



TIERED TREATMENT FOSTER CARE WORKGROUP REPORT AND RECOMMENDATIONS

Presented to the Public Children Services Association of
Ohio (PCSAO) and the Ohio Department of Job and
Family Services Office of Children Services
Transformation

By Mighty Crow Media, LLC
Gretchen Clark Hammond, PhD, MSW, LSW, LCDCI, TTS
and Erica Magier, MSW, LSW

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TTFC Leadership Team

Angela Sausser	Executive Director, PCSAO
Scott Britton	Assistant Director, PCSAO
Kristi Burre	Director, Office of Children Services Transformation (ODJFS)
Karen McGormley	Project Manager, Office of Children Services Transformation (Workgroup Co-Chair)
Kari Akins	Policy Manager, Office of Children Services Transformation
Timothy Schaffner	Executive Director, Trumbull County Children Services (Workgroup Co-Chair)
Gretchen Clark Hammond	Mighty Crow; Project Management for PCSAO
Erica Magier	Mighty Crow; Project Management for PCSAO

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Executive Summary

The Public Children Services Association of Ohio (PCSAO) put forth its Children’s Continuum of Care Reform Plan (CCCR) in 2018 (updated May 2019) with four bold strategies intended to improve Ohio’s continuum of care and address identified gaps. As the plan states, “The continuum of care focuses on four specific strategy areas so that children can be safely diverted from coming into foster care; when in care can experience a robust, well-trained, and supportive foster care system; when returning home, the family is supported to avert reentry into care; and if and when a child requires residential care, it will be short-term, high-quality, and close to family” (p. 4). The four strategies are: (1) Intervention, Crisis, and Diversion Services; (2) Foster Care Services; (3) Aftercare and Reunification Services; and (4) Residential Care Services.

The CCCR Reform Goal is “To reduce reliance on congregate care settings and embrace that kids do better with families, Ohio needs to establish a children’s continuum of care that focuses on intervening with community-based short-term crisis stabilization and diversion services. If children need to be removed from their families, there needs to be a robust care system that can support the challenging needs of kids in a family-based setting while focusing on reunification” (p. 4).

“Strategy 2: Foster Care Services” is intended to create a robust foster care system that can meet the variety of challenging needs of children while focusing on reunification efforts. Within this strategy, there are three core tasks: (A) Develop statewide foster parent recruitment and retention assistance; (B) Modernize Ohio’s foster care system; and (C) Establish a new exit from foster care to permanency with the Kinship Guardianship Assistance Program (KGAP).

To address Strategy 2, item B: PCSAO convened a group of over 40 stakeholders representing public child welfare, private foster care agencies, behavioral health and family service providers, foster caregivers, former foster youth, parents who have experienced reunification, and state government. The focus of this convening of stakeholders was to expand the levels of foster care beyond “traditional” and “treatment” as these are the two levels that currently exist in Ohio.

The Tiered Treatment Foster Care (TTFC) Stakeholder Group¹ convened monthly in June, July, August, September, and October in day-long meetings (10:00 am to 3:00 pm). The charge to the group was as follows: The Stakeholder Committee will recommend a new system of treatment foster care levels/categories, services and supports, rates, incentives and outcomes that can be supported by multiple stakeholders, including public agencies, private providers, foster parents, and the State of Ohio. The recommendations from this Committee will be presented to PCSAO’s Board of Trustees and Executive Membership for review and approval.

The group was co-chaired by Tim Schaffner (Trumbull County Children Services and PCSAO) and Karen McGormley (ODJFS Office of Children Services Transformation). Facilitation of the meetings, project management support and the writing of the final recommendations report was provided by Mighty Crow (Gretchen Clark Hammond and Erica Magier), and research support was provided by Kelley Gruber from the Institute for Human Services.

The Work Plan for the TTFC Stakeholder Committee included the following key decision/priority areas:

¹ A list of Stakeholder Group members is provided in the Appendices.

1. Review Research from other states or Ohio jurisdictions, including national models and supports.
2. Identify shared values in order to develop a statewide flexible model that can win broad-based support.
3. Communicate progress with peers and within associations in order to build support beyond the committee.
4. Recommend a final statewide model.
5. Advocate for statewide adoption of the model.

