2	2	
Becket	NH	M + F	12 up to 18	46	51	39
Becket Subacute Care	NH	M + F	12 up to 18		1	
Brandon School	MA	M	8 up to 18	1		
CALO	MO	M + F	9 up to 18	1		
Coastal Harbor	GA	F	7 up to 17	1	4	2
Cottage Hill	MA	F	12 up to 18	2	2	1
Crotched Mountain	NH	M + F	5 up to 22	3	3	2
Devereux	MA	M + F	M: 6 up to 21 F:13 up to 21	28	23	20
Devereux	CO	M + F	12 up to 21	1	1	1
Devereux	FL	M + F	4 up to 17	2	1	1
Devereux Group Home	MA	M + F	M: 6 up to 21 F:12 up to 21		2	
Devereux	TX	M + F	13 up to 22		1	1
Eagleton School	MA	M	9 up to 22	10	7	
Easter Seals-Zachary Rd	NH	M + F	5 up to 22	3	1	1
Fall River Deaconess Home	MA	F	11 up to 22	1	2	3
Foundations for Behavioral Health	PA	M + F	5 up to 21	1	1	
Foundations for Living	OH	M + F	11 up to 18	1	1	
Gulf Coast Treatment Center	FL	F	12 up to 18	1	1	
TN Clinical Schools Dba Hermitage Hall	TN	M + F	M: 13 up to 17 F: 10 up to 17			1
Hillcrest	MA	M	12 up to 18	10	12	9
Hillcrest ITU	MA	F	11 up to 18	5	7	6
JRI Centerpoint	MA	M	13 up to 18	1		2
JRI Cohannet	MA	F	13 up to 18	1	1	2
JRI Glenhaven	MA	M + F	12 up to 22		1	2
JRI Meadowridge Academy	MA	M	12 up to 22	2	3	6
JRI Pelham	MA	F	12 up to 22	2	1	4
JRI Walden St	MA	F	12 up to 22	2	2	2
Mountain Lake Academy	NY	M	12 up to 21		1	3
Natchez Trace Youth Academy	TN	M	12 up to 17	1	2	3
New Hope	SC	M + F	12 up to 21	1		
Pine Haven	NH	M	5 up to 15	5	6	3
Sandy Pines	FL	M + F	5 up to 17			2
San Marcos Treatment Center	TX	M + F	8 up to 18		1	1
Silver Springs	PA	M + F	6 up to 14			1

Spaulding Youth Center	NH	M + F	5 up to 21		1	2
Stetson School	MA	M	9 up to 22	8	9	10
Stevens Home	MA	M	12 up to 17	3	6	3
Sununu Youth Services Center	NH	M + F	13 up to 17		1	1
Trillium	OR	M + F	5 up to 17		1	
Turning Points	MI	M		1	1	
Walden Behavioral Center	MA	M + F	12 up to 17	1		
Whitney Academy	MA	M	10 up to 12	5	3	2
Youth Villages	OR	M			1	
TOTAL Out-of-State				**152**	**164**	**136**

Appendix C

Fiscal analysis by program by FY and funding department

[See attached excel spreadsheet]

Appendix D

DRS rate adjustment & extraordinary financial relief (EFR) requests

Granted Rate Adjustment/EFR Comparison
State Fiscal Year 2012 - State Fiscal Year 2017 to Date

