DEPARTMENT OF HUMAN SERVICES

Legislative Report

Ensuring Access to All Levels of Care Needed: An Analysis of Children's Residential Care

Health Care Administration

Office of Medicaid Medical Director

March 2026

For more information contact:

Minnesota Department of Human Services
Health Care Administration
P.O. Box 64981
St. Paul, MN 55164-0981

651-431-2460

For accessible formats of this information or assistance with additional equal access to human services, email us at aasd.dhs@state.mn.us, call 651-431-2600, or use your preferred relay service. ADA1 (3-24)

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Contents of this Report

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This report was prepared by Michael Koehler, MA, LPCC, Behavioral Health Researcher with the Office of the Medicaid Medical Director, DHS.

DHS Sponsors:

Neerja Singh, PhD, DHS Clinical Director; Dr. Nathan Chomilo, DHS Medical Director and Julie Marquardt, DHS Medicaid Director

DHS Contributors:

Tim Quan, Enterprise Product Manager, Nancy Just LICSW, Supervisor, Ryan Vargas, Children's 1115 lead, Tara Hjelmberg, MA, LMFT, Clinical Policy Lead, Regina Acevedo, Behavioral Health Researcher

I. Executive summary

Background

There has been a growing need to address systemic challenges impacting children's intensive behavioral health services and the lack of adequate treatment options within Minnesota for children with mental health or substance use issues. The social, economic, and long-term aftermath of the COVID-19 public health emergency, and longstanding racial and ethnic inequities all impact the well-being of our children, families, and communities. Despite recent efforts in Minnesota to address the ongoing crisis in children's behavioral health care such as opening Psychiatric Residential Treatment Facilities (PRTF)[1], expansion of Youth Assertive Community Treatment and Children's Intensive Behavioral Health Services (CIBHS), there remains major gaps in in the continuum of care. On a daily basis, many children and youth in MN are not able to access appropriate levels of care for their mental health needs, due in part to the current system's inability to respond to elevated levels of aggression and/or other complex conditions.

Consequently, tribal nations, counties, and caregivers are forced to look outside the state at great financial burden in addition to the strain and potential trauma to the child and family. Moreover, juvenile correctional facilities across the state are increasingly having to bear the burden of caring for children with acute psychiatric needs that are denied access to PRTF and psychiatric hospitalization.

Demographics of Children Experiencing Residential Care

Significant inequities exist in these levels of care among children and youth of diverse backgrounds. Minnesota Medicaid data shows a picture of the overrepresentation of children from marginalized communities in out-of-home treatment. The "State of America's Children" report by the Children's Defense Fund (2023) detailed rates of out of home treatment for American Indian and Black youth as 14.6 and 1.4 times the overall population, respectively, in Minnesota. Compared to other states, Minnesota has had a 29% increase in children experiencing foster care from FY2012-2021. The overrepresentation of American Indian and Black children in the child welfare system is a factor this study seeks to further analyze as it relates to reliance on residential care settings.

It should be noted that there are two separate, distinct populations of children utilizing residential care in Minnesota. Children may enter out of home placement via child protection or juvenile justice for treatment of mental illness in a residential facility. Children from marginalized communities, namely Black/ African American and American Indian are more frequently entered into foster care through juvenile justice which can in turn lead to ongoing involvement in the justice system. The second group constitutes children

[1] PRTF is a Medicaid Psych Under 21 benefit that was first implemented in Minnesota in 2017.

who are in need of residential care as a result of mental illness. Due to how residential treatment is funded these children and families are forced to go through the child welfare system even though the parents are not being charged with neglect or abuse.

Gaps in Access

Minnesota has seen an overall decrease in admissions in residential treatment facilities, falling by one-third from 3,195 in 2016 to 2,041 in 2020. Along with the reduction in residential admissions due to beds closing, the number of available treatment beds has also decreased significantly from over 2,400 beds in 2005 to 1,586 in 2023.

In 2021, there were a total of 501 children treated in residential treatment centers, of which 291 in Juvenile Correctional Facility (Minnesota Department of Human Services, 2021). 159 children that same year were sent out of state for treatment due to being unable to access care in Minnesota. This equates to roughly a third of children requiring higher levels of care being forced to look out of state for appropriate treatment.

As part of Minnesota's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid program in 2022 more than 700 youth involved in juvenile justice were referred for diagnostic assessment. Of these youth less than half were reported to have received an assessment thus exacerbating the demands on juvenile detention facilities and staff to care for children with serious emotional disturbances without adequate support or understanding of the child's psychiatric conditions. For youth that did receive assessments it is unknown as to what services, if any they were referred. Child welfare referrals for this same time are similarly stark with over 4,500 children referred for diagnostic assessment and only 263 reported as receiving the service.

Gaps in care

Findings of previous reports have identified major gaps in the state's system of care for children with intensive behavioral health needs. Past reports conducted by DHS have attempted to analyze and make recommendations to the Children's Intensive Services continuum of care. The 2018 Children's Intensive Needs Report from the Amherst H. Wilder Foundation determined that many of the youth with complex behavioral health needs cannot be adequately served in the current provider system. It is also evident that many of these children once admitted to a facility, experience unnecessarily lengthy stays due to insufficient services available in the community to include in a discharge plan.

Community feedback

Stakeholder engagement with counties, tribes, providers, and community members along with previous research has shown a lack of adequate support to help children and families access appropriate levels of care in their communities or to be able to remain in their communities. Specific issues which have been raised include the lack of capacity to serve children and youth who have complex behavioral health needs, the limited availability of intensive services that have research-based effectiveness, and the limitations in the availability of individual outcome data to assess effectiveness across the array of services.

The children experiencing the most difficulty accessing appropriate levels of care have been identified in numerous reports going back to 2009. They include:

- Autism Spectrum Disorders with self-injury or aggression
- Reactive Attachment Disorder/Post-Traumatic Stress Disorder with aggression
- Co-occurring disorder of Mental Illness/Developmental Disability and Conduct Disorder
- Mental illness with brain trauma (Traumatic Brain Injury, fetal alcohol)
- Mental Illness and Complex medical issues
- Borderline personality features and severe emotional dysregulation
- Schizophrenia

The 2022 Children's Summit sponsored by DHS conducted extensive analysis, review, and engagement amongst child behavioral health experts, community partners, providers, counties, and tribes to develop actionable solutions to the problems facing Minnesota's continuum of care for children. Themes that emerged from the Summit that cut across many areas of focus impacting children's behavioral health needs include strong recommendations from community members to have a more streamlined, robust, and accessible service continuum for families with thorough follow-up care. The Children's Summit report was used as a needs assessment for this study and is based on extensive stakeholder input that real action is needed to address the critical lack of services for children with behavioral health conditions.

National trends

Minnesota is not unique with regards to challenges faced in providing appropriate care to youth with significant behavioral health needs. The problem of inadequate or insufficient community-based services is an issue other states have attempted to address with varying degrees of success. Some themes and actions being taken that emerged from state level analysis include:

- Significant investments in workforce development, family, and kinship care
- Building a broad array of community-based services
- Increasing reimbursement rates for children's residential and community providers
- Using data to more effectively manage and understand demographics of youth likely to enter residential care
- Ensuring all partners involved in a child's treatment are trained in trauma-informed care and are incentivized to provide collaborative care

Summary of Recommendations

Addressing the complex issues of providing appropriate care for children with serious emotional disturbances necessitates a collaborative, cross-sector approach. No one solution will solve the ongoing problem of lack of treatment beds and inadequate community-based resources. Key recommendations include:

- Involving communities most impacted by current gaps, structural inequities and structural racism, in creating culturally responsive models of care, including traditional healing, as part of the continuum of care development
- Raising reimbursement rates for providers to support 1:1 staffing and enhanced training, with a focus on staff retention
- Investing significantly in a diverse and skilled workforce by exploring innovative pathways for correctional and residential treatment direct care staff to attain more sustainability and opportunity for advancement
- Developing a range of community-based services for aftercare, step-down care, and prevention is essential to reduce the demand for hospitals and residential facilities
- Exploring Medicaid reimbursement for children's residential facilities with more than 16 beds designated as Institution for Mental Disease (IMD) through avenues like a federal 1115 waiver
- Improving data systems to understand health inequities for youth involved in residential care
- Increase access to trauma-informed and culturally-responsive diagnostic assessments for juvenile justice or child welfare involved youth

II. Legislation

The legislature allocated administrative funding for DHS to conduct an analysis of the utilization and efficacy of current treatment options for children under Minnesota's Medicaid program to identify systemic obstacles in transitioning children into the community and community-based treatment from intensive residential treatment settings. The analysis identified crucial points during a child's care where the system missed the opportunity to transition the child to family-focused, community care models from residential settings. DHS collaborated with a wide variety of stakeholders including counties, tribes, the Department of Health, the Department of Education, hospitals, children's treatment facilities, social workers, juvenile justice officials, and parents of children receiving care. DHS may also collaborate with children receiving care when conducting the analysis.

Sec. 13. REDUCING RELIANCE ON CHILDREN'S CONGREGATE-CARE SETTINGS. This act includes $200,000 in fiscal year 2022 and $0 in fiscal year 2023 for an analysis of the utilization and efficacy of current residential and psychiatric residential treatment facility treatment options for children under the state Medicaid program. The commissioner of human services must conduct the analysis. When conducting the analysis, the commissioner must collaborate with the Department of Health, the Department of Education, hospitals, children's treatment facilities, social workers, juvenile justice officials, and parents of children receiving care. The commissioner may collaborate with children receiving care when conducting the analysis. By February 1, 2022, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a report that identifies systemic obstacles in transitioning children into community-based options; identifies gaps in care for children with the most acute behavioral health treatment needs; and provides recommendations, including estimated costs, to develop infrastructure, eliminate system barriers, and enhance coordination to ensure children have access to behavioral health treatment services based on medical necessity and family and caregiver needs.

(MN Laws 2021, 1st Special Session, Chapter 7, Article 17, section 13)

III. Introduction

Purpose of report

DHS is required to submit a report to the legislature that identifies systemic obstacles in transitioning children into community-based options; identifies gaps in care for children with the most acute behavioral health treatment needs; and provide recommendations, including estimated costs, to develop infrastructure, eliminate system barriers, and enhance coordination to ensure children have access to behavioral health treatment services based on medical necessity and family and caregiver needs.

Background

Much of the policy discussion around residential care utilization relates to children who are separated from their families through involvement in the child welfare system. There has been increased focus over time on keeping children in their families whenever safely possible or with a foster family. Child welfare reform efforts at the federal level – notably, the Family First Prevention Services Act (FFPSA) of 2018 has influenced state policy and practice significantly, further spurring policy initiatives that had already reduced the numbers of children being separated from their families. The FFPSA endeavors to keep children in their own families or in a family-like setting to the greatest degree possible. It places enormous emphasis on the value of children growing up in families and in the least restrictive setting.

According to children's advocates, it is critical to note there are children who are forced to be a part of the child welfare system because of the use of Title IV-E funding for the room and board. These children are included in numbers tracked in the child welfare system making it difficult to assess which children are in the system due to parental abuse/neglect and which are there due to their serious mental illness. Parents must send their children with significant mental health issues to these settings due to multiple reasons such as the low availability of intensive community based mental health service options or severity of mental health symptoms necessitating residential treatment. Families of children manifesting symptoms of serious mental illness including but not limited to aggressive or self-harming behavior and inappropriate sexual behaviors need meaningful treatment options sufficiently helpful to stabilize their children and offer parents effective strategies for managing worrisome or dangerous behavior at home.

How this report was prepared

As part of the 2022 DHS Children's Summit working groups identified specific needs for children involved in acute and sub-acute care such as hospital emergency departments, PRTF and children's residential treatment. This report stems in part from action steps identified in the Children's Summit to provide clear guidance to the legislature on needed reforms to the children's behavioral health continuum of care to alleviate overreliance on residential and group care.

Katie Burns from 10,000 Lakes Consulting conducted background research and analysis for literature review and state level analysis. Dr. Kristin Morris of Genesis Consulting engaged in community sessions with parents, schools and community members and youth. DHS also held meetings with Child Advocates, organized visits, and discussions with direct care staff at facilities licensed by DHS and the Department of Corrections (DOC), and met with therapists, psychiatrists, nursing staff, and emergency department personnel. Additionally, DHS contracted with Public Consulting Group to facilitate stakeholder focus groups and informational webinars to gather feedback and insights for this report.

IV. Study findings

A. Literature Review

Overview of Residential Care Utilization at a National and State Level

It is important to understand the demographic and health characteristics of children experiencing a residential care stay, how long they reside in a residential facility, and the reasons driving their need for this level of care. This information helps policymakers and stakeholders better understand who is being served in these facilities and what their needs are. This is essential information in creating targeted strategies to serve various subgroups of these youth in other settings where possible and to ensure residential services are tailored to the needs of young people who do need this setting for treatment.

Children may need residential care for a variety of reasons when their unique circumstances require a level of support and intervention that cannot be provided in a typical home or community setting. Some common reasons why children may need residential care include: serious mental illness, safety concerns, complex trauma, medical needs, educational challenges, family disruption, substance use disorder, and specialized therapeutic treatment. Children and families may also benefit from residential treatment to assist and prepare for reintegration after separation due to unsafe conditions in the home.

Residential care for children is meant to be a short-term solution, not a temporary solution, and the ultimate goal is to support their successful return to their families or communities when it is safe and appropriate to do so. The decision to admit a child in residential care should be based on a careful assessment of their needs and circumstances, with a focus on providing the necessary support and interventions to help them thrive and eventually transition back to their home where it is the responsibility of the community to ensure a safe and stimulating environment.

Demographic Characteristics of Children Experiencing a Residential Care Stay

A recent in-depth analysis of residential care utilization found that almost 20,000 children were admitted to residential care on any given day across 15 states between 2012 and 2015. The largest share of children and youth in residential care were youth ages 13- 15 (approximately 40 percent) followed by youth aged

16-17 years old (25 percent). Boys comprised almost 60 percent of the residential care population, while girls made up about 40 percent of the population (Zhou et al, 2021). Similarly, a 2015 analysis of national Adoption and Foster Care Analysis Reporting System (AFCARS) data found that 63 percent of youth in residential care were male and 37 percent female (Capacity Building Center for States, 2017).