The following pages contain the expanded levels of Tiered Treatment Foster Care. These levels are intended to provide a structure for Ohio's counties that allows for flexibility to make decisions that best meet the needs of the child served and best supports the adults engaged in the child's life as parents and caregivers. Each tier provides guidance for decision-making with the realization that there will always be circumstances and situations that extend beyond the description provided, requiring thoughtful and intentional decision-making by child welfare professionals to best match the child with the tier that meets his or her needs. Please Note: These tiers do not include what is often called "basic" or "traditional" foster care, as that level of foster care is NOT treatment foster care. This workgroup was focused on treatment foster care and the creation of tiers within this system.

Purpose: The Stakeholder Committee will recommend a new system of treatment foster care levels/categories, services and supports, rates, incentives and outcomes that can be supported by multiple stakeholders, including public agencies private providers, foster parents, and the State of Ohio.

Recommendations: The recommendations in this report reflect the cumulative work of the stakeholder group that occurred between June 2019 and October 2019. These recommendations center around a common value shared by stakeholders: We all want children to be in homes where healing can take place, be near their birth families and help children return home. They include:

Recommendation 1: Expand and enhance the levels of foster care beyond traditional and treatment by creating three tiers of treatment foster care that better meet the variety of challenging needs of children entering the system and those that may be stepping down from congregate care or entering treatment foster care in lieu of congregate placement. This expansion will establish a range of tiers, which includes the highest form of treatment foster care. This recommendation recognizes that some counties may have a tiered system in place that may correspond with these proposed tiers.

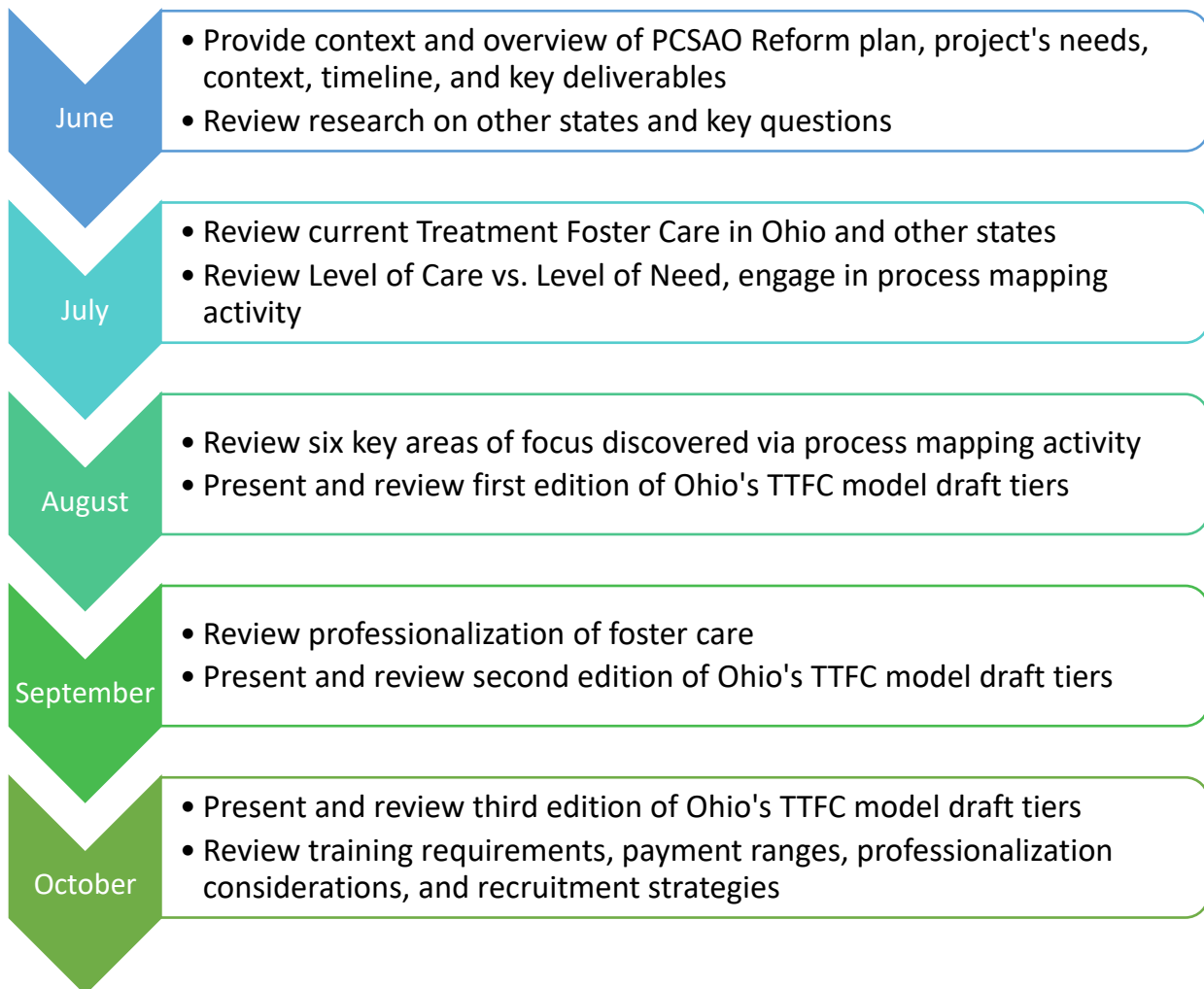
Recommendation 2: Adjust foster care per diems based on the level of care provided by establishing a standard per diem range for traditional foster care that is consistent across the state. Establish consistent per diem ranges for the three tiers of treatment foster care while further standardizing the core features of quality treatment foster care. These ranges should consider actual cost of living, including costs associated with the expected care needs of the child. We recommend a workgroup to focus on this issue, as it is quite complicated.