jv - 04/04/17

Amounts are classified by the State Fiscal Year in which they are paid

	Program	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2017 Carry Forward	Total	Percentage of Total
1	Brookhaven		$136,922	$0					$136,922	3%
2	Community House		$72,978	$60,815	$49,115				$182,908	4%
3	HC Crisis						$347,893		$347,893	8%
4	HC Park Street			$79,343			$136,554		$215,897	5%
* 5	HC Residential	$163,002		$94,364	$125,818				$383,184	8%
6	HC T-House			$111,407	$60,592	$45,444			$217,443	5%
7	Lund		$250,000	$319,688	$369,465	$221,638	$368,423	$149,122	$1,678,336	37%
8	NFI Allenbrook					$62,000			$62,000	1%
9	NFI Group Home			$70,152		$115,500			$185,652	4%
10	Onion River	$67,200	$86,951	$130,213	$182,125	$86,532	$40,800		$593,821	13%
11	Retreat - ARCC						$11,284	$45,136	$56,420	1%
12	Retreat - Linden Street						$33,852	$135,408	$169,260	4%
13	Seall - 204 Depot St	$85,292	$4,485		$25,354	$94,788	$71,000		$280,919	6%
14	Seall - 206 Depot St								$0	0%
15	Valley Vista								$0	0%
16	VPI - Newbury House								$0	0%
17	VPI - VSFG								$0	0%
18	WCYS								$0	0%
	Total	**$315,494**	**$551,336**	**$865,982**	**$812,469**	**$625,902**	**$1,009,806**	**$329,666**	**$4,510,655**	**100%**

* Program closed as of 06/30/2016

Please note: Amounts not yet paid are estimates based on annual costs of approved rate adjustment amounts.

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Rate Adjustment/Extraordinary Financial Relief Requests Log
State Fiscal Year 2016 - State Fiscal Year 2017

jv - 04/05/17

Amounts are classified by the State Fiscal Year in which they are requested.

	Type of Request	Date of Request	Program Name	Reason for Request	Amount Requested	Amount Granted	Status of Request	Notes
SFY 2016 Extraordinary Financial Relief/Rate Adjust Requests								
1	Rate Adjustment	7/13/2015	Lund	Six additional Residential Counselors	$221,638	$221,638	Granted	
2	Rate Adjustment	9/21/2015	Onion River Crossroads	Program Change - Contracting w/ Methodist Home for Children	$40,800	$40,800	Granted	
3	Rate Adjustment	10/3/2015	Seall - 204 Depot Street	Program Change - Turorial Program	$73,475	$73,475	Granted	
4	Rate Adjustment	10/4/2015	Seall - 204 Depot Street	Bathroom Renovation	$27,500		Denied	Did not meet materiality
5	Financial Relief	5/17/2016	NFI - Allenbrook Program	Low occupancy (averaged 69%) and salary/fringe increase	$138,193	$62,000	Granted	
6	Financial Relief	5/18/2016	NFI - Group Home Program	Low occupancy (averaged 78%) and salary/fringe increase	$132,737	$115,500	Granted	
7	Rate Adjustment	6/14/2016	HowardCenter - Crisis Program	Six additional Interventionists	$252,000		Denied	
8	Financial Relief	6/14/2016	HowardCenter - Residential Program	Low occupancy (averaged 68.7%)	$116,743		Denied	Program Closed 6/30/16
9	Financial Relief	6/14/2016	HowardCenter - Transition House Program	Low occupancy (averaged 45.1%)	$90,614		Denied	
				SFY 2016 Total	**$1,093,700**	**$513,413**		
SFY 2017 Extraordinary Financial Relief/Rate Adjust Requests								
1	Rate Adjustment	6/30/2016	Lund	Education	Unclear		Rejected	
2	Rate Adjustment	7/27/2016	Brookhaven		Unclear		Denied	
3	Rate Adjustment	8/22/2016	Lund	Add'l nurse, increase to health Ins. Costs, furniture replacement, etc.	$182,769	$146,785	Granted	
4	Rate Adjustment	9/19/2016	Seall ($791,000 + $35,000 in start up costs)	New Program	$826,000	$713,725	Granted	$35k w paid outside the PNMI rate for start up costs
5	Financial Relief	1/14/2017	Seall - 206 Depot Street	Low occupancy (averaged 68.3% for first two months of start up)			Granted	Full monthly cost reimbursement for 6 months: Nov 16 - Apr 17
6	Financial Relief	1/20/2017	HowardCenter - Crisis Program	Six additional Interventionists	$347,893	$347,893	Granted	
7	Financial Relief	1/20/2017	HowardCenter - Park Street Program	Low occupancy (averaged 83.4%)	$137,000	$137,000	Granted	
8	Rate Adjustment	1/23/2017	Brattleboro Retreat - ARCC	Program change - decrease in beds but continuing with current staff			Granted	
9	Rate Adjustment	3/8/2017	Brattleboro Retreat - ARCC	Two Shared Direct Supervisor Positions (25% to ARCC Program)	$45,136	$45,136	Granted	SFY17 Rate Adj to start 4/1/17 for three months totaling $11,284
10	Rate Adjustment	3/8/2017	Brattleboro Retreat - Linden Street	Two Shared Direct Supervisor Positions (75% to Linden St. Program)	$135,408	$135,408	Granted	SFY17 Rate Adj to start 4/1/17 for three months totaling $33,852
11	Rate Adjustment	3/24/2017	Community House	Four additional staff members	$135,358		In Progress	
12	Rate Adjustment	3/28/2017	NFI - Allenbrook Program	NFI notified DRS that they will be submitting a request for staffing	TBD			
				SFY 2017 Total	**$1,809,564**	**$1,525,947**		
				SFY 2016 - SFY 2017 Total to Date	**$2,903,264**	**$2,039,360**		