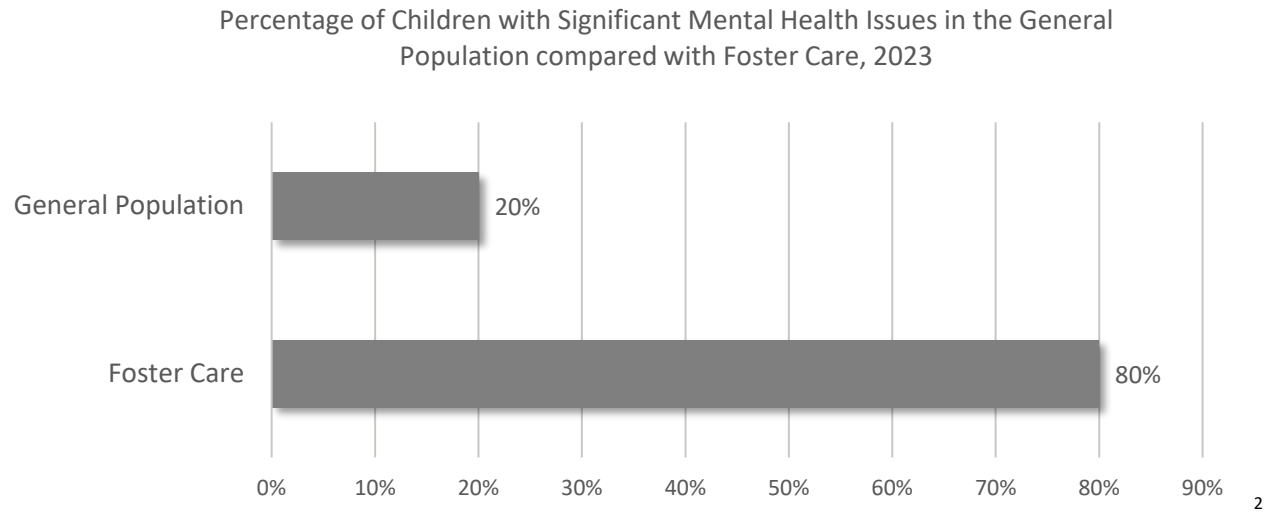
The largest proportion of youth experiencing a residential care stay were white (41 percent), followed by Black/African American youth (30 percent), Hispanic youth (20 percent); youth identifying with two or more race/ethnic groups (five percent); undeterminable/missing race/ethnicity information (two percent); American Indian/Alaska Native/non-Hispanic youth (two percent); and Asian, Native Hawaiian/other/Pacific Islander youth (less than one percent). (Capacity Building Center for States, 2017.)

It is critical to note that nationally Black youth are overrepresented in the residential care population. In 2019, Black children and youth comprised 26 percent of young people in residential care (Children's Bureau, 2018a) and only 14 percent of the total population. Nationally, Black male youth are particularly overrepresented; they are almost 30 percent more likely to experience residential care as a result of child welfare involvement than other young people (Capacity Building Center for States, 2020).

Extended duration of stays in residential care treatment facilities have been observed with American Indian children experiencing the longest stays of up to 3.6 years compared to an average of 93 days across all races in Minnesota.

A substantial percentage of children and youth who are admitted in residential care have a diagnosed mental illness or other clinical disabilities. To prevent these youth from entering residential care, states need to employ a range of targeted strategies for youth experiencing one or a combination of these issues, ranging from early trauma screening to trauma-focused care (Capacity Building Center for States, 2017).

Percentage of Children Nationally with Mental Health Issues in Foster Care Compared to General Population



[2]

Young people admitted to residential care and therapeutic foster homes[3] have significantly higher levels of risk due to mental illness and can be harmful to themselves or others compared to those in traditional foster care. (Center & Chapin Hall, 2016).

Children's Residential Facility Capacity loss in MN (defined by MN Rule 2960) [4]

YEAR	LICENSED BEDS
2005	2,474
2023	1,586

Approximately 14 percent of all children ever in foster care will be in a residential care setting. The risk of residential care appears to be highest during the mid to late teenage years, particularly around age 16 (Covington et al., 2022).

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[2] Office of the Administration for Children & Families, 2023

[3] Group and residential care programs are each a type of live-in, out-of-home care in which staff are trained to work with children and youth whose specific needs are best addressed in a highly structured environment. (U.S. Department of Health & Human Services , 2023) Treatment foster care (TFC), also called therapeutic foster care, is out-of-home care by foster parents with specialized training to care for a wide variety of children and adolescents, usually those with significant emotional, behavioral, or social issues or medical needs. (U.S. Department of Health & Human Services, 2023)

[4] (AspireMN, 2023)

The complexity of circumstances for those involved in residential care has increased. More specifically, the population now using residential care is more likely to have documented mental illness (Dale et al., 2007). One target group for more comprehensive intervention, therefore, are likely older youth with complex care needs (Covington et al., 2022). The steep decrease in children's residential facilities capacity nationally is due to a complex confluence of factors that includes the conversion of children's residential facilities to psychiatric residential treatment facilities, unfavorable economics worsened by the COVID-19 pandemic, inability to meet and maintain state regulatory requirements, and workforce shortages.

Below is a diagram showing the continuum of care available to adults and children.

ARMHS—Adult Rehabilitative Mental Health Services IRTS—Intensive Residential Treatment Services ACT—Youth Assertive Community Treatment
CTSS—Children's Therapeutic Support Services PRTF— Psychiatric Residential Treatment Facility

The most common diagnosis seen in children in Minnesota experiencing residential care setting treatment is shown in the table below:

Minnesota Medicaid Data, Fiscal Year 2016 – 2022: Top 5 Diagnosis by Gender of all Races:

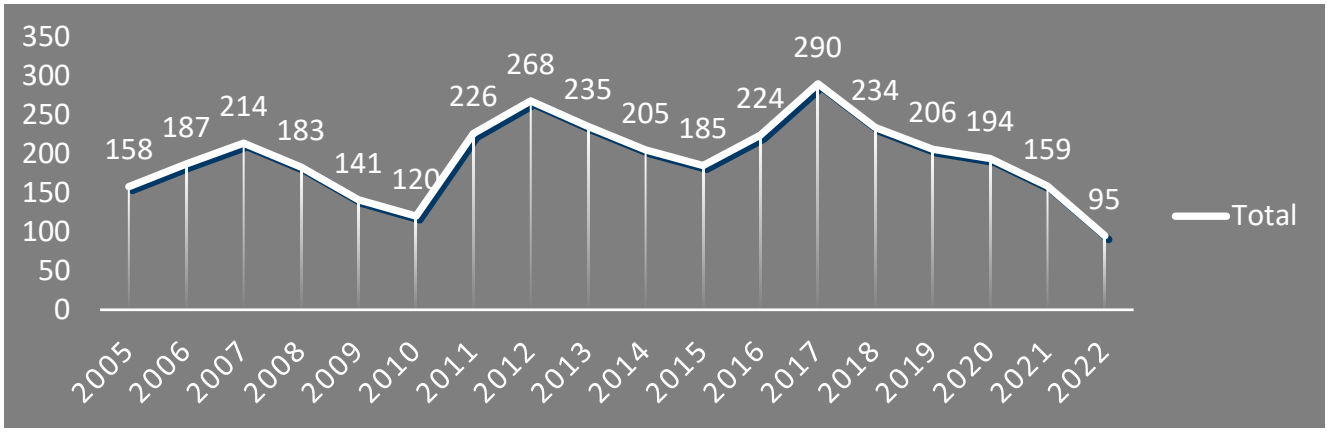
Female	Male
Stress disorder, unspecified	Hyperactivity disorder, combined type
Attachment disorder of childhood	Stress disorder, unspecified
Hyperactivity disorder, combined type	Defiant disorder
Depressive disorder, recurrent, moderate	Attachment disorder of childhood
Defiant Disorder	Unspecified psychosis not due to a substance or known physiological condition

It needs to be noted that the above diagnoses are based on claims data which is not always equivalent to clinical primary diagnosis. Also, while some diagnosis shows common diagnosis that may be treatable in community-type settings, there may also be other factors leading to residential care treatment settings.

Children sent out of state for residential care

The number of children being sent out-of-the-state of Minnesota for residential care treatment is concerning. Primary reasons for children being sent out of state for residential care stays include abandonment, significant mental or physical health impairment of caretaker, child behavioral health problem/diagnosed mental health condition, sexual abuse, and others. Between 2005-2022, there have been 3,524 events where a child was sent out-of-state, 2,872 children sent out-of-state, with at least 652 children being sent out-of-state more than once.

Graph: Number of Events where Children have been sent out of Minnesota over time, Minnesota Medicaid Data/ Interstate Compact on Placement of Children (ICPC), Calendar Year 2005 - 2022



Demographics of Children sent out of the state of Minnesota, Minnesota Medicaid Data/ Interstate Compact on Placement of Children (ICPC), Calendar Year 2005 - 2022

Racial Group	Distinct Count of Individuals	Count of Events	% of Race Group Experiencing more than one out-of-Minnesota Experience
Blank Race – No record in MMIS	598	704	14.91%
American Indian/Alaskan Native	86	118	27.12%
Asian	25	31	19.35%
Black or African American	447	568	21.30%
Multiple	131	172	23.84%
Pacific Islander/Native Hawaii	Masked	Masked	Masked

Unable to Determine	478	581	17.73%
White	1,103	1,347	18.11%
Grand Total	2,872	3,524	18.50%

Below is a table showing the top destination states for children sent out-of-state of Minnesota for residential care treatment from calendar year 2005-2022. Many of the receiving facilities in these below states specialize in mental-behavioral health care. The average length of stay in these facilities often exceeds a year, with the average being 432 days and a maximum stay for some children exceeding 5-8.25 years.

Top Receiving States by Numbers of Minnesota's Children, Minnesota Medicaid Data/ Interstate Compact on Placement of Children (ICPC), Calendar Year 2005 - 2022

State	Distinct Count of Individuals	Count of Events
Wisconsin	1,579	1,845
Iowa	427	482
South Dakota	315	360
Utah	300	347
Missouri	70	76
Indiana	50	56
Michigan	42	50
Texas	28	32

Trends in Residential Care Utilization Over Time

Since 2000, the number of children experiencing a residential care stay has dropped substantially. Despite these substantial reductions, a significant number of children – nationally almost 44,000 in 2019 – still experience staying in a residential care facility (Covington et al, 2022). The FFPSA's passage in 2018 introduced fundamental reform to the child welfare system, both by creating federally funded opportunities to offer families preventive services and by requiring new significant administrative processes and program features to receive Title IV-E child welfare funding for residential care. While some states were already intentionally taking steps to reduce residential admissions, FFPSA significantly disincentivized this by limiting duration of federal payment for stays in many facilities and requiring more upfront assessment of young people, nursing capacity in residential facilities, and oversight. While we want to

create support systems in the community to mitigate the risk of involvement with child welfare system, there are children who are in residential facilities, whose families are involved with child welfare and there is a lack of appropriate options in the community for these children. This group of children should be differentiated from the children who are in residential settings due to complex mental illness. There are currently no accessible data platforms to identify these two groups of children so that adequate planning and responses can occur.

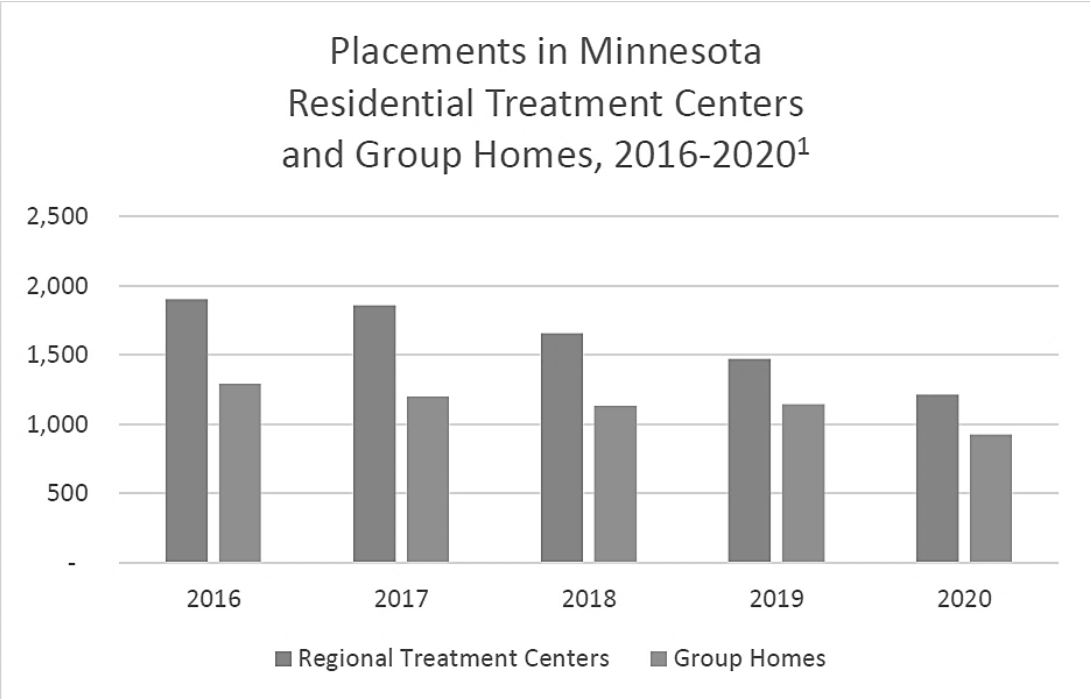
States have made considerable progress in reducing residential care. Utilization of residential care decreased steadily beginning in mid-2015 through the end of 2019, resulting in a roughly 33 percent decline between May 2012 and December 2019. Decreases were most substantial among youth ages 13-15 and in children younger than nine. The number and percentage of boys in residential care declined more substantially than girls in residential care over this time (Zhou et al, 2021).

While there is a general trend of less utilization in residential care, the numbers of children boarding in hospital emergency departments has been increasing. The COVID-19 pandemic greatly exacerbated an already understaffed and strained capacity to meet the demands for urgent mental health care. There are other compounding factors including fewer psychiatric beds and fewer qualified staff to provide appropriate treatment (National Insitute of Mental Health, 2023).

Improvements, however, have occurred unevenly – across states, across age groups, and across racial and ethnic groups. Ten states increased the number of children in residential care facilities between 2011 and 2017, while most states reduced residential care utilization (Chronicle of Social Change, 2019). In addition, the same substantial proportion (more than one third) of children aged thirteen and older in the child welfare system lived in group settings in 2017 as did ten years ago (Annie E Casey Foundation, 2019).