Recommendation 3: Professionalize the role of foster parents by determining skills required, support provided, and expectations for entering foster care as one's primary area of focus. Professionalization is not synonymous with employment; rather professionalization should be focused on role definition, skill expectation, training needs, and mentorship. Professionalism should also consider recruitment, capacity-building, and other important issues. We recommend a workgroup to focus on this issue just as we did with payment, as it is also quite complicated.

The leadership team recognizes the evolution of the child welfare system that is currently underway and knows that the topic of Tiered Treatment Foster Care is one of many issues that are being discussed as the state prepares for the implementation of the Family First Prevention Services Act (FFPSA).

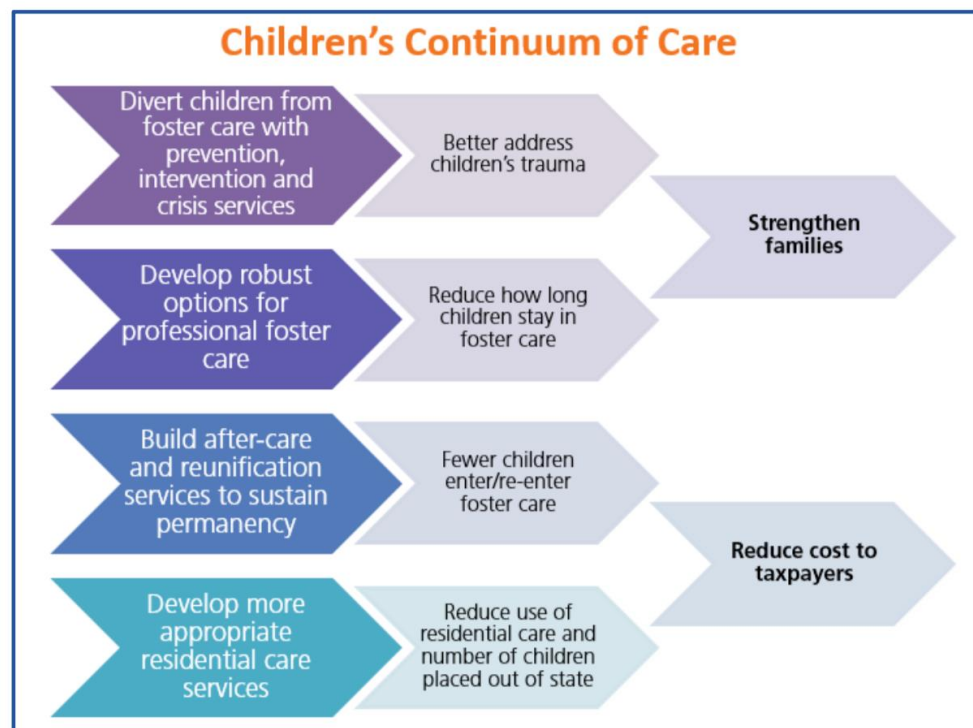
Stakeholder Workgroup Overview

The Tiered Treatment Foster Care Workgroup convened in June, July, August, September, and October 2019 from 10:00 am to 3:00 pm. Summaries from each meeting are provided in this section. Meetings were facilitated by the team from Mighty Crow and incorporated presentations, large and small group discussions, and process mapping activities. These facilitation techniques were employed to help facilitate discussion and gather opinions of all members of the stakeholder committee. Detailed meeting summaries are provided in the appendices, with a broad overview provided below.



Recommendations and Rationale