Appendix E

Summary of Themes from Stakeholder Feedback

Context

The Turn the Curve Advisory Committee has gathered information from a variety of stakeholders including family members, mental health workers, Family Services workers, and residential program staff. This document is a summary of the information gathered during that process. The information gathered will be used to support Local Interagency Teams (LITs), educate professionals, increase dialogue about the importance and value of parent voice, improve communication with families, and address barriers and challenges that get in the way of children/youth being supported in their community.

Themes from Family Surveys

1. Why was your child placed in a residential placement?
2. What would have helped to keep your child at home and in the community?
3. Was there a CSP (Act 264, coordinated service plan) prior to the need for an out of home placement?
4. If you had a CSP, were you offered support from a Parent Rep?
5. Describe the process that led to your child's placement.
6. When your child was placed in a program, were you given sufficient information about what you and your child could expect from the program?
7. How was the communication between the residential program, you and your team while he/she was there? How about visits?
8. Thinking of your child now, how is/was planning for your child coming home?
9. Thinking of your child now, what has been helpful? What has gotten in the way?
10. If your child was in DCF Custody during his/her residential treatment, when did that custody start? Would you like to comment about that?
11. What are your recommendations for us?

The themes below represent a sample size of and does not necessarily represent each area of the state or all the strengths and challenges that may exist. This was a voluntary survey so there may be some sampling bias; therefore, we do not know if the cross-section of respondents represents all families such as those who are fully engaged with treatment, those who struggle with being engaged and those parents who once their child is in residential were unable to continue the relationship with their child.

The themes that emerged from those who responded were:

1. The SOC is complicated and challenging for families to navigate.
    a. We use a lot of terms and jargon (waivers, wraps, CSP, CRC, LIT) that don't resonate with families and makes it difficult for families to know where they are in the process of Act 264 and what kind of meeting they had.

    b. We need to be providing families a copy of their CSP so they have the information and a clear picture of what was discussed and what should happen.
2. Many parents agreed that a lack of availability of local services and supports, a lack of high quality services locally, and help coming too late were big factors in why their children reached the level of need for residential treatment.
3. Having a local team and strong working relationships was important to families.
4. Families want to stay connected with their child during the residential placement.
5. Parents stressed that more work to build skills in the whole family is needed when a child is in residential care.
6. Families noted difficulty with communication. They would like:
    a. To be included in decision making instead of letting them know of decisions is critically needed.
    b. To know about the programs being considered, the process to get there, and to be able to talk to/visit the program to learn more.
7. Some families indicated they had to consider DCF custody to access the supports and services their child needed. It is important families are provided complete information to truly understand their options and the benefits/challenges of each path (residential, DCF custody, home supports), as well as, the limitations within each system
8. There needs to be better education to local teams so they know to offer parent representation and to be able to articulate to families what that means.