In Minnesota, from 2016 through 2020, use of residential care (defined here as admissions in Residential Treatment Centers and Group Homes) declined. Residential care stays fell by one third from 3,195 in 2016 to 2,041 in 2020 (Minnesota Department of Human Services, 2016-2020).

Number of Children in Minnesota Residential Treatment centers and Group Homes, 2016-2020



Institution for Mental Disease Consideration for Residential Facilities

Historically, the Institution for Mental Disease (IMD) exclusion has been part of the Medicaid program since its creation in 1965, aimed at prohibiting payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases except for inpatient psychiatric hospital services and for Psychiatric Residential Treatment Facilities (PRTFs) for individuals under the age of 21 . Furthermore, IMDs are identified as providing mental health services with 16 or more beds in the facility. This exclusion is the only program under Medicaid that does not pay for medically necessary care based solely on the type of illness. It is believed that if this exclusion is repealed, it would incentivize the institutionalization of people with mental illness. As other states have achieved through 1115 waiver, repealing of IMD exclusion can create more opportunities for individuals to receive care by mental health professionals with the focus on ease of access.

According to advocates, due to the federal government deciding that a previous approval was granted incorrectly, the IMD exclusion was implemented in 2017 in Minnesota. As a result, children's residential facilities were adversely impacted with the loss of federal financial participation. The ripple effects of IMD determinations were felt across the continuum of care as suddenly counties faced footing the entire cost of treatment a residential facility where previously Medicaid had covered this portion of the cost. Title IV-E or in Minnesota the behavioral health fund has historically covered the room and board portion.

It was not until legislation was passed in 2019 that the state would indefinitely cover the lost federal share for treatment in a residential facility. Even with the state making up for this loss, there remains a need for federal support for Medicaid to cover treatment in these facilities and enable realistic reimbursement rates to support the increased demand on this level of care.

With Medicaid coverage for children's residential being an allowable service, children's residential treatment providers would be able to expand their service area, hire more direct care staff, and alleviate the pressure of individuals requiring emergency room or correctional facility beds for mental health services. With today's understanding of mental health diagnoses and treatments, the expansion of reimbursable services for mental health treatment should be the next advancement of the Medicaid program. Minnesota is exploring an 1115 Waiver Demonstration through the Centers for Medicare and Medicaid Services (CMS) which would primarily eliminate the IMD exclusion, allowing residential mental health facilities with 16 or more beds to receive Medicaid reimbursement. Use of emergency departments and correctional facilities for mental health services will likely decrease as a result. Additionally, Medicaid reimbursement may provide a more stable revenue stream, allowing facilities to raise wages for their staff and provide relief to staff turnover.

State Strategies to Reduce Residential Care Utilization

Increasing Kinship Care

For those children involved in the child welfare system, states are increasing the number and proportion of them living with families, even if they cannot remain with or return to their own parents. As part of this effort, states have increased the number of youths living with other relatives or friends, known as kin. Nationwide, the number of kinship situations increased by seven percentage points, from 25 percent to 32 percent, over a ten-year period from 2007 to 2017 (Annie E Casey Foundation, 2019.)

Minnesota substantially increased the proportion of children care for in families over that same 10-year period. The percentage of children being cared for in families increased by 14 percentage points from 73 percent to 87 percent between 2007 and 2017. Twenty-three other states provided for an even higher percentage of children in families in 2017 (Annie E Casey Foundation, 2019.)

Decreasing Duration of Stays

Increasing recognition of the need for children to grow up in families – and the need to return young people to their families (or, if that is not possible, to a foster family) as quickly as possible – has created more urgency around reducing the length of residential care stays and keeping family members closely engaged with young people living in residential facilities.

In this context, duration of stay is a key metric to monitor for residential care (Zhou et al, 2021). Researchers at Chapin Hall examined duration of stay in residential settings between 2012 and 2018 by looking at quartile durations. This method looks at the experience of, for example, 25 percent of children experiencing residential stays (the "25th percentile") and asks how many days elapsed before they left

residential care. The 25th percentile of children experienced a 14 day stay on average; the median (50th percentile) about had a two month stay on average, and the 75th percentile had a stay of roughly seven months on average. The length of stay remained constant for much of this time, with declines occurring in more recent years ranging from a 20 percent reduction in days for those at the 25th percentile over this time to a decrease of roughly nine percent in days for those at the 75th percentile.

From a demographic perspective, researchers found that children ages 13-15 had the longest quartile durations while children under age 9 had the shortest durations. Boys had longer stays on average as compared to girls. White children experienced the longest quartile durations, with African American having the next longest average stay (Zhou et al., 2021). It should be noted that there was no differentiation in the data between children who were in residential treatment solely due to their mental illness and children who were in residential and who were removed from their homes.

Expanding Evidence-Based Community-Based Services

States wishing to decrease their use of residential care need to ensure a robust continuum of community-based mental health services is available and accessible to all youth, especially those most at risk of a residential care stay. More specifically, they should employ a two- pronged approach: (1) use evidence-based interventions to target the complex mental health needs of youth and (2) provide additional services and supports for their families (Chadwick Center and Chapin Hall, 2016). Families (whether biological, adoptive, or foster) need effective, intensive support to keep youth who have mental illness and/or experienced trauma at home. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rated the following interventions as "Well Supported by Research Evidence"[5]:

Evidence-based community-based services for serving youth: [6]

Program Name	**Description**	**Covered under Minnesota Medicaid?**
Children's Intensive Behavioral Health Service (CIBHS)	Brings together the most promising features of foster care and mental health residential treatment for	Yes

[5] for a program to earn its highest rating of "Well Supported by Research Evidence", the CEBC requires that at least two randomized controlled trials have shown an intervention to be effective and that program impact is sustained at least 12 months after services have ended as compared to a control group.

[6] Chadwick Center and Chapin Hall, 2016 and Capacity Building Center, 2017

	children and teenagers with severe emotional and behavioral disorders.	
Coping Power Program (CPP)	A cognitive-based intervention for aggressive and disruptive children ages 8-14 who are at risk for later delinquency, particularly during the transitional period to middle school, as well as their parents/caregivers. For children, the program focuses on anger management, social problem solving, and practicing avoiding peer pressure. For parents, the focus is on supporting their parental involvement and consistency.	No
Children's Therapeutic Services and Supports (CTSS)	A flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention.	Yes
Community Access for Disability Inclusion (CADI) Waiver	Program that provides home and community-based services to children and adults with disabilities who require the level of care provided in a nursing facility. These services are an alternative to institutionalization. The services help a person live as independently as possible in community settings and promote optimal health, independence, safety and community integration.	Yes

Dialectical Behavior Therapy (DBT)	Evidence based comprehensive treatment delivered via three modalities; individual therapy, group skills training, and telephone coaching by a team of DBT-trained providers.	Yes
Multi-systemic therapy (MST)	An intensive family-focused and community-based intervention for adolescents with possible substance abuse issues whose behavior puts them at risk of out-of-home treatment and/or involvement with the juvenile justice system.	No
Parent-Child Interaction Therapy (PCIT)	Assists young children ages 2-7 and their parents. The intervention focuses on improving attachment between parents and children, play therapy, and decreasing defiant and aggressive behavior challenges.	Yes, Early Childhood Evidenced-Based Practices
Parent Management Training, Oregon Model (PMTO)	Focused solely on parents of children ages 2-18 exhibiting disruptive behavior. The program teaches parents family management strategies and skills to address underlying clinical issues and associated challenging behavior, such as school difficulties, antisocial behavior, delinquency, and substance use.	No
Positive Parent Programs (Triple P), Level 4:	This program is geared toward parents of children from birth to 12 years old with moderate to severe behavior and/or emotional challenges as well as other parents interested in gaining deeper understanding of positive parenting. It teaches strategies to	No

	promote social competence and self-regulation to reduce challenging behavior in their children.	
Problem-Solving Skills Training (PSST)	This is a child-focused intervention for children ages 7-14 exhibiting behavioral problems. The goal is to help youth reduce inappropriate or disruptive behavior by slowing down and generating/thinking through multiple potential solutions to problems through a cognitive-behavioral lens.	No
Promoting Alternative Thinking Strategies (PATHS)	This is a classroom-based program for children ages 4-12 intended to reduce aggressive behavior. It teaches skills in self-control, emotional understanding, positive self-esteem, relationships, and interpersonal problem solving.	No
The Incredible Years	This program is geared toward children ages 4-8, their parents, and their teachers. It aims to promote social and emotional competence and prevent, reduce, and treat behavioral and emotional problems.	No, county funded
Treatment Foster Care Oregon – Adolescents (TFCO-A)	This approach to therapeutic foster care is intended to both prevent residential care and to serve as an appropriate step-down from that level of care. The intervention provides youth ages 12-18 with severe emotional and behavioral disorders the opportunity to live with a family. The program also prepares and supports caregivers to effectively	No

	parent young people with these challenges.	
Youth Assertive Community Treatment (Youth ACT)	An intensive, comprehensive, and nonresidential rehabilitative mental health service. Services are delivered using a multidisciplinary team approach and are available 24 hours a day, 7 days per week, teams work intensively with youth with severe mental health or co-occurring disorders to assist them with remaining in their community while reducing the need for residential or inpatient placements.	Yes

Evidence-based Care, Quality, and Outcomes

Implementation of Evidence-Based Practice in Residential Care Settings

Over time, public oversight agencies and other funders have begun to ask more of residential care providers. Policy makers and licensing agencies had concerns about quality and cost of care, lack of an evidence base supporting residential care, and geographic distance between vulnerable children staying in these facilities and their families and home communities. Oversight entities wanted to know what outcomes they were purchasing from care providers (James, 2017).

In the context of a policy environment that is strongly encouraging reductions in residential care utilization and shorter stays when residential care is necessary, residential care providers are under increasing pressure to demonstrate implementation of a thoughtful program model, evidence-based practice, and positive outcomes. The knowledge and research base for residential care program models, however, is still in an early and formative phase. Research on various residential care models lacks sufficient rigor in the form of randomized trials to make definitive conclusions about which model(s) is most effective. Related research, however, points to several promising characteristics for effective program models, including small numbers, a stable and sufficiently trained workforce, engagement of families, a strong behavioral health management program, a trauma-informed care approach, shorter stays, and continued, step-down services following discharge (James, 2017).

Providers have attempted to implement some evidence-based practices but report significant concerns in their ability to adopt new practices or models with fidelity. Notably, cost and workforce development are two significant obstacles to effective adoption of evidenced-based practice on a national level (James, 2017).

Measuring Quality of Care

Various researchers have examined quality of residential care over time. Researchers have considered what attributes of a residential care program would be important to include in a quality measurement framework. Seven such studies were compared to identify areas of overlap and agreement. Researchers found there was considerable overlap and consolidated these areas of agreement into eight domains (Huefner, 2018).

After deep concern evolved about residential care facilities and their treatment of youth, the State of Florida required the development of quality metrics for residential care providers. Florida's work built on the efforts of previous quality measurement research. A multi-year effort began in 2015 to develop, pilot, and validate a quality framework that became Florida's Quality Standards Assessment. The Florida Department of Children and Families contracted with the Florida Institute for Child Welfare at Florida State University to develop and validate the measurement system. These measures focus on attributes of a high-quality residential care program rather than on outcomes.

The new system, which was fully implemented on July 1, 2022, includes 59 metrics across eight domains. The eight domains include the following:

- Assessment, Admission, and Service Planning
- Positive, Safe Living Environment
- Monitor and Report Problems
- Family, Culture, and Spirituality
- Professional and Competent Staff
- Program Elements
- Education, Skills, and Positive Outcomes
- Pre-Discharge/Post Discharge Processes

As part of testing this set of quality metrics, the Institute fielded a pilot study in 2021 to evaluate associations between the new measures and youth outcomes across 160 residential programs. The analyses found that higher performance on standards across all eight domains were linked with improvement in youth-reported conduct problems, while higher performance within two domains is

associated with reductions in total difficulties. Researchers emphasized these findings are preliminary and should be interpreted as such (Boel-Studt et al, 2022).

Currently Minnesota's residential facilities are licensed by DHS and DOC under the rules 2960 and 2955 respectively.

While applicable only to Florida residential care providers, Florida's experience can be reviewed with the consideration that there have been concerns noted regarding the inadequacy of their system (https://winknews.com/2023/06/14/mom-daughter-florida-psychiatric-facility-failed/

State of Florida Residential Care Quality Measurement Domains and Standards:[7]

Domain	Standards
Assessment, Admission, and Service Planning	• Assessment driven services • Inclusive admission process • Individualized service plans • Measurable goals define expectations
Positive, Safe Living Environment	• No physical, verbal, or emotional abuse • Youth and families' rights maintained and respected • Basic needs met • Youth kept safe from other youths' problem behaviors • Effective crisis management • Limited seclusion and restraint • Prevention of self-harm

[7] Boel-Studt, et al, 2018

Monitor and Report Problems	• Assess consumer satisfaction • Staff trained to immediately report problems • Established grievance process • Report all allegations to external agencies • Clean, hygienic facility
Family, Culture, and Spirituality	• Involve families in treatment decisions, care, and activities • Family visits encouraged • Staff trained to support reunification and maintaining family connection • Community connection is promoted • Culturally sensitive interactions & services • Religious, spiritual, and moral values supported
Professional and Competent Staff	• Comprehensive staff training • Regular supervision and support for staff • Criminal record screens for all staff • Appropriately qualified staff
Program Elements	• Least restrictive level of care provided • Care provided in a family-like environment (to extent possible) • Support participation in normal activities • Promote youth personal identity • Respect for youth privacy • Strong program (clearly defined model, evidence-informed, trauma-informed)

	• Full range of needed services • Monitor youth and milieu • Quality improvement approach • Regular staff meeting to coordinate care • Services provided in smaller groups; staffing based on youth needs • Psychotropic medication monitored • Physical health care needs met • Licensure and accreditation
Education, Skills, and Positive Outcomes	• Academic testing provided • Education progress monitored • Special education needs supported (IEPs) • Vocational training opportunities (age appropriate) • Prosocial behavioral skills developed • Symptom reduction monitored • Skills, competencies, and knowledge needed for transition to life after group care • Program engages in regular evaluation activities • Emotional, behavioral, and educational progress measured and reported
Pre-Discharge and Post-Discharge Processes	• Individualized transition planning • Individualized discharge planning • Connect family and/or caregivers to community resources • Follow up with you and caregivers post-discharge

Outcomes of Residential Care Stays

In addition to assessing the above attributes about the quality of residential care programs, the literature suggests the following outcome metrics are important to track (Building Bridges Initiative, 2017):

- Runaway/elopements
- Admissions to hospitals or other 24-hour levels of care
- Length of stay in the residential care
- Recidivism/return to residential care setting[8]
- Inappropriate Use of psychotropic medications
- Severity of psychiatric symptoms
- Functioning at home/school/community

Li et al conducted a meta-analysis of 23 studies comparing longer term outcomes between residential care and family foster care among 13,630 youth in care. Their research concluded that children living in family foster care homes had consistently better experiences and fewer problems across three outcome indicators as compared to children living in residential care (Li et al., 2019). The outcome measures this research considered were the youth's own perceptions of their care; the presence of self-directed, negative behavior; and externally- directed problematic behavior toward others. It is also important to note that a child with mental illness may not benefit from a family foster setting and will require residential level of care. This again points to the lack of differentiation in many of the studies between the two populations of children.