Children’s Continuum of Care Reform (CCCR) Goal: To reduce reliance on congregate care settings and embrace that kids do better with families, Ohio needs to establish a children’s continuum of care that focuses on intervening with community-based, short-term crisis stabilization and diversion services. If children need to be removed from their families, there needs to be a robust foster care system that can support the challenging needs of kids in a family-based setting while focusing on reunification.



CCCR Strategy Areas:

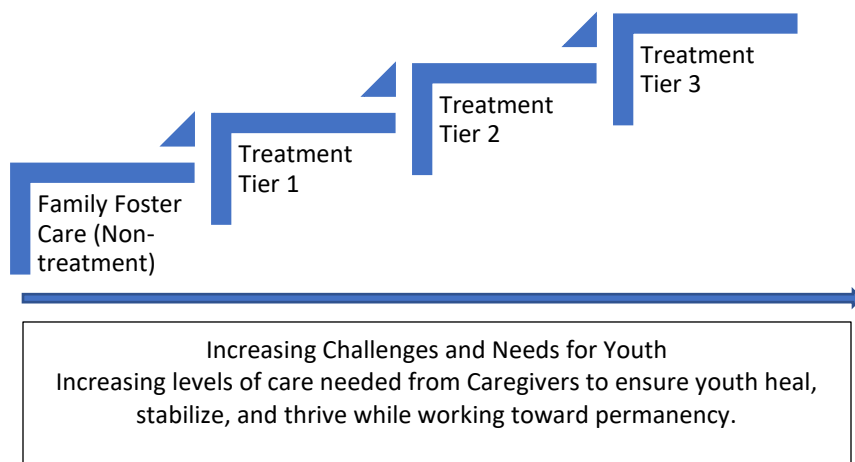
1. Intervention, Crisis, and Diversion Services
2. Foster Care Services
3. Aftercare and Reunification Services
4. Residential Care Services

The recommendations in this report focus on the second CCCR Strategy Area: Foster Care Services, with specific attention to modernizing Ohio’s foster care system through the development of tiers for treatment foster care, expanding the levels of foster care beyond traditional and treatment. This strategy seeks to create a robust foster care system that can meet the variety of challenging needs of children while focusing on reunification efforts.

Recommendation 1: Expand and enhance the levels of foster care beyond traditional and treatment by creating three tiers of treatment foster care that better meet the variety of challenging needs of children entering the system and those that may be stepping down from congregate care or entering treatment foster care in lieu of congregate placement. This expansion will establish a range of tiers,

which includes the highest form of treatment foster care. This recommendation recognizes that some counties may have a tiered system in place that may correspond with these proposed tiers.