Themes from Focus Group with VCORP

1. How are you currently measuring outcomes? How would you like to be able to measure?
2. What works well about the referral process? What are the challenges?
3. Are you seeing outcomes for children and youth improve? Why or why not?
4. What do you see being necessary for children/youth to stay in their community?
5. What keeps children/youth in residential longer than they need to be there? What can you be doing to reduce length of stay?
6. What could improve the discharge planning process?
7. What helps facilitate an effective working relationship with a youth's local team?
8. What are your ideas to increase capacity for foster care and resource parents?
9. How do you see the landscape for the System of Care (SOC) in Vermont, including levels of the SOC?
10. Solutions to current barriers (funding, procedures, policies)?
11. When you think of effective family engagement, what does that look like?

Themes from Focus Groups with Family Services and Mental Health Staff

1. What are we seeing kids are getting from residential care?
    a. What is successful
    b. What are the challenges
    c. Where are the gaps?
2. What would you need to shorten their length of stay?

3. What could improve the discharge planning process?
4. What helps facilitate an effective working relationship with residential programs?
5. What would you need in your community to prevent kids from needing a residential level of care?
    d. What are your ideas to increase family capacity to keep kids at home?
    e. What are your ideas to increase capacity for foster care and resource parents?
6. Are there systems issues (procedures and policies) that you see either make the process more difficult, or if changed make this process easier?
7. What are your thoughts about the therapeutic foster parent recruitment and what would make that better?
8. What keeps the therapeutic foster parents you know in the work?
9. Anything else you would like to add?

Strengths:

- **Well-trained, and well supported providers** foster parents, as well as providers = the best outcomes
- **Stability & consistency:** residential placements, when done well, offer the stability needed:
  - early months provide a lot of time to practice skills
  - shorter term placements preferred;
- **Good assessments:** Staff appreciate the concentration of all the info, providers, in one place
  - Clear & shared understandings of the needs and goals
  - It works best amongst providers when there is a clear understanding in the first place of the youth's needs across all wellness domains
- **Family Oriented Work:** helpful for one of the providers when the residential programs said parents had to participate in a group while kids were in residential (Howard Center's Reunification Groups)

Areas for Growth:

- **Logistics**:
  - Transportation
  - Funding for the families to meet basic living needs: clothes, transportation to get to appointments, food, etc.
  - Scheduling with family

- **Residential System of Care (Operations, Billing, Administrative, & Systems Level work):**
  - Complexities of billing is challenging for workers
  - Funding barriers exist that get in the way of providing services creatively
  - Families feel split when working with treatment provider and a DCF-FSD worker
  - Discharge planning is a struggle
  - Providers and the community lose contact with what is happening which impacts reintegration

- In-state placements aren't meeting specialized needs

- **Residential System of Care (Direct Service: Community Providers, Community-Based Supports, & Foster Placements):**
  - Workers don't have enough input on the placement recommendation
  - Workers' capacity limitations get in the way of providing needed/requested services which impacts their resilience/well-being/wellness in the work
  - Inconsistent quality and quantity of services within districts; having the send a youth/family far away to get the services they need (whether that's the residential placement or not) is a huge challenge
    - There is not enough quantity/quality of community supports, especially for needs for interim services (for kids and their families). A frequent cause of *why* children/youth stay in residential is the lack of community-based services in the first place.