Casey Family Programs (2022) concludes that overall, youth who experience residential care stays are:

- Almost 2.5 times more likely to become delinquent as compared to youth in foster care
- Experience poorer educational outcomes (including lower math and English test scores and lower graduation rates) than youth in family foster care
- Less likely to reach permanency as compared to youth raised in non-relative foster families; and

[8] More than half of psychiatric patients are readmitted from discharge within three months, many with a history of adoption. These children require longer stays and are more frequently admitted to residential facilities than those without similar clinical symptoms (D'Aiello, Menghini, Averna, Labonia, & Vicari, 2021)

- Lack opportunities to develop life skills and positive relationships

A related study analyzed differences in how teenagers exit the foster care system and how those differences relate to child demographic characteristics, residential treatment history, and county characteristics. This study found that teenagers whose predominant treatment type was in residential care were more likely to run away from that setting as compared to adolescents in foster care, kinship care, or a mixed out of home treatment history [9] Teenagers in kinship care were most likely to exit the foster care system to permanency (Wulczyn et al, 2017).

Assessment Tools and Out of Home Treatment Processes

Many states began using more standardized and comprehensive tools and processes to assess children and the type of services they needed prior to passage of the FFPSA. Thirty-seven states were using the Child and Adolescent Needs and Strengths (CANS) assessment in 2014 (Capacity Building Center, 2017).

The CANS instrument supports decision-making on service planning and level of care needed. It lays the groundwork for monitoring a youth's ongoing progress and evolving needs.

In addition to using an assessment tool, the State of California also required all counties to implement an Interagency Placement Committee (IPC) before placing a child in a residential care facility. This process involves a multi-disciplinary team of professionals from child welfare and partner agencies. Its purpose is to review the needs of youth and compare those needs with the criteria established for admission to a Short-Term Residential Treatment Program. The IPC must also consider the input of a Child and Family Team in determining whether a residential care is appropriate for a youth. These reforms occurred as part of a broader effort, called the Continuum of Care Reform (CCR) to reform the child welfare system, make more preventive services available to families, and reduce the number of children in residential care. It should be noted that families whose children are in the child welfare system only because of their child's need for residential treatment find these teams, screenings, and relative searches an unnecessary intrusion into their lives when a mental health professional has already assessed that the child needs residential level of care.

The FFPSA established new requirements related to out of home treatment of youth in residential care facilities. Youth in a QRTP must have an assessment conducted by a Qualified Individual either prior to or within 30 days of admission in the QRTP to determine whether the admission is appropriate. A Qualified Individual is a trained professional or licensed clinician not employed by the state agency and is not connected with any residential setting.

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[9] "Mixed placements" are defined as spending less than 90 percent of out-of-home-care in any one care type.

New Approaches to Residential Care Models

Historically, residential care was based in a philosophy and practice that separated children from their parents– both in moving a child out of their home and maintaining separation of child and family during their residential stay. It was thought to be helpful for the child's focus to be the "milieu" of the residential program. Engagement with family, through family visits, visits home, or phone calls, needed to be "earned" as a privilege and typically only after a period the youth had lived in the residential facility.

Focusing on Families

With increasing focus on keeping children with families and broad recognition that young people should grow up in families, more innovative programs have shifted their treatment philosophy. Focusing on the family is now recognized as a critical component of effective residential treatment (Building Bridges Initiative, 2017). The approach to care is to help families develop and consolidate culturally acceptable strategies to meet the needs of their child rather than "fixing" the child.

Strategies to promote family involvement include the following (Building Bridges Initiative, 2017):

- Emphasizing the role of the program is ultimately to return a youth to their family by conducting a pre-admission meeting in the youth's home; requiring families to agree to participate in care prior to a young person being admitted to a facility; and giving families ability to direct or give input on care
- Redesigning programs by offering less structured milieu activities and outings to make room for focusing on youth/family interactions each day; building in a touchpoint with family each day; establishing an open-door policy that allows visitation at any time and places no restrictions on phone calls; and treating any loss of family engagement as a serious matter demanding urgent action

Creating an emphasis for staff that their role is to work with families through their job titles (i.e., "Youth and Family Counselors"; inclusion of family engagement skills on staff performance evaluations; and by providing clinical supervision on family work on a regular basis

- Promoting regular in-person connections between youth and family members by ensuring youth have regular opportunities to spend time at home with staff support to facilitate this as needed. Some programs have also chosen to reduce their service area to a designated surrounding area (for example, a 30-mile radius) to make it more feasible for youth and family to stay connected.

- Providing training to parents to the same degree as staff members

- Including families in program governance and working committee

Culturally Appropriate Care

All children need culturally responsive care as a core part of their program model. Historically, racially minoritized children – Black/African American, Hispanic, American Indian, Asian Pacific Islander, and multi-racial – have lacked access to care that is responsive to the cultural needs & strengths of them and their families. This is especially important considering the over-representation of diverse populations in the child welfare system and among those living in residential care facilities.

Culturally responsive providers exhibit awareness and acceptance of cultural differences, awareness of their own culture and its implicit biases, understand how to work across cultures, and acquire and adapt their skills commensurate with their clients' cultural context (Pumariega et al, 2005). It is also helpful to have a diverse workforce as racially concordant clinician-client pairings may minimize the likelihood of cultural misunderstandings or distrust (Cooper et al, 2003).

Young people of color experience barriers to access for mental health care and are less likely to access preventive mental health services than their white counterparts. These barriers include population-level factors such as socioeconomic status and stigma; provider issues such as lack of cross-cultural knowledge and ineffective patient engagement strategies; and systemic factors including geographic location of providers and lack of knowledge about culturally competent practices (Pumariega et al, 2005). This disparity in access results from myriad complex causes, including distrust of the mental health system among African Americans due to experience with discrimination and involuntary treatment (Sussman, Robins, & Earls, 1987) and cultural and language barriers for Hispanics (Ruiz & Langrod, 1997). Underutilization of community- based mental health services may both exacerbate risk of a youth experiencing a mental health crisis and require special attention for youth of color being discharged from residential settings and in need of step-down services.

Close involvement of family members in the care of a young person may shed light on important cultural or spiritual traditions within the family and help inform how to treat a youth consistent most effectively with her/his cultural context. For example, with the family's consent, a cultural healer or herbal remedy may be an important component of treatment for some youth. Providers can also assist parents develop skills in addressing aggressive or self- harming behavior in a way that is consistent with their cultural values and beliefs (Pumariega et al, 2005).

Mental health service models should resonate with culturally diverse youth and families, who are more accepting of practical approaches and interpersonal therapies. Clinical interventions designed specifically for culturally diverse populations are available as well as traditional approaches that may need to be adapted for use in a specific cultural context (Pumariega, 2005).

Practices to Support Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ+) Youth

LGBTQ+ youth face particular issues around discrimination, safety, and lack of affirmation for who they are. LGBTQ+ youth involved in the child welfare system are often there at least in part because of tension and

lack of acceptance around their gender identity within their biological family (Cook and Cohen, 2018). Residential care settings that can actively affirm a youths identify are critical for this population (Remlin et al, 2017).

The following practices are highlighted as strategies to support LGBTQ+ youth (Remlin et al, 2017):

Out of home treatment options

- Allow youth a choice about whether to be care for in accordance with their gender identity.
- Check in with youth repeatedly about how they continue to feel about their care (do they feel safe? Do they feel comfortable?) and allow youth to change their minds about their treatment setting. Make sure youth know they can change their mind about their treatment setting.
- Ask youth whether they would like to have a single room or a shared room with another youth.

Employee hiring, orientation, and training

- Discuss service to LGBTQ+ youth during interview process and ask scenario-based questions about how applicant would address situations involving LGBTQ+ youth.
- Revisit topic of working with LGBTQ+ youth during new hire orientation to convey expectations
- Hire a diverse staff reflective of the population served, including transgender staff
- Provide training to all staff about how to work effectively with LGBTQ+ youth
- Provide more intensive training prior to a transgender youth moving into the program around how to support the youth, including allowing the youth to determine whether to share transgender identify with peers
- Provide ongoing coaching to staff

Supporting Youth Once in Care

- Promote respectful interactions between peers and support youth in working through issues
- Convene both general support groups and LGBTQ+ specific support groups to both staff and youth

Discharge Planning and Aftercare

The transition process out of residential care and back to the family of origin or other family is a sensitive time. The goal of effective discharge planning is to prepare young people and their families to make a thoughtful transition in which both youth and family are robustly supported with the goal of maintaining improvement resulting from intensive treatment and preventing a need to return to residential care. The following discharge and aftercare practices have been found to be effective (Building Bridges Initiative, 2017):

- Contemplate discharge considerations prior to admission and begin active discharge planning once the youth is admitted
- Creating a staff position solely focused on discharge
- Ensure that when a youth has been removed from home, they should always have a robust permanency plan and several back up permanency plans
- Assist families in learning how to manage and resolve conflicts
- Establishing strong positive community connections prior to discharge, such as connections with other families with relevant lived experience and the youth's school
- Having the same staff who provided therapeutic services in residential care setting continue to do so in the youth's home
- Helping families get their basic needs met and providing mental health services to other family members
- Providing crisis support and respite services to help a family support the youth at home
- Extending the duration of time for which aftercare services are available for up to one year.

B. State Level Analysis

The work of five states in managing utilization of residential care was examined to provide examples of how Minnesota may adopt similar practices. Early impacts of national implementation of the Family First Prevention Services Act (FFPSA), a significant federal law passed in 2018 with the goal of increasing the number of youths growing up in families rather than in residential care. The experiences of California, Maryland, North Carolina, New Jersey, and Tennessee were examined to look at the strategies used to keep children in family settings wherever possible, to provide assessments and engage families, and to reform how and where funding flows within public family-serving systems.

The experience of these states demonstrates that there are multiple ways in which states can more effectively manage utilization of residential care. Their experience also strongly calls attention to the need to have a wide spectrum of community-based mental health services to support young people and their families. Some state experiences also demonstrate the urgency of ensuring high quality residential care is available for young people who need this level of care.

Common themes across these states include the following:

- States need to use their data strategically. Information about how youth enter and exit residential care is foundational to more effective management of residential care. Understanding the demographic and health characteristics of those utilizing residential care is similarly an essential starting point for these efforts. The age, race/ethnicity, gender, and geographic residence of young people in residential care are essential pieces of information.

- It's not possible to effectively manage or reduce residential care utilization – or to ensure alternative community-based services are available to those who need them --- without understanding what populations of youth are most likely to use residential care, for what length of time, and what services they may need to stay in family settings.

- It is imperative to ensure an array of community-based interventions are available to serve young people and their families as part of the work to reduce reliance on residential care. Without sufficient community-based service capacity, young people with intensive needs will be under-served. They may continue to struggle within their family setting, or they may be at risk of homelessness, staying in shelters, on the streets, emergency rooms, or in county human service offices without an alternative place to go. They may also be at risk of lengthy stays in psychiatric hospitals because they do not have another place to which they can transition after they complete treatment for their most acute needs.

- The most successful approaches to managing residential care utilization are truly cross-sector in nature, putting young people and their families as the center of focus, rather than focusing on child welfare or mental health systems. New approaches need to focus on improving family functioning and stability of all family members (parents and siblings) and keeping parents engaged with their children's treatment.

- Timely, high quality, trauma-informed assessments conducted by trained clinical professionals are essential to understanding the situations of young people and to effectively plan for services/support they and their families may need.

- Disaggregation of data is critical to seeing disparities across the continuum of care and within residential care settings.

- Even in the context of FFPSA, there is ample room to build quality-driven payment reform and new rate-setting strategies into the residential care treatment space. In addition to the limitation of federal payments for non-Qualified Residential Treatment Program (QRTP) residential stays under the FFPSA, innovative rate-setting methodologies may help create additional incentives at the provider level and across the system to support shorter duration stays and improve transitions back to family-based settings.

- Investment in the workforces of residential care facilities is a critical input to ensuring young people receive high quality care. Providers are experiencing challenges in having adequate numbers of staff overall, high turnover rates, and in training their staff in trauma-focused care. These challenges have intensified in the wake of the COVID-19 pandemic.

- All partners involved in providing services to youth and their families need training in trauma- informed screening, assessment, service planning, and trauma-focused care. Without this knowledge, children are more likely to be misdiagnosed and to not receive the care they need to heal.

- Although some states are discussing the concept of centralized referral for scarce and available bed space, no state has implemented a statewide "wait list" for residential care beds.

An Early Look at Changes to Residential Care as States Implement FFPSA

States are still in the early stages of implementing FFPSA reforms to residential care. Many states had begun to reduce reliance on residential care prior to the passage of FFPSA. A recent analysis conducted by the American Academy of Pediatrics and Chapin Hall (2023) found the following:

- Most states have reduced utilization of residential care and increased utilization of kinship care. 30 states also report keeping some proportion of residential care "as- is"

- Stays in Qualified Residential Treatment Programs (QRTPs) now comprise a significant proportion of residential care in many states; however, there is limited to no QRTP capacity in other states. Majority of the residential programs in Minnesota, meet the criterion for QRTP.