Rationale: *Ohio (and other states) have received increased scrutiny for the overreliance on congregate care (e.g. group homes and residential treatment) for youth, especially older youth and teens. Within the current system, there are only two options: “traditional” or “basic” foster care and “treatment” foster care. Treatment foster care has grown to encompass children with a wide range of needs related to behavioral health, physical health, violence and delinquency, educational needs, etc. As such, those children with less severe needs (but needs nonetheless) are being placed within the traditional foster care system and children with higher needs are in congregate care. The norm for who best fits within basic/traditional and who meets criteria for treatment have shifted to accommodate this situation. Multiple tiers allow for a system with options that better reflect the needs of children and the level of care expected from caregivers/foster parents. Multiple tiers allow Ohio to better understand the challenges of children who are being served by examining trends between and within groups. Tiers also allow for a reset in terms of who should be served through traditional foster care and who should be served through the tiered system.*



Recommendation 2: Adjust foster care per diems based on the level of care provided by establishing a standard per diem range for traditional foster care that is consistent across the state. Establish consistent per diem ranges for the three tiers of treatment foster care while further standardizing the core features of quality treatment foster care. These ranges should consider actual cost of living, including costs associated with the expected care needs of the child. We recommend a workgroup to focus on this issue, as it is quite complicated.

Rationale: *In an examination of maintenance payment expenditures for January through July 2019, it became evident that payments varied greatly from county to county, with no similarity based on county size (rural vs. metro). Treatment foster care organizations identified the variance in rates as a challenge to contracting and for recruiting partners who know that the payments vary greatly from county to county, seemingly regardless of child need. Because payment is a complicated issue and may require Ohio to explore ways to pay for treatment foster care, we recommend that this issue continue to be discussed in a workgroup that includes PCSAO, ODJFS Office of Child Welfare Transformation and Office of Families and Children,*

Medicaid, and other key stakeholders. These discussions were underway during the TTFC Stakeholder group and need to continue. Included in this process is a comparison of Ohio's payments with other states, which is provided as an attachment to this report. In addition to establishing a consistent range, this workgroup should consider a sustainable and equitable system for how families are compensated when the level of care adjusts down. This group should explore ways to adjust the current model, such as paying for a foster parent to mentor or work with the child's biological family post reunification or incentivizing this work with biological or kin families.

Recommendation 3: Professionalize the role of foster parents by determining skills required, support provided, and expectations for entering foster care as one's primary area of focus. Professionalization is not synonymous with employment; rather professionalization should be focused on role definition, skill expectation, training needs, and mentorship. Professionalism should also consider recruitment, capacity-building, and other important issues. We recommend a workgroup to focus on this issue just as we did with payment, as it is also quite complicated.

Rationale: *The topic of professionalization garnered much discussion during the TTFC stakeholder meetings. The ideas of: employment of foster care parents versus other professional arrangements, the need for crisis support, role definition, improved communication with case workers, and the development of a community of care for adults serving in this important role were all components of this discussion. As we delineate the increasing needs of children within the tiers, we must also delineate the increasing expectations of care for foster parents. Meaningful training that supports caregivers in their ability to work with children in tiers two and three is an area of great importance, including creating opportunities to be a respite provider as a way of gaining experience before a higher tiered placement. The topic of "professionalization" is also one that corresponds to the challenges of recruitment and retention of foster parents. Looking at their needs as individuals and as a community of caregivers is important, as those needs will help frame training opportunities, crisis supports, and mentorship opportunities. Helping define the role of the treatment foster parent as both "parent" and "member of the treatment team" is necessary to prevent role confusion. Developing a framework for shared decision-making for foster parents with the support of the caseworker and/or treatment foster care agency is also a key part of professionalization.*

Context for the Tiers

Current definitions within the Ohio Administrative Code² for foster care are as follows:

- "Family foster home" means a foster home that is not a specialized foster home.
- "Foster home" means a private residence in which children are received apart from their parents, guardian, or legal custodian, by an individual reimbursed for providing the children non-secure care, supervision, or training twenty-four hours a day. "Foster home" does not include care provided for a child in the home of a person other than the child's parent, guardian, or legal custodian while the parent, guardian, or legal custodian is temporarily away. Family

² <http://codes.ohio.gov/oac/5101%3A2-1>

foster homes, pre-adoptive infant foster homes and specialized foster homes are types of foster homes.