Recommendations:

1. Improve transitions between levels of care, & the in- vs. out-of-state programs.
2. Increase community and natural supports that are accessible & responsive, and emphasize prevention & early intervention-work.
3. Within treatment agencies, availability to more family oriented work
4. Improve partnerships within communities (especially schools), and offer more access to wider geography areas.
5. Increase in therapeutic foster homes AND provide them more training, free respite support, and better compensation.
6. Improve SKILLS of system of care, including education, training and awareness for community providers of the system of care.
7. Improve CAPACITY of system of care, in part to streamline service access and efficiency of services, as well as address themes of staff burnout/wellness needs.
8. Grow residential placements and services' ability to meet (or focus on) specialized needs/demographic groups.
9. Standardize certain clinical and operational practices.

Appendix F

Request for Information to:
Enhance Community-based Supports for Children and Youth

Summary: *This RFI has been written in response to a statewide focus on working to turn the curve on the number of children and youth who are placed in residential care. The Agency of Human Services would like to hear from regions/communities about what they think is needed in their local area to build up their system of care to ensure children and youth are supported, whenever possible, in the community. The Agency of Human Services has created this RFI to be able to hear from local experts as to what they need to increase their system of care to best serve the children, youth and families in their area.*

I. Background

In June 2015, the Agency of Human Services held a dialogue to discuss the increased concern about the number of children and youth (4-18 years of age) in residential placements. The goals of this meeting was to:

- generate consensus around the problem,
- identify opportunities and strategies to change course,
- identify resources available, and
- garner a commitment from the group to carry the conversation forward and engage partners in development of recommendations.

During this meeting, the group reviewed the trend lines for residential placement, looked at the current system of care in Vermont and engaged in small group discussions to begin brainstorming where we see opportunities to turn the curve by addressing the issue from all levels of the system of care. Three main points were agreed upon at this meeting:

4. 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.
5. A problem was identified that needs resolution: trend lines for residential and out-of-state residential are going in the wrong direction.
6. There is commitment to do better than we are doing now.

Since that meeting an AHS and AOE interagency team formed to move forward **with the goal of increasing the number of children, youth and families served in community settings and sustaining those community resources**. This interagency Turn the Curve (TTC) Advisory Team is comprised of staff from the Department for Children and Families Family Services Division, AHS Central Office, the Department of Mental Health, the Department of Disabilities, Aging and Independent Living, and the Agency of Education. This team has created a work plan and is focusing on a number of areas that directly impact the ability to turn the curve. These areas include: Leadership, Fiscal/Cost and Policy, Systems and Interventions, Stakeholder Engagement, Accountability, and Workforce Development.

II. Vision, Mission, and Guiding Principles of TTC Focus

A. Vision: All children and families will live in their communities and have access to a comprehensive array of services and supports.

B. Mission: AHS will increase the number of children, youth and families served in community settings and sustaining those community resources.

C. Guiding Principles:

5. Children and youth live in their communities.
6. Families have access to supports and services in their community.
7. Community teams are supported with resources to assist families so children can remain in their community.
8. Children, youth and families have access to more intensive levels of care when necessary.