    - Minnesota has 18 licensed QRTPs in the state and 4 out of state

- States pursued different strategies to establish, implement and finance QRTPs as well as the oversight processes to both place and monitor youth stays in QRTPs

- 32 states including Minnesota are now using the Child and Adolescent Needs and Strengths (CANS) instrument as their assessment tool

- Leading barriers to FFPSA implementation are related to workforce and staff; therapeutic foster care models; funding; and foster families. Sufficient funding is noted as the most important factor to ensure successful implementation; funding is needed for transitioning group care facilities to QRTPs; further development and availability of community-based preventive and aftercare services; and to bolster family and community engagement at all points of care

- Quality, training, and sustainability of staff are major impediments to successful development of QRTPs

- Despite federal requirements for QRTPs, young people surveyed do not see a meaningful difference between pre-FFPSA residential care norms and new QRTP quality of care.

- Policy recommendations geared at states to bolster state implementation of FFPSA include the following (American Academy of Pediatrics and Chapin Hall, 2023):

    - Provide resources to professionalize QRTP staff to facilitate high quality, individualized treatment

    - Work across child welfare, juvenile justice, and health care systems to successfully implement FFPSA provisions

    - Integrate QRTPs into a state's continuum of prevention, aftercare, and reduce unnecessary use of out of state care

    - Create a framework for monitoring QRTP performance and outcomes

California

A complex set of factors helped to drive California's Continuum of Care Reform (CCR) initiative. Over a long period of time, different stakeholders wanted to redesign child welfare services by bringing them to children and families and with the aim of keeping families together, when possible, rather than children having to separate from their families to obtain the services they need. A significant lawsuit related to residential care funding was also underway and ultimately resulted in a significant rate increase for residential care providers. This significant enhancement in funding levels prompted policymakers to initiate conversations on the services the State was purchasing at these increased rates, especially during growing concerns about the negative impacts of group care on youth living in residential care settings.

California has a state-supervised, county administered system for human services programs. Prior to CCR, some counties were housing children in county-administered shelters. Although many stakeholders desired for these to be shut down, this shelter system of care had some strong coalitions of supporters at the local level. In addition, in 2015, two thirds of youth in residential care remained in those group facilities for more than two years (California Department of Social Services, 2015).

The California legislature passed Assembly Bill 403 in 2015, which built upon prior reforms intended to improve permanency outcomes for youth in the child welfare system and reduce the population of children in the foster care system overall.

Essential components of the CCR include the following:

- Creating Child and Family teams for all kids in the child welfare system. The goal of these teams was to promote meaningful engagement for all partners, including the child and family members. These were also intended to help determine what support would be needed for family members or kin to become a foster parent for the young person and to provide that support

- The State committed to paying full cost of payments to unlicensed foster families while they were in the process of getting licensed (and would therefore be eligible for federal foster care payments once they were licensed). This was done to secure emergency care with families, which helped facilitate kinship care. This new policy built in incentives to spur counties to help families complete the licensing process or the counties would have to take on a share of these emergency costs over a period

- Significantly changing payment rates and structures to put more resources in the hands of foster families to get the services they needed. California's rate structure changed and moved from an age-based rate to a need-based rate. The complexity of the rate structure moved to upstream services to get the right array of services available to youth

- Expansion of Intensive Services Foster Care program to support youth with complex needs in family-based settings

- Resources to support creative strategies to identify families and recruit/support foster parents

Successes

- California significantly reduced the number of children and adolescents living in residential care facilities by almost 60 percent (California Department of Social Services, 2022)
- The state also substantially increased care with families. Among youth supervised by county probation departments, first involvement with a relative or extended family member increased by 53 percent. Among youth supervised by county welfare agencies, first involvement with a relative or extended family member increased by 24 percent. Importantly, stability for these family-based care settings also improved. Seventy-five percent of youth first involved with a relative and still in care at 12 months are still living with that relative. (California Department of Social Services, 2022)
- California reformed its residential care system by phasing out non-therapeutic group care and creating Short-Term Residential Therapeutic Programs (STRTPs). Residential care has shifted from shelter (or "care and supervision" group homes) to providers of Medicaid mental health services for young people with complex mental health issues. Eighty-seven percent of youth living in STRTPs receive mental health and therapeutic care (California Department of Social Services, 2022)
- California brought youth living in out-of-state facilities back to California
- The state did an effective job in establishing jointly agreed upon guidance to counties across Medicaid and Department of Social Services

Challenges

Although California has made strong headway in keeping more young people in families, there have been some challenges:

- Counties report there is a shortage of beds for youth with more intensive needs and among certain demographic subgroups of young people. Although there are technically beds available, kids often can't get into the programs because the programs do not provide the services they need or are not the right fit for them
- Sometimes, children are not admitted (or they are prematurely removed from care) because of their behavior. The "behavior issues" are caused by trauma and facilities should be able to recognize and provide treatment through a trauma-informed lens
- There is also a mismatch of gender-specific bed capacity – 70 percent of beds are for boys and 30 percent are for girls, even though population needing them is much closer to a 50/50 split

- It is also challenging to find beds for lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ+) youth
- Larger numbers of younger children (aged 12 and younger) need these services and it is not developmentally appropriate to care for them with older kids who are typically aged 16-18
- There are some technical provisions of CCR that sometimes result in absurd outcomes. For example, young women living in pregnant/parenting teen homes who hit their residential time limits shortly before birth or when their child is very young may need to abruptly move. This can cause disruption at a time when stability is greatly needed. For another example, the rules around reassessment can be triggered when a young person simply moves campuses of the same provider or goes to stay in a psychiatric hospital for a short period of time with a planned return to the residential provider. The reassessments can be traumatizing for the young people involved
- As was the case prior to CCR implementation, there is enormous variation of service/provider availability across different geographic areas of the state
- Residential providers tend to be clustered in the northern part of California because housing is less expensive there. Despite the challenges this created in terms of keeping youth engaged with their families, youth from southern California were situated with northern California providers simply because more providers were there
- Like other states, more rural parts of California have fewer providers. The state tried to regionalize some service availability to address gaps in service availability and to organize philanthropic communities around this. Service availability on a statewide basis remains a challenging issue to address
- California has 58 counties and 109 federally recognized tribes (many of whom are smaller and lack formal agreements with the state). There is some tension around whether tribes or counties are responsible to pay for services for American Indian children. There is also significant variation across counties in how they approach and administer child welfare and mental health programs and services

Lessons Learned

- The State of California invested a significant amount of unrestricted money to help make reforms possible. In return, the Department of Social Services wanted detailed reporting on how flexible funds were being spent. There were some tensions around the level of detail and standardization of reporting between counties and the state. Counties submitted information in formats that were difficult to summarize and made it more challenging for the state to make

a strong case to the legislature about how counties were creatively and effectively using this funding

- California lost many "mom and pop" smaller residential providers as part of CCR implementation. There were attempts to have these providers – who historically provided a place to live but not any type of behavioral health services – obtain licensure to provide intensive services for complex mental health needs as Short-Term Residential Therapeutic Program providers. This was not a realistic goal because they lacked the requisite experience and infrastructure to move from providers of housing to providers of intensive behavioral health services

- It should also be recognized that efforts to significantly reduce residential care utilization will almost certainly result in a reduction in the number of residential care beds. To the extent there is an excess amount of non-therapeutic residential care capacity, this is an expected – and desirable – outcome. The challenge is finding the appropriate balance of capacity for the populations of young people who need services in this type of setting and to ensure the provider can offer that level of care

- California youth who still experience residential care stays typically have intensive needs. And, of the residential care population, a very small percentage have very complex needs, such as co-occurring mental and/or physical health issues. Although many of these young people enter residential care through their involvement in the child welfare system, they have long-term, chronic needs the child welfare system really isn't designed to address with its focus on acute safety concerns. The State created "strike teams" involving mental health, child welfare, provider and county staff were put into place to be problem solvers for individual youth. Urgency and level of system knowledge varies considerably across these partners.

New Jersey

New Jersey has a strong depth of experience in its work to reduce residential care utilization. Its efforts have been underway for two decades and resulted in a 45% reduction in utilization of residential care between 2009 and 2016 (Casey Family Programs, 2018). New Jersey has a state-administered system for administering health and human services programs through its Department of Children and Families. This agency houses both Child Protection and Permanency as well as Children's Systems of Care, which manages statewide behavioral health, substance abuse treatment, and developmental disability services.

System-Wide Improvements

New Jersey has worked diligently to prioritize relative care close to a child's natural community for kids who are removed from their parents. New Jersey's child welfare practice model is based on the following core strategies:

- Assist families to create family teams to help develop plans tailored to their family needs
- Work hard to identify and screen relatives for family care. Provide support to facilitate care with relatives
- Aim to provide for children in a family setting that can be expected to be permanent if needed, unless an alternative short-term care setting is needed for therapeutic purposes
- Aim to provide for children close to their parents' home, unless a care setting outside of the community will help a child achieve her/his goals
- Aim to care for a child in a setting that will allow the child to stay in her/his same school

New Jersey prioritizes relative care settings by giving investigators the ability to situate children with relatives in emergency situations and considering relative caregivers presumptively eligible. If a relative care setting is not viable, the state uses a matching algorithm to compare a child's characteristics with available foster care homes to identify options for out of home care.

New Jersey also has worked hard to recruit family foster parents and to develop more sophisticated recruiting strategies. These efforts have been extremely successful. In 2018, the number of licensed family foster homes was more than double the number of children in out of home care (Casey Family Programs, 2018). The state has also developed strong support services – including a child health nurse and a parent peer program - for foster families to help retain them and to needed resources and information. Availability of these services has strengthened families' ability to care for kids and avoid residential care.

The child welfare-focused work has been complemented by the development of the Children's System of Care (CSOC), which is intended to remove barriers between child-serving systems. CSOC helps reduce the number of families involved in the foster care system by providing a continuum of mental and behavioral health services to all families, regardless of their insurance status. Parents no longer need to turn over custody of their children for youth to receive the services they need. The state has focused significant resources in developing a spectrum of community-based services that allows families to access care. CSOC includes the following:

- Family support organizations
- Mobile Response and Stabilization Services (MRSS), which is available 24/7 on a statewide basis to respond within one hour of a call for assistance. This service is available to anyone in crisis, regardless of income, geography, and insurance status. MRSS staff can also assess whether a child needs ongoing services and provide referrals to those services. These services have helped stabilize foster care amidst challenging circumstances that might otherwise prompt a residential care stay.

- Care management organizations (CMOs) provide care coordination services for young people with more complex and intense needs. CMOs organize Child Family Team (CFT) meetings and create/implement individual service plans.

New Jersey's children's initiative helped to reduce the number of young people involved in the child welfare system overall. This reduced caseloads for staff, which allowed staff to focus more intensively on the children and families whom they serve. Staff capacity was also reconfigured to provide different types of support for families through staffing after hours and to support in home care.

Planning for Out of Home Care

Admission to out-of-home residential treatment programs occurs only after a thoughtful process involving supervisory consultation and approval. The CFT must document the following:

- The youth will benefit from residential treatment
- The youth meet medical eligibility criteria for out of home treatment
- Community-based treatment options are unable to meet the youth's needs
- Delineation of the family's specific responsibilities while the young person is in residential treatment

Once the CFT gets to this stage of the process, the youth's care manager identifies options for programs with the needed level of care. The CFT considers the options and assists the youth and family with selecting a provider. The care manager then coordinates with both the family and provider to schedule the admission and gather required information.

Assessment and Monitoring

New Jersey uses a Child and Adolescent Strengths and Needs assessment for any child involved in the child welfare system. This is typically completed prior to an out-of-home treatment. The assessment documents top needs and strengths, which informs service planning, service monitoring, and functional improvement evaluation over time. This is updated every 90 days and serves as the basis of an updated care plan. CFT members consider whether a child still needs a residential setting or whether the youth is ready to transition to a less intensive level of care.

New Jersey also has an integrated single record, which is helpful for seeing service utilization across a range of systems and serves as a critical information-sharing tool.

Maryland

The State of Maryland's Children's Cabinet focused its efforts on addressing both out-of-home and out-of-State treatments in initiatives spanning the education, juvenile justice, child welfare, and mental health systems. This broader look at residential care focuses on keeping young people closer to their families and providing services in the least restrictive setting possible. Maryland is also struggling with having adequate capacity to serve youth.

From a mental health standpoint, this means addressing the complex needs of Maryland youth in out-of-home care. The Children's Cabinet convened a "Hospital Overstay" Workgroup to create a plan for young people admitted to a hospital for psychiatric reasons and staying past the point of medical necessity because they had nowhere else to go and receive the type of follow up services they needed, either in a children's residential facility or through intensive community-based services. This initiative also included youth currently living in a Residential Treatment Center at risk of losing their care due to behavioral issues.

Closures of residential facilities are exacerbating the challenge of how and where to treat youth needing intensive levels of care. Although there are technically residential beds available, youth attempting to be admitted to residential treatment centers are being denied because the facility doesn't offer programming specific to their needs; the facility is concerned about youth behavior; and/or the facility doesn't have the staff available to support clients in all "available" beds. Medical eligibility criteria for residential treatment care are included as Appendix A.

Maryland's plan to address hospital overstays and improve service availability across the continuum includes the following:

1. Initial research and data collection to gauge the scope of the issue	• Survey hospitals/RTCs to identify factors that trigger an "overstay"; identify youth characteristics predictive of an overstay; and monitor for earlier intervention. • Develop plans/strategies for out of home care by creating an interagency policy on reporting specific youth at risk for review • Explore funding to address out of home care needs of non-funded adolescents

2. Immediate and Long-term Specialized Bed Creation	<u>Psychiatric Residential Treatment Facility (PRTF) beds</u> • Develop a collaborative Memorandum of Understanding between agencies to facilitate appropriate use of transition bed contracts • Identify funding source for transition bed contract • Procure contract for transition beds • Evaluate utilization at defined time intervals after implementation to determine future needs <u>Specialized Group Homes</u> • Develop a plan to serve youth that require multi-specialty needs and need highly specialized programming to address those needs (e.g., aggressive behavior, intellectual disabilities, history of human trafficking)
3. Youth-Centric Mobile Crisis & Other Community- Based Programs	Strengthen utilization of Crisis Response Teams for diversion in every jurisdiction and develop regional alternatives that provide stabilization services to divert youth with escalated behavior from hospitals. • Secure funding • Create broader awareness and collaboration of community-based services available across all public child-serving agencies • Identify an evidence-based and evidence-informed menu of services across Medicaid and Title IV-E for eligible children & youth • Identify gaps such as need for respite and build those into system of care • Work with providers to offer services under current financing structures

	• Track and monitor emergency room and hospitalization utilization • Identify resource development needs based on input from local care teams and agencies
4. Monitoring and Evaluation of New Policies and Protocols	• Create a universal protocol for discharge planning process for youth following hospitalization • Provide training in new universal protocols • Develop recommendations for universal consent policy to facilitate some information sharing across agencies serving youth, taking into account privacy and confidentiality concerns • Train providers on resources available upon discharge to help providers identify needed services as part of discharge planning process
5. Interagency Data Collection and Reporting Strategies	• Develop a plan to include near real-time short-term transition bed availability within CJAMS

North Carolina

North Carolina is a state-supervised, county administered system with 100 counties. A significant swath of the state is rural. Although North Carolina's residential care utilization has decreased over time and there have been some helpful steps forward, the state has struggled with different interpretations of policy and practice at the local level.