- “Specialized foster home” means a medically fragile foster home or a treatment foster home.
- “Medically fragile foster home” means a foster home providing specialized medical services designed to meet the needs of children with intensive health care needs as identified in section 5103.02 of the Revised Code.
- “Treatment foster home” means a foster home that incorporates special rehabilitative services designed to treat the specific needs of the children received in the foster home and that receives and cares for children who are emotionally or behaviorally disturbed, chemically dependent, mentally retarded, or developmentally disabled, or who otherwise have exceptional needs.

Many states, including Ohio, have recognized that treatment foster care serves a wide range of children with varying needs that are often complex and challenging. Thus, they have moved in the direction of developing tiers of treatment foster care to better describe the characteristics of the children coming into care and the expectations for foster parents. Additionally, with the recognition of the need for children to be in family environments as opposed to congregate care environments, there is movement in many states to delineate tiers of care.

A Technical Expert Panel from The Substance Abuse and Mental Health Services Administration (SAMHSA), the Center for Medicaid Services, and the Administration on Children, Youth, and Families was convened on September 27 and 28, 2012 to answer the question, “What does the Research Tell us about Services for Children in Therapeutic/Treatment Foster Care with Behavioral Health Issues?”³ A summary of some of their key findings is provided here:

1. What do we know about therapeutic or treatment foster care?

“Therapeutic/Treatment Foster Care (TFC) is a community-based, less restrictive alternative to more restrictive settings (e.g., group care, psychiatric residential treatment facilities, long-term residential programs). TFC models generally treat seriously emotionally disturbed youth who have a high likelihood of needing more restrictive long-term residential treatment. Many variations of TFC models exist. TFC plays a different role in states' systems of care depending upon its location in the system (e.g., child welfare, juvenile justice, mental health). States license TFC in different systems for different purposes. The design of TFC programs administered by child welfare agencies may differ significantly from the design of TFC programs administered by mental health agencies” (p. xvii)

TFC serves youth who tend to be high service-need with a wide range of presenting problems including significant social, emotional and mental health problems. Youth in TRC may need more structure and services than are provided in regular foster care.

³ Substance Abuse and Mental Health Services Administration. (2013). *What does the research tell us about services for children in therapeutic/treatment foster care with behavioral health issues?* Report of the SAMHSA, CMS and ACYF Technical Expert Panel, September 27–28, 2012. HHS Publication No. (SMA) 14-4842. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

“TFC is a treatment setting, yet there is no standard implementation of TFC across child-serving systems or across states. While many TFC agencies are incorporating key components of the Foster Family-based Treatment Association Standards, there is widespread variation in TFC programs’ conformity to those standards. There is no uniform set of enrollment criteria for TFC. State license TFC in different systems for different purposes. TFC programs vary in implementation readiness and duration” (p. xix).

2. *What do we know about identifying youth appropriate for TFC?*

“Screening instruments, assessment requirements and level of care criteria vary widely in practice and in published research. No one measure meets all needs. Existing assessment measures for youth have limitations; there is a need to improve measures used to assess key youth and family domains. Rather than using a ‘one size fits all’ assessment for youth in foster care, systems serving youth receiving child welfare services should employ an array of assessment tools to appropriately evaluate the domains of social-emotional well-being for youth and evaluate functioning across age groups” (p. xx).

“Measures that inform practice have greater utility. Funding should not drive the decision to adopt specific measurement instruments. Assessment measures and tools should be free or open source. The field should not employ measures simply because they are included in existing management information systems (MIS). Functional assessments and psycho-diagnostic evaluations of youth in TFC should be reimbursable” (p. xxi).