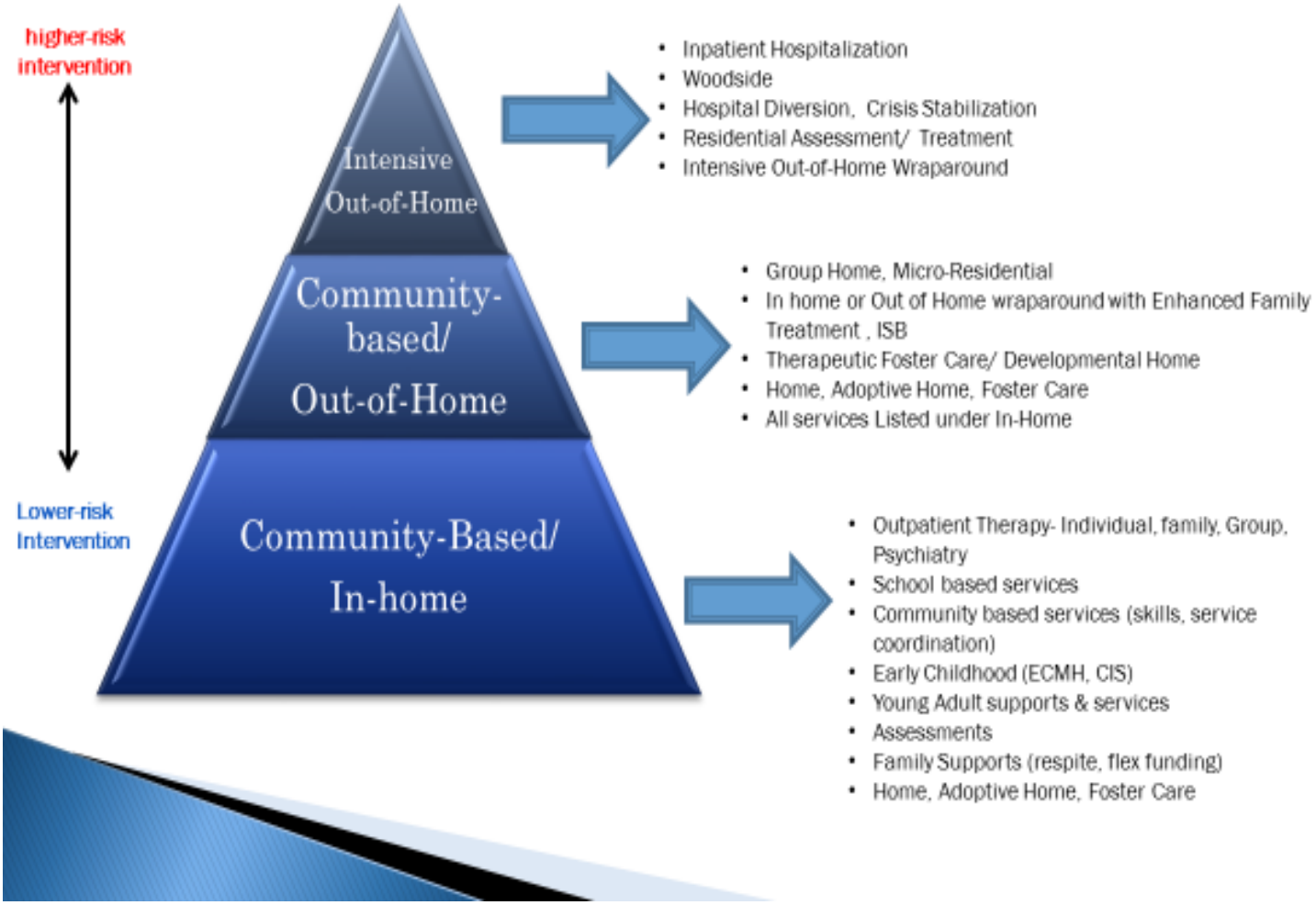
III. RFI Purpose and Goals

The Agency of Human Services recognizes the importance of serving all young people in the least restrictive setting possible. Through this RFI, the Agency seeks to hear from parties with creative solutions to serving children and youth in the communities.

The goals of offering community-based supports to children, youth and families are:

1. Diligent efforts are made to serve children in the community whenever possible;
2. Children and youth are served near their communities of origin whenever possible;
3. Culturally responsive supports and services are developed to serve children and youth.
4. Children/youth can safely return to the community in a timely fashion when a residential setting has been required.
5. Family partnership occurs in all aspects of the programming.
6. Best-practices, evidence-informed and evidence-based interventions are used that have been shown to reduce the need for residential placement.