North Carolina's child welfare reform work was prompted in part by a federal 2015 Children and Family Services Review, which identified numerous problems with North Carolina's child welfare system. Outcomes for foster youth, particularly for children of color and especially with respect to guardianship and permanency, were not meeting expectations. The state met only one of seven federal performance standards and failed to demonstrate substantial conformity with any of seven outcome measures or any of seven systemic factors.

The state lacked an electronic, unified case management system. This was problematic because counties were not able to trace history of out of home care or status of children involved in the child welfare system when they moved across county lines. The state has taken steps to address this through the creation of NC Families Accessing Services through Technology (NC FAST), which is not yet fully implemented. Medicaid and child welfare IT systems are not integrated, and some counties still are not using electronic case management systems.

Partnering for Excellence

Benchmarks, an alliance of child- and family-serving providers, has played an important role in supporting providers and working with State and county officials to support improved child welfare, mental health, substance abuse disorder, and developmental disability services for North Carolina residents. Benchmarks leads Partnering for Excellence (PFE), which is a voluntary initiative to support partnership between Local Management Entities (LMEs)/managed care organizations (MCOs), county Departments of Social Services and private providers. The State's six LME/MCOs determine eligibility for mental health services and are responsible for coordinating/providing care.

PFE aims to achieve the following:

- Improve child well-being outcomes
- Decrease the number of youths entering Department of Social Services custody
- Decrease Child Protective Services re-assessments
- Decrease needs for high-intensity behavioral health services
- Contain Medicaid, State, and county costs for youth in the child welfare system

Counties and MCOs had staff co-locate to facilitate their work with families and participated in cross-system training and cross-agency collaboration. This intentional partnership helped partners better understand each other and how to work together more effectively.

PFE participating counties use both a trauma screening tool and a more in-depth trauma- informed assessment tool. The use of these tools prior to when a child is in crisis can be very helpful in more proactively identifying a young person's needs through a trauma-focused lens.

- The Project Broadcast Trauma Screening Tool is a single page questionnaire completed by a Department of Social Services social worker after gathering information from the youth, birth parents, other caregivers, and other relevant sources. The tool prompts the social worker to ask a young person four standard questions about their experiences. The social worker is also prompted to note potentially traumatic events experienced and any trauma-symptomatic behavior the young person is exhibiting.

- Children screening positive for trauma are referred for an in-depth Trauma-Intensive Comprehensive Clinical Assessment (TiCCA). That assessment explores potentially traumatic events and their resulting impacts; reviews DSS involvement; uses a set of age-dependent measures; pulls information from many people involved in the youth's life (social worker, birth parents and other family members, school staff, other health care providers, and other previously involved professionals). The TiCCA results in trauma-informed diagnoses and holistic recommendations for referrals to trauma-informed services. A comprehensive assessment also considers the entire family's well-being and how a service plan can support and improve the entire family's functioning.

North Carolina does not currently require counties to use a standardized assessment tool and there are no timing requirements associated with when an assessment must be completed. An early PFE pilot involving youth either in DSS custody or receiving In-Home/Treatment services showed that 90 percent of children overall and 100 percent of children in DSS custody screened positive for trauma (Benchmarks, 2023). Benchmarks now advocates that all youth in the child welfare system should receive a trauma-informed assessment within five days of their entry into the system. By the time a child becomes involved with the child welfare system, the likelihood the child has experienced some type of trauma is very high. Benchmarks takes the view that this is the right time for assessment and service planning before a young person goes into crisis. When a youth in the child welfare system experiences a crisis and has not had an assessment, it can take two to three weeks to obtain an assessment. It is much more likely that a youth will move into residential care when this occurs.

Benchmarks evaluated how diagnoses changed among the same group of young people both prior to their county being involved in PFE and during the county's PFE participation. Prior to PFE, children were more likely to be diagnosed with a psychosis-related disorder; during a county's PFE participation, the same group of youth were more likely to receive a diagnosis of post-traumatic stress disorder (PTSD) after they were assessed using the TiCCA standardized assessment tool. The trauma-focused diagnoses serve as the basis for a plan to get appropriate services in place before a youth begins to exhibit problematic behavior. The positive results of these earlier, more comprehensive assessments were demonstrated by lower rates of emergency department, hospitalization, and crisis services utilization. Emergency room visits decreased from seven percent to three percent; hospital stays decreased from five percent to one percent; and crisis service utilization decreased from four percent to one percent (Benchmarks, 2023).

PFE won national recognition in 2016 through the Institute for Medicaid Innovation's Medicaid Managed Care Best Practices Compendium as both the Most Innovative Children's Health Best Practice Award and the Most Innovative Best Practice across all categories. Despite this success, the initiative has not been implemented on a statewide basis. It requires counties to truly be prepared to take on a new way of working with young people and their families.

Benchmarks is advocating for more effective integration between North Carolina's child welfare and Medicaid systems at the state and county level. The organization sees room for significant improvement in providing behavioral health services to children involved in the child welfare system and their family

(whether birth parent, kinship care or foster family) to bolster likelihood of achieving permanency for the child. Benchmarks also sees an urgent need for intensive services that could be either a precursor or stepdown from a PRTF stay.

Lessons Learned

- Timely, high quality, trauma-informed assessments are essential to understanding what youth need and to serve as the basis for a comprehensive service plan. Assessments and subsequent service planning need to be done before a child is in crisis and with the aim of avoiding a crisis. This helps get services in place more proactively and helps keep a young person in her/his family (whether biological, kin, foster, or adoptive). If counties wait until a crisis occurs, a young person is much more likely to experience a destabilizing separation from family, multiple moves, and the young person is much more likely to enter residential care.

- Medicaid and child welfare systems have very different drivers, and their system goals are not aligned. Medicaid wants to see young people served in the least restrictive setting; it's viewed as a positive when youth step down in levels of care. For those young people removed from their families and served in a high intensity setting such as a PRTF or residential care, this almost certainly entails multiple moves. These multiple moves are a challenge from a child welfare system standpoint given that system's incentive to avoid multiple moves and establish permanency for a young person.

- It's essential to collect and analyze data. It is important to aggregate summary- level data from assessments to understand what services youth need and then to geo-map existing service availability in the state. This helps policymakers understand what services are needed, where those services (if they exist) are located, and to see gaps at a system-wide level. Like many other states, North Carolina has significant provider and services shortages, especially in rural areas. It is also important to study outcomes so that public dollars can be spent most efficiently.

- States need to improve entire systems rather than focus only on reducing residential care utilization. They need to focus on supporting entire families heal from multi-generational trauma through effective community-based trauma-informed services.

It is critical to build out community-based services for moderate and intermediary behavioral health needs prior to reducing residential care capacity. North Carolina is struggling in part because this work has not been done at the scale needed to serve youth and their families. There is very limited capacity, for example, for adolescents in the juvenile justice system. Lack of residential service capacity compromises the safety of both these teenagers and the communities in which they live.

States and counties need to invest in their child welfare workforce. Staff need training in trauma-focused cognitive behavioral therapy (CBT), which is expensive and time-consuming. States need to provide sufficient incentives to ensure this happens.

Tennessee: Performance-based contracting

If state and local governments are to move away from use of residential care toward use of community-based services, they need payment models that adequately disincentivize residential care and support robust community-based services. There needs to be both adequate funding to pay for services across the continuum and smart payment methodologies to align payment rates with desired outcomes (MacBlane, 2017).

Historically, a level daily rate created no financial incentives to avoid residential care where possible or to reduce the duration of residential care stays. Facilities could receive Title IV-E payments for the "boarding" component of costs for youth involved in the child welfare system who were with them for the duration of their stay. A facility attempting to shorten duration of stays lost revenue because they would be paid for fewer days of care. FFPSA now creates a significant disincentive for residential care stays by limiting federal funding for non-QRTP stays to a maximum of 14 days and putting numerous safeguards in place related to oversight and monitoring of QRTP involvement. While this approach will limit federal funding of residential care stays, it does not adjust or restrict how state or local governments may choose to continue purchasing residential care with their own funds.

The State of Tennessee innovated around payment structures to residential care providers more than 10 years prior to FFPSA's passage. Their payment methodology is still relevant within the context of FFPSA and demonstrates how state and local governments can use performance-based contracting (PBC) to purchase and improve outcomes for vulnerable populations. Tennessee uses PBC to purchase permanency outcomes by focusing on provider performance on exits to permanency; number of days in care; and rate of re-entry to care.

The State of Tennessee began to work with Chapin Hall in 2005 on the design and implementation of this new system, initially with five pioneering residential care providers. The work relies on data housed at the Center for State Child Welfare, which includes foster care trajectories of all children in out-of-home care for member states. As part of the background research for this initiative, Chapin Hall created provider-level profiles to assess the degree to which variation existed across providers related to foster care outcomes. This involved the development of a risk adjustment methodology to control for each provider's unique youth population in making these comparisons. Residual variation between providers can therefore be fairly attributed to providers themselves rather than to the composition of their patient populations. This initial analysis established that Tennessee residential care providers varied in their ability to achieve

permanency outcomes for youth in their care and it was therefore possible for individual providers to improve their performance (Chapin Hall fact sheet).

Once this variation in performance was established, the next phase of developing the PBC system involved creating a baseline for each provider based on that provider's historical performance. Baselines for exits to permanency, number of days in care, and rate of re-entry to care was based on performance during the two fiscal years prior to the introduction of PBC. Each provider also received a provider-specific target for improvement compared to that provider's historical baseline.

The State of Tennessee also put in place a system of financial risk-sharing with providers. If providers exceeded their targets, they would receive a share of the savings; if providers fell short of their targets, the State would impose a financial penalty. After the first three years of implementation, the initial five providers reduced days in care by eight percent and increased permanency exits by six percent. This was accomplished without increasing re-entry. After the first five years of PBC implementation, Tennessee providers achieved a reduction of 235,000 care days relative to expectations, resulting in estimated cost savings of $20 million (Chapin Hall fact sheet).

Tennessee is still using its PBC methodology for paying providers. Over time, methodological adjustments have been made and the program was recently refreshed. PBC data provides a useful foundation for conversations between the State and contracted providers about how to best serve Tennessee's youth living in residential care.

Other Potential Options for Innovative Payment Models

Other options also exist to create additional innovative payment methodologies. Options for payment models to support an intensive therapeutic, shorter-term program include the following (MacBlane, 2017):

- Creating a tiered rate structure that is highest at entry into the residential care setting when need for intensive services is at its highest level and then decreases over time as service needs change;
- Creating tiered rates according to a child's assessed level of need; and/or
- Creating blended or case rates for youth for the duration of their time in foster care to allow them to be served flexibly, while incentivizing permanency and lower intensity of care whenever possible.

Using Data to Manage Residential Care

States and counties interested in more effectively managing their residential care utilization can begin by asking the following questions (Alpert, 2017):

- What is the probability that a child entering foster care for the first time will go directly to a group care setting?

- What is the probability that a child will spend most of his/her time in foster care in a residential care?
- Are some children more likely than others to be in residential care?
- Does length of stay vary depending on the type of treatment setting?
- How long do children usually spend in residential care settings?
- When children enter foster care and are admitted directly in residential care, what's the likelihood that they will step down, and how long does it take?
- When children enter foster care and are admitted directly with a family, what's the likelihood they will step up to a non-family foster care setting, and when do those disruptions usually occur?
- To what extent do responses to the above questions vary across age, gender, race/ethnicity, or geographically related characteristics of youth?

Understanding whether residential care utilization in each state is driven by heavy reliance on residential care as a first option or more impacted by longer stays is a critical insight. It would help a state understand whether it needs to focus more on reducing flow into the residential care system or on accelerating transitions to community-based care (Alpert, 2017). Policymakers and all stakeholders can also learn a great deal by stratifying data related to the questions above by age, gender, race/ethnicity, and zip code of origin. This is helpful baseline information to understand what populations of youth are most likely to be served in residential care and the types of strategies that may be needed to support them in family-based settings.

States have taken different approaches to how they analyze, use, and publicly report related to stays in residential care. Minnesota currently publishes an annual report on out-of-home care. Among many other child welfare-related data elements, it includes statewide and county level data on numbers of children living in various types of residential facilities. DHS also has an online child welfare dashboard that includes state and county level data on nine state and seven federal child welfare measures. Some other states publish additional data about out-of-home care involvement in annual reports and/or through on-line dashboards on which users can filter data by characteristics of interest. Examples of data published by New Jersey and Maryland are listed below.

Comparing Data Points about Residential Care Published by Selected States:

State	Data Published	Other Key Characteristics
New Jersey	Four measures that can specifically drill down to residential care and can drill down to view by age group, gender, race/identity for all measures 1. Children in Out of Home Care – Point in Time 2. Children in Out of Home Care Longer than 36 Months 3. Children Entering Out of Home Care 4. Predominant Admission to Residential Care Depending on the measure – can also view by setting type, removal episode, number of admissions, time in residential care, sibling care, stability timeframes, case goal, residential care type	• Statewide or county view • Trend over eight-year period • Data as recent as 2022
Maryland	1. Number and percent of out of home care by type 2. Average age of entry by setting type 3. Average length of setting-by-setting type 4. Out of home care occurrences per person by type 5. Number of out of home occurrences for youth county of residence, out-of-county of residence and out- of-state care	

Below is an example of the DHS Data Dashboard percentage of children in out-of-home care that received a medical exam or child and teen checkup within a specified timeframe in 2022:

State Performance Measures

DEPARTMENT OF HUMAN SERVICES

(4) Physical Health at Entry

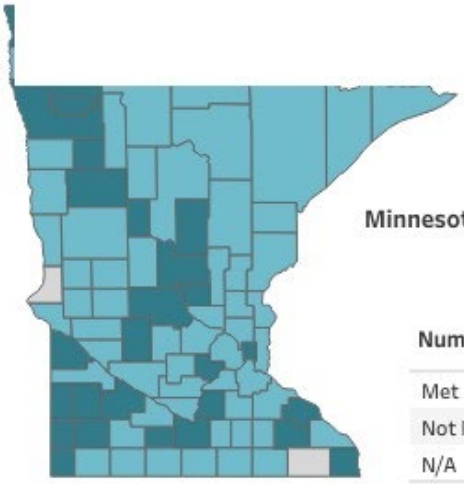
Description: Of all children entering out-of-home care during the given period, who stayed for at least 30 days, what percentage received either a medical exam or a comprehensive child and teen checkup within 30 days of entering or in the 12 months prior to entering out-of-home care?