3. *What do we know about the essential elements of TFC?*

The consensus panel ranged the following list of essential elements of TFC:

- Demonstrating the TFC agency’s ability to support TFC parents
- Including TFC parents as members of the treatment team
- Assuring reduced caseloads for staff supporting TFC parents
- Investing in TFC parents
- Assuring the TFC agency’s ability to supervise TFC parents
- Providing specialized training to TFC parents
- Monitoring the behavior of TFC youth
- Establishing therapeutic alliance between TFC parents and the youth in their care
- Providing 24/7 support/coaching to TFC parents
- Providing appropriate aftercare resources for youth
- Providing older youth in TFC with preparation and training for adulthood
- Coordinating services for everyone involved in the TFC treatment plan
- Monitoring the use of psychotropic medications for TFC youth
- Assuring that TFC parents are able to meet the psychosocial needs of youth in their care
- Supporting and engaging the family whom the youth will go to following TFC
- Providing individual mental health treatment for youth
- Conducting service planning for youth
- Providing academic support for youth
- Providing social skills training for youth in TFC
- Scheduling regularly held clinical supervision for TFC staff to assure their effective working relationship with TFC parents
- Maintaining TFC homes with professional treatment parents
- Involving birth or biological parents in treatment planning and implementation
- Providing higher reimbursement rates for TFC parents
- Bundling of TFC services

4. *What are recommendations for the implementation of what we know?*

Key points included:

- (1) TFC requires multifaceted interventions;
- (2) Placement of a youth should be based on needs;

- (3) There is a need to expand the use of best practices in TFC;
- (4) The Administration on Children, Youth and Families (ACYF) considers well-being as important as safety and permanence;
- (5) The TFC treatment plan must be individualized, address the specific needs of each youth and include preparation for that youth’s transition out of child welfare service;
- (6) TFC families should be reimbursed at higher rates than regular foster care families; and
- (7) There is a need for flexible funding options that promote both youth treatment and youth well-being.

Social and Emotional Well-Being: The Administration on Children and Families released an Information Memorandum on April 17, 2012 on the subject of Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services⁴. This Information Memorandum included a framework detailing the Intermediate Outcome Domains and the Well-Being Domains for children, broken down by developmental stages. This framework is helpful in conceptualizing what is considered to be age-appropriate development, across six domains of functioning. This framework informed the development of the tiers and is included in the Appendix B.

Understanding the Impact of Trauma: The recognition that many children who come to the attention of the child welfare system have experienced traumatic events has grown in the past decade. The impact of trauma and traumatic events is also an area of increased knowledge and understanding. As such, the proposed tiers for treatment foster care integrate the reality of trauma as very likely in the lives of children in the system of care. In November 2014, The Child Welfare Information Gateway, a division of The Children’s Bureau) published a factsheet for families, “Parenting a Child Who has Experienced Trauma” which included many helpful tips for understanding the impact of trauma on children⁵.

Table 1. Effects of Trauma on Children

Trauma may affect children’s ...	In the following ways
Bodies	<ul style="list-style-type: none"> • Inability to control physical responses to stress • Chronic illness, even into adulthood (heart disease, obesity)
Brains (thinking)	<ul style="list-style-type: none"> • Difficulty thinking, learning, and concentrating • Impaired memory • Difficulty switching from one thought or activity to another
Emotions (feeling)	<ul style="list-style-type: none"> • Low self-esteem • Feeling unsafe • Inability to regulate emotions • Difficulty forming attachments to caregivers • Trouble with friendships • Trust issues • Depression, anxiety
Behavior	<ul style="list-style-type: none"> • Lack of impulse control • Fighting, aggression, running away • Substance abuse • Suicide

⁴ ACYF-CB-IM-12-04: Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services

⁵ Source: <https://www.childwelfare.gov/pubPDFs/child-trauma.pdf>

Table 2. Signs of Trauma in Children of Different Ages¹

Young Children (Ages 0–5)	School-Age Children (Ages 6–12)	Teens (Ages 13–18)
<ul style="list-style-type: none"> • Irritability, “fussiness” • Startling easily or being difficult to calm • Frequent tantrums • Clinginess, reluctance to explore the world • Activity levels that are much higher or lower than peers • Repeating traumatic events over and over in dramatic play or conversation • Delays in reaching physical, language, or other milestones 	<ul style="list-style-type: none"> • Difficulty paying attention • Being quiet or withdrawn • Frequent tears or sadness • Talking often about scary feelings and ideas • Difficulty