IV. Vermont's Current Levels of Care



V. Priority populations identified by AHS that need enhanced community supports (based on data analysis from children/youth in residential care)

- ✓ Young children (under 8 years old)
- ✓ Adolescent girls with self-harming behaviors, suicidal attempts and significant suicidal ideation.
- ✓ Children/Youth with developmental disabilities and significant behavioral problems (e.g. aggression).
- ✓ Latency aged youth (8-12 years old)
- ✓ Adolescents 13-17 years old

- ✓ Children/Youth with sexually harmful behaviors
- ✓ Children/Youth with aggressive behaviors
- ✓ Children and youth who were adopted

VI. Priority issues identified by AHS to consider when responding to this RFI:

- ✓ Adoption competence-the ability to assist families in accessing supports, to work through the challenges of parenting a child who was adopted, knowledge of community resources, education about grief and loss, and supporting families at risk of discontinuity/dissolution of their adoption.
- ✓ Skills to know how to work within a trauma-informed capacity and being able to provide trauma-specific interventions to children, youth and families.
- ✓ Skills and/or knowledge in the components of comprehensive, wrap-around services
- ✓ Ability to engage in utilization review and create outcomes data
- ✓ Commitment to working with the whole family.
- ✓ Engaging in collaborative relationships that reestablish/maintain relationships with mental health providers, community and school supports.
- ✓ Understanding the importance of coordinating services

VII. State's Response to the information gathered in this RFI

The Agency expects to use the information received from this process to develop one or more competitive Requests for Proposals (RFP) for the delivery and administration of therapeutic, community-based supports. All submissions obtained through this request may be used to inform the ongoing development of Vermont's System of Care, as well as, AHS program and policy development. The Agency reserves the right to use any portion of the materials submitted. The Agency will not return any materials submitted. If after review of the responses, Agency staff may contact respondents for further information. Otherwise, there will be no acknowledgement by the Agency of receipt of any submissions or direct response to questions that submitting parties might pose regarding the RFI.

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

VIII. Eligibility to submit an RFI

All interested parties are encouraged to respond to this RFI. Submissions will be accepted from any agency, person, or entity wishing to comment upon and/or provide input regarding Vermont's desire to enhance community based supports and services. All parties responding to this RFI must identify themselves and provide a brief explanation of their interest in Vermont's System of Care.

IX. RFI Submission Questions

Respondents are encouraged to respond to all questions. However, partial responses will be accepted and reviewed. Considering the information above, provide your thoughts about how you could enhance and creatively support children, youth and families in a community based setting:

1. In your region, how would you restructure your current system of care and what would you need to do that? What would you see the role of the State in this process?
2. Is there a payment methodology which would assist in your ability to provide supports and services?
3. What measures are you taking to ensure children/youth do not need to go to a residential setting?
4. What supports and resources are needed to facilitate seamless transitions into and out of residential placements?
5. What performance measures should be adopted to monitor and ensure the effectiveness of your programming?
6. What partnerships could be established to provide the services needed by children and youth (including but not limited to mental health, developmental services, education, medical/dental, substance abuse treatment, recreation, family partnership, independent living skills, and community transition)?
7. How would your programming enhance current utilization review to ensure after-care plans are made early, progress is monitored and lengths of stay in residential (when required) are reduced?
8. Describe how your proposal would incorporate, coordinate and/or collaborate with other regional or state initiatives/pilots that may be present in your region (e.g. wrap around supports, therapeutic foster homes, etc.)?
9. Respondents are welcome to include any other recommendations or thoughts they think will be helpful.

X. Schedule for RFI

RFI Published	Tuesday, September 26, 2017
Deadline for Submission of Questions	Monday, October 9, 2017 by Noon
Question and Answer Phone Call	Tuesday, October 10 from 1:00-2:00 Conference Call Number: 1 (631) 992-3444, Conference Room Number: **256-583-604**
Deadline for Receipt of Submission	Monday, October 23rd

XI. Questions and RFI Submissions

The point of contact for this Request for Information is:
Cheryle Bilodeau, Agency of Human Services, Interagency Planning Director,
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