State Performance Standard: 70.0% or greater

Dashboard Filters

Performance Measure
(4) Physical Health at Ent..

Year
2022



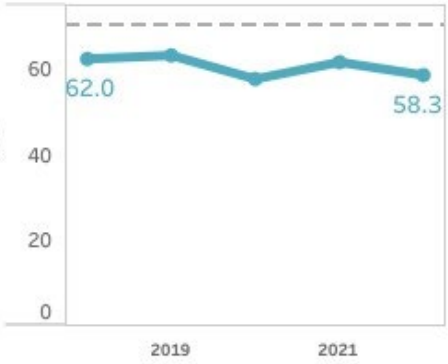
Minnesota Performance (2022)

58.3%

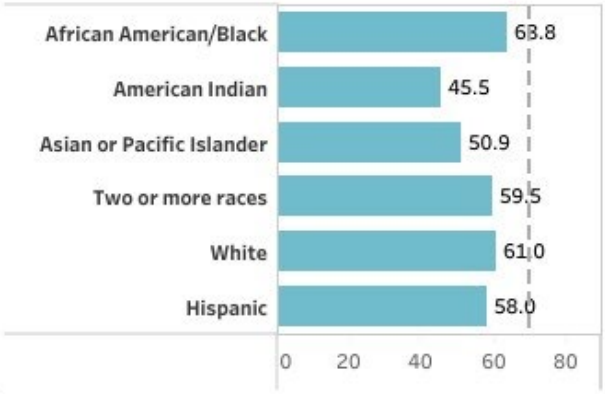
Number of Agencies

Met	23
Not Met	55
N/A	2

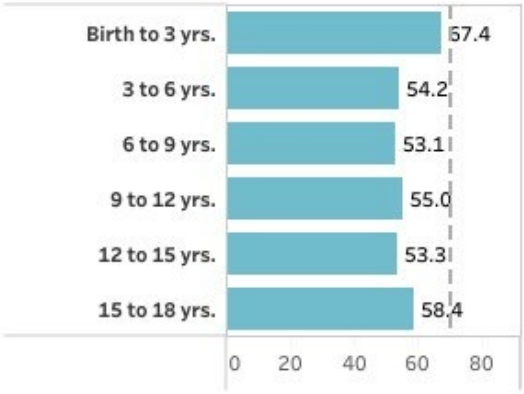
(4) Physical Health at Entry Trends



(4) Physical Health at Entry by Race/Ethnicity (2022)



(4) Physical Health at Entry by Age (2022)



Community Partner Engagement

Focus Groups

DHS contracted with Public Consulting Group (PCG) to engage in conversations with a variety of partners to learn how children's intensive behavioral health services could be improved. Partners included children's residential providers, managed care organizations, schools, hospitals, and juvenile justice perspectives as well as members of the American Indian Mental Health Council. Data was collected from partners through listening/co-creating sessions, questionnaires, and storytelling sessions to identify emerging strengths and themes. Strengths and themes were identified to assist the State in gaining an understanding of the areas that are going well and highlighted service gaps and opportunities for improvement. Direct quotes from community partners are included to highlight the reality of providers and families struggling to meet the demand for children with intensive behavioral health needs. Service gaps and opportunities are categorized into four primary themes:

1. Systemic barriers
2. Lack of resources across the continuum of care
3. Inadequate culturally responsive services
4. Ineffective communication and collaboration

Systemic barriers

Systemic barriers that hinder the effectiveness of services was a major concern shared by partners. A perception exists that the State's approach is more punitive than strength-based, emphasizing the need for more support, training, and less burdensome processes. Certain policies and requirements were identified as impediments to accessing necessary care, such as mandatory meetings and loss of Medicaid coverage for youth in secure facilities.

> A parent described their experience obtaining mental health treatment. They said it was not helpful for them to go through a grant program offered by the residential treatment provider. Once their son was discharged the family had no services and their son's behaviors returned. They stated family therapy and monthly meetings were helpful and that is when interacted with them and answered any questions. They stated the communication while their son was in residential treatment was very good but at discharge they stated, *"I just feel that at the end things felt not supported and alone."*

Ambiguity and confusion surrounding service access and funding also contribute to the challenges faced by families.

- There is a lack of understanding regarding blending funding streams and accessing funds, resulting in difficulty in providing adequate support.
- Transfer of diagnostic testing information between providers is limited, leading to redundant testing procedures.

> *"We use a diagnosis like a ticket in order to qualify for those service programs."*
>
> *Even in a non-pandemic year, it takes months to get medically evaluated because of a shortage of providers in Minnesota. The U's autism clinic stopped adding names in 2021 after its waiting list reached 600.*
>
> *"It is stomach-turning to think of all the kids who are waiting right now for a diagnosis."*

[10]

Compensation for services emerged as a major concern, as stakeholders noted that current rates are insufficient to provide reasonable wages for staff or cover expenses.

- Inconsistencies in rates across counties and inadequate Medicaid reimbursement rates further compound the financial limitations faced by agencies.
- Need for funding to maintain agency stability, address safety concerns, and provide aftercare services as required by the Family First Prevention Services Act.

> *“If you want to keep kids in the community then fund the aftercare services….If you don’t stop the bleeding with providers we are going to have less and less providers.”*

The workforce shortage was identified as a significant problem across all stakeholder groups, creating difficulties in delivering quality care.

[10] (Olson, 2023)

- Incentives for hiring and retaining staff, particularly in rural areas and for bilingual personnel, were deemed necessary.
    - Providers report a common occurrence of new direct care staff becoming overwhelmed when exposed to youth behaviors in residential programs. Many leave within days or hours after receiving weeks of paid orientation.
- Training opportunities were found to be lacking, with limited availability and funding for licensure, continuing education, and advanced training.
- Importance of creating a safe environment for skill development without punitive measures and promoting cross-systems training to enhance collaboration.

> "*I see facilities that operate lower census not because of beds but lack of staff."*

Education and community awareness were identified as crucial factors for improving the system.

- Need to educate families and the public about agency functions, staff roles, and how to access services effectively.

> *"Communities need education to help understand what is needed and how to help someone who needs help and advocate for themselves. It's like we are putting them in the bullpen with no tools or resources they need. They need education on local community services and then what exists within the wider system. Local providers need an understanding of the larger/wider system to help explain it to the people needing the services."*

- Efforts are required to combat the belief that youth must be sent away for treatment, promoting the availability and effectiveness of local services.
- Education on stakeholder roles and service access is essential, particularly for social workers and agencies.

A 10-year-old was in a special needs school and kicked the teacher in the calf; the school wanted them charged. Probation reinforced the need to discuss the situation and how the school social worker could be supported before filing charges. The probation officer shared that they do more social work than criminal justice work (e.g., crisis planning and accessing services) and how families could benefit if the public understood how to access services and community resources available, recognizing that probation's resource is placing youth in detention.

Lack of resources across the continuum of care

Access to the full range of services, including acute care, residential treatment, community-based intervention services, and primary prevention services, is limited, particularly in rural and Native American Indian communities. Behavioral health care services, including outpatient treatment, are not readily available in many areas, requiring families to travel long distances.

- Hospitalization alone does not address underlying family needs or cultural considerations. Residential treatment programs have waitlists, and there is a shortage of facilities that can accommodate serious and specialized needs.

"*We are relying on our detention centers to deal with our psychiatric kids."*

- Detention centers are sometimes used as substitutes for psychiatric residential centers.

There is a need for specialized services addressing various conditions, including aggression, sexualized behaviors, substance use disorders, fetal alcohol syndrome, and eating disorders.

- Provider staffing shortages lead to inadequate one-on-one care for high-needs youth, posing risks to both the youth and staff.
- Community-based intervention services are lacking in several areas, including transitional services, intensive outpatient care, in-home services, specialized programs for autism, and support for families affected by violence.
- Therapeutic foster care homes, respite care, and therapeutic schools are also in short supply.

Increasing face-to-face availability of services is important, as telehealth may not be effective for everyone. Alternative appointment times outside of school hours are needed.

- Primary prevention services, focusing on childhood and early intervention, are deemed crucial in reducing risk factors and promoting mental health.
- Informal parental support programs are not universally available, and there is a call for increased resources and interventions in schools to address underlying issues and prevent future challenges.

Inadequate culturally responsive services

It is crucial to recognize and respect the impact of historical trauma on different populations and cultures. Some populations may have inherent distrust of the system, and behaviors perceived as "difficult" or "resistant" may stem from trauma.

- Native American communities have a direct connection to the land, and their spiritual, ritual, ceremonial, and cultural practices should be integrated into Western treatment approaches. Efforts should be made to retain Native Indian youth in their communities and honor indigenous knowledge.

> *"Things were taken from Natives not that long ago, have a sense DHS is trying to heal this, lots of hurt, pain and anger, still room for healing and starting there. Not always about tossing money at the issue, but there is a component of seeing the faces, personalizing the families you are working with. Thinking about rapport with the families they are working with. DHS is working toward this regarding money and policies, but intergenerational healing takes time and the way to heal this is to hear the stories and interactions. It has taken time to not view DHS as DHS but as a partner/person. Relationships matter."*

Providing information in the native language of families, translating materials, and having interpreters available during interactions are necessary steps.

- There is a need for an increase in bilingual staff who can communicate in languages such as Korean, Somali, Hispanic, and Micronesian.
- Person-centered care and culturally responsive reintegration are essential.
- Demand for psychiatric therapists who specialize in serving Black, Indigenous, and People of Color (BIPOC) populations.

The lack of connection between residential facilities and the youth's community is a concern, as skills learned in treatment may not be applicable or accepted when the youth return home, perpetuating a cycle of challenges.

"There is no connection to the facilities and the youth's community. They learn new skills and tasks/tools while in treatment and are disconnected from their community and then when they return to the community those coping skills are not necessarily accepted. They then get pushed back into the pattern of what the original issue was that resulted in the placement and a continuous cycle. The issue is that residential facilities have zero connection with the youth's community and family. The youth need to learn skills that can be incorporated into their lives and not things that work in the environment the child is currently residing in, it must make sense for when they return to their community."

Cultural considerations, such as incorporating food and cultural practices into meetings and acknowledging the needs of LGBTQI+ and Two-Spirit communities, are essential.

- Cultural inclusion should be prioritized in both in-patient and outpatient settings, with an understanding of practices like smudging and the availability of designated spaces and materials for cultural practices
- Culturally sensitive relationships and healing intergenerational trauma take time, and it is important to personalize interactions and build rapport with the families being served.
- Cultural liaisons can play an active role in ongoing discussions, and efforts should be made to disperse information across all levels and involve trusted adults, spiritual advisors, and community members in the treatment process.
- The medical and sterile environment of residential and hospital settings may be dehumanizing and fail to consider the cultural and holistic aspects of individuals.

Ineffective communication and collaboration

Silos exist between different systems, such as schools, social services agencies, the courts, and treatment providers, leading to fragmented care and a lack of coordination.

- Families require a warm handoff to treatment rather than simply receiving a list of places to contact
- The language used by workers to describe a youth's mental health and behavioral challenges can significantly impact their acceptance into a treatment program.
    - There is a need to reimagine or redefine aggression. It is a response to trauma and being labeled as aggressive or violent limits the ability to serve the child because those labels lead to providers refusing to serve them.

- Effective communication with families should focus on the child's needs, helping them understand the situation and providing opportunities to practice new skills before transitioning home from residential services. However, policy requirements and timeframes often result in missed opportunities to build rapport and establish effective communication with youth.

Stakeholders expressed frustration about being repeatedly asked the same questions and providing feedback without seeing any actionable steps for improvement.

- Stakeholders feel that their input and feedback are not being translated into concrete actions, leading to a sense of being unheard and a perception that the process is performative rather than impactful.

> *"Feels like community stakeholders are providing actionable items and DHS isn't putting into action what the feedback is providing. Made to feel unheard and seems more 'performative' and did it to say we did it."*

- They emphasize the need for prioritization and clearly defined next steps based on the information provided.
- Collaborative thinking and group discussions should be utilized before policy or program rollout to ensure that challenges and barriers are adequately addressed with input from all relevant parties.
    - Communities/parents should be involved from the very first day when the state is going to roll out a new policy impacting children and families. Seeking this feedback is currently perceived like an afterthought or a formality.

Black/ African American and LGTBQIA+ engagement

Genesis Consulting provided further in-depth research with a subset of data from the African American and LGBTQIA+ communities aim to provide additional context from a different lens/community. Themes that emerged from these stakeholder groups included the following:

Theme 1: Accessibility (knowledge/financial/system)
Knowledge

	Both parents and students feel that speaking about mental health in the African American community can often feel taboo. Some parents mentioned a deep tie to their church and the importance of relying on preachers and pastors to confide in. Some students felt like they were not seen or heard in this context (of speaking with church clergy) and often felt judged and that church clergy did not have the knowledge to provide adequate advice to this issue.
	Those who identified as African American and LGBTQIA+ felt that those identities of ethnicity and sexual orientation were very difficult to overcome in the religious (Baptist) community.
	Parents felt as though they did not have adequate knowledge on where to find mental health services needed for their child(ren). Students often did not want to share with their peers what they were going through in school for fear that they would be treated differently by teachers and bullied by students. Often, the student(s) did not know how to ask for help as they did not know what they were experiencing was mental health related.
Financial	
	Limited to no insurance was a barrier in some instances.
	Some stakeholders, especially community-based organizations desired to have more funding around training for culturally relevant care/training as well as more support for CBOs who understand the community but lack the financial resources to adequate serve as part a patient's continuity of care plan.
System	
	Stakeholders from all groups agreed the system itself was too bureaucratic in nature. The wait to receive a referral from a provider to see a mental health provider was not always conducive, especially when an adolescent was in a mental health crisis. Additionally, families had to wait weeks if not months to see a mental health provider.
	Parents and students, when thinking about great mental health services, often found that utilizing CBOs as an in-between proved valuable as they waited to see a mental health provider.

	Stakeholders in the medical community expressed their concerns about the conditions of treatment facilities and the worry of leveraging emergency and urgent care facilities to receive care in an emergency as those providers aren't often equipped to handle mental health crisis. There is a desire to work with more closely with CBOs to establish a system of care for emergent scenarios that does not exist on a broader level.
Theme 2: Culturally appropriate care/ability for practitioners to recognize lived experiences	
	Providers [some] acknowledge that there is a lack of cultural understanding when treating patients and parents have acknowledge that they felt as though some providers judged either them as parents identifying as LGBTQIA+ or their child(ren). Furthermore, parents reiterated the importance of funding CBOs with proper staff and financial resources to continue to work in the community and provide mental health services and not just serve as a conduit of resources to and for providers.
	Some providers feel that initial training and formal education lack the ability to view mental health from a trauma-informed and cultural perspective with respect with nuances unique to different communities.
Theme 3: Community-based organizations	
	Parents and other stakeholders felt the importance of leveraging CBOs as experts in the field of community engagement and care.
	CBOs sometimes felt frustrated with the limitations they face and desire to have financial resources needed to assist with emergency care and well as standard mental health services for the community.

Children's residential direct care focus groups

DHS conducted focus groups with children's residential facilities (CRFs) participating in hospital decompression grants to gain insight into challenges and successes direct care staff have experienced with this level of care. Discussions with direct care and clinical staff at DHS licensed children's mental health treatment residential treatment centers revealed multiple instances of children languishing in institutional care due to lack of appropriate options. These situations included:

- Children staying in shelter for up to 2 years
- Children with Autism diagnosis confined to juvenile detention for over a year while awaiting PRTF

- Children in acute psychiatric distress being arrested at hospital emergency departments or inpatient psychiatric hospitals for aggression and sent to juvenile detention

Below includes a summation of the main themes including barriers and opportunities to serve more children in need of residential care.

Staffing/ workforce:

- Background check delays result in weeks or months new hires having to wait.

> *"Background checks take too long, sometimes up to 2 months. People cannot wait that long without a paycheck."*

    - Many find other work due to the delay
- High turnover rates due to other opportunities available, acuity of youth
    - Impacts quality of care and client outcomes
- Need for ongoing training and support for direct care staff to improve recruitment and retention.
    - Ex. North Homes has over 40% turnover rate and more than 40 open positions agency-wide
        - Could serve many more youth if staff were available
    - Volunteers of America program licensed for up to 20 beds, currently only able to serve 7 due to lack of workforce

Need for continuum of care:

- Lack of step-down options, post-discharge, and aftercare
- System silos do not allow for warm handoffs, coordination of care
    - Diagnostic Assessments and treatment history often does not follow child to new care setting
    - PRTFs and hospitals may choose to not admit children with high levels of aggression or acuity and end up in facilities with far fewer resources to provide optimal care
        - Ex. Juvenile justice facility with severely autistic child removed by law enforcement from psychiatric hospital for aggression now bashing head against wall in detention

Rates/ financial stability:

- Host county rates do not support need for intensive staffing
    - Can be a disincentive for providers to expand or maintain capacity due to lack of adequate wages for direct care staff
- Providers cannot compete with other areas for pay
- Challenge to innovate and truly implement evidenced-based practices

Youth/ family needs:

- Acuity and complexity of youth has continued to increase

> Youth have become overly reliant on technology and devices for self-regulation which has created an expectation and demand for 1:1 staffing in residential programs.

- Need for separate therapeutic environments for children with aggression related trauma vs. non-aggression
- Despite telehealth family involvement has continued to present challenges
    - Ex. Even with technology making telehealth more accessible to families, providers report family engagement while a child is in residential treatment has been challenging

A mother's son was treated at a children's hospital for an attempted suicide by overdose. He was at the children's hospital for four days and was told he would need inpatient services for depression, and they couldn't take him home. The mother stated they were in "crisis mode from being in the children's hospital to residential treatment" and "did not know the options available to us" and thought they'd most likely have to get treatment in South Dakota or North Dakota and thought they'd have to secure temporary housing. "It was a very negative experience."

The mother stated, "It felt like [our son] was left in a concrete prison. He had no shoestrings, it was a locked facility, concrete walls, and he was in with children who dealt with drugs and violence in the home, who were violent themselves, didn't have parents, or who were using substances. He was exposed to a lot more than he was used to or had been." The mother described their son's accommodations as a room with a bed in it, concrete walls, and bars on the windows- "it was a concrete bunker." The doctors created a treatment plan and determined how long he stayed; the family was not involved in the process. His parents could visit him for 30 minutes per day and any items they brought into the treatment facility were searched.

After her son was discharged from residential treatment, it took six weeks to get him into outpatient treatment. She stated he did not care for it–he was an athlete and played hockey and lacrosse. He was not interested in the activities the youth did in the group like meditation and arts and crafts.

He participated in the program for three days before he died of suicide.

VI. Report recommendations

To address the pressing need for a comprehensive children's behavioral health continuum of care, a strategic vision championed by the State is essential. Children's residential and congregate care facilities are but one component of a system of care that is interdependent and optimally functional based on care coordination and elimination of system silos. Children and families utilizing these levels of care have unique needs that require specialized approaches. As mentioned above, for some children with serious mental illness, kinship or family-type settings may not be appropriate and require residential treatment.

Ongoing workforce shortages and significant increases in behavioral health needs of children, exacerbated by the COVID-19 pandemic, has only continued to strain the existing underbuilt and underfunded system to the breaking point. Without meaningful, strategic action, children in need of intensive behavioral health care will continue to overburden hospital emergency departments and residential facilities with limited capacity to meet the demand. Moreover, there is a concerning trend of children labeled as aggressive being diverted into the juvenile justice system where they are far less likely to receive adequate treatment for behavioral health conditions. The following recommendations are based on research, national trends

and represent the needs within Minnesota as voiced by stakeholders.

Financial Relief to Children Facilities:

1. Work force measures for Youth Care Professionals (YCPs):

    a. Explore and identify flexibilities through establishment of formal mentorship programs that will enable new staff to gain exposure to real-world working conditions while awaiting background check, particularly with children and youth.

    b. Development of a strong and dedicated youth behavioral health workforce

        i. Establishing youth direct care professional as a viable career path, offering attractive incentives and professional growth opportunities.

    b. Increase recruitment for direct care professionals of diverse backgrounds through enhanced incentives and benefits.

    c. Establish a Youth Care Professional Training Institute

        i. Include opportunities for Juvenile Justice professional to receive trauma-informed care training.

    d. Grants to support physical environmental changes, retention and hiring of YCPs.

        i. Ex. Creating more therapeutic and welcoming environments for children with trauma and sensory issues.

    e. Onsite psychological support for YCPs[11]

    f. Training grants for therapists working in residential facilities.

    g. DHS and MDH to work with different licensing boards to support the youth care professionals working in the residential settings to establish a path to become independent mental health professionals.

    h. Specialized grant programs focusing youth care professionals' retention in the work force across the State including DOC and DHS licensed facilities.

[11] Youth care professionals are frequently subjected to high acuity and stress situations with youth in crisis. These situations may involve de-escalation of suicidal or homicidal threats and severe aggression and assault.

2. Invest in Aftercare and Community-Based Services [12]

    a. Increase funding and grant opportunities for providers providing culturally relevant care to enhance prevention/ intervention and aftercare/ step-down services for youth transitioning out of residential care.
        i. Community-based services are key to helping reduce the revolving door and recidivism that produce costly overreliance on hospitals and residential care.
    b. Counties using emergency departments as shelter for children in foster care who do not meet medical necessity to access hospital level of care, counties have had instances of staffing children in hospital EDs as a contribution to the shelter care at the hospital.

        i. Opportunity to develop more appropriate responses to children that meets their needs for care without accessing safety net care that is not medically necessary

    c. Community-based group care is a desperately needed level of care for many children who require a step-down structured environment to sustain stability and also engage in developmentally appropriate growth in the community at the child's highest level of community engagement/least restrictive level of care

    d. Many children whose needs exceed or are not aligned with what can be offered within the residential treatment milieu are children with disabilities, sometimes co-occurring with mental illness and more often the co-occurring need is behavioral in nature. There is an insufficient service array that can design treatment and individualized care responses to support these children – within group home care, residential treatment or an intensive care response within foster care settings, and the flexibility to create this care between service silos is needed.

    e. Investment in kinship care for children in out of home placement situations where serious mental illness is not the primary condition

    f. Expand mobile transition services for children in residential facilities to mitigate risks of future care out of the home or community

    g. Investment in residential programs to provide resources for implementing innovative approaches such as the Building Bridges Initiative.

    h. Fix the Medicaid outpatient community-based rate structure so early intervention and transition care is available to children and families
        i. With a functional rate structure providers can:

[12] Aftercare definition

1. deliver early interventions and prevent more acute care,
2. grow the field to individualize treatment and respond to externalizing mental health symptoms (instead of simply identifying residential treatment as needed out of fear or a lack of other options)
3. help design and provide needed aftercare, and,
4. elevate the critical component of family engagement/care coordination and team-based responses to children's needs that currently are not attended to as they should be due to a lack of resources

i. Conduct an analysis of the payment and cost structures for Children's Residential Facilities. There is a need to breakdown the costs for room and board and treatment. For both the aspects (room & board and treatment) it is imperative to explore ways to help the providers meet the costs associated with accepting and treating children with complex needs.

j. Identify and implement strategies to support develop of PRTFs in Minnesota.

k. Expansion of family-centered in-home children's mental health services that can assist in transitioning youth away from institutional care including:
   i. Children's Intensive Behavioral Health Services (CIBHS)
   ii. Youth Assertive Community Treatment (Youth ACT)
   iii. In-Home Children's Therapeutic Services and Supports (CTSS)
   iv. Bridging Services
   v. High Fidelity (HiFi) Wraparound
   vi. Build effective service models to include:
   vii. Respite
   viii. Children's Residential Crisis Stabilization
   ix. Community-Based Group Home Care
   x. School-Linked Mental Health

3. Investment in availability of high-quality, trauma-informed assessments to ensure tailored and effective treatment interventions with clear outcomes.

Systemic/Administrative:

1. DHS in collaboration with providers and community advocates will seek CMS approval of the Health Equity Demonstration Implementation Protocol, the demonstration benefit package for Minnesota Medicaid recipients, including short- and long-term residential services provided in residential, inpatient, correctional, shelter, and emergency department settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. Through possible federal waiver , the state will be eligible to receive federal financial participation for Minnesota Medicaid recipients who are short and long-term residents in IMDs under the terms of

this demonstration for coverage of medical assistance, including mental health benefits that would otherwise be matchable if the beneficiary were not residing in an IMD.

   a. Provide federal reimbursement for short-term residential treatment stays in children's residential facilities designated as IMDs (Institution for Mental Disease)

   b. Enhance treatment and outcome standards of care for participating providers

   c. Increase access through enhanced eligibility standards based on medical necessity

2. DHS to review and revise MN Rule 2960 standards of care. DHS to look at possible alignment or combining of 2955 and 2960 (both DHS and DOC) to support serving youth living with a mental illness who might demonstrate aggressive and inappropriate sexual behavioral concerns.

   d. To include high quality residential care framework like Florida's Quality Standards Assessment

   e. The licensing rule needs to transition to statute where the antiquated language/inconsistencies and other challenges can be updated to reflect current practice, and updates as needed can be conducted outside of the burdensome environment of rulemaking.

3. DHS, DOC and counties to look at current system of screening children/youth for residential stays in the context of Third Path and identify the obstacles in having an objective, equitable system of determining need for residential interventions. This includes clarification and documentation of the process when youth are being sent out of State for treatment.

4. Explore revisions to MN 245.4874 statute to allow earlier access for juvenile-justice involved children to receive diagnostic assessment.

5. Explore and recommend a child-focused and uniform model of reimbursement for Children Residential Facilities to support the facilities in MN to treat children with complex needs and mitigate out of state treatment. Some examples could be "money follows the child" model with following options:

   f. Tiered reimbursement that incorporates gradient for working with more acute situations

   g. Need based rate that can include parents/ family needs such as housing, food, income stability, etc.

      i. Incentives for building more diverse direct care staff.

Redefine and Revise Approach Data Collection and Utilization:

1. Initiate and sustain community driven models of seeking community input in co-creating treatment and prevention interventions for children and youth through use of tools such as Community Toolbox
2. Data system to track youth care professional work force and conduct analysis to mitigate loss of work force.
3. Development of a comprehensive statewide data system that tracks the referral and treatment history of youth.
    a. Explore enhancements to SSIS or development of new system that meets needs of youth involved in multiple out of home treatment settings. Any recommendations regarding data including SSIS enhancements should consider the impact to the end user, which are our front-line case workers at the county level.

    b. The State has a fragmented system of capturing data with negligible qualitative data elements available. It is recommended that State works with counties and tribal nations to develop a state-wide comprehensive, user-friendly, equity-based data management system to facilitate seamless communication on child and families' needs. This includes children and youth across the whole State, irrespective of the door they are coming in (such as DOC, Mental Health, Child Welfare, Counties, MDE, Disability Division).
        i. To effectively collect and use data to improve outcomes, we need an investment in an integrated data system that works across state departments and ideally supports a young person's treatment team members to input their respective data.
    c. Need to disaggregate data to understand needs based on gender, disability, ethnicity etc. to identify health inequities.
        i. Need for community input, particularly for those most impacted by tracking this data.
    d. Acknowledge and encourage the power of narratives of youth and families. Invest in qualitative data collection strategies to capture unique struggles, aspirations, needs and strengths of Medicaid enrollees, through an equity lens.
        i. According to advocates, families often fear seeking help for their children's mental illness due to their experience of being blamed for their child's illness. It is important to put measures in place to assure the families that their asking for help is not going to "punish" or "label" them as "bad parents."

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Interview with Victor Isler. Mr. Isler previously served as Director of a county social services dept and as a member of North Carolina's Child Well Being Council. Currently Assistant County Manager for Guilford County, North Carolina. April 12, 2023.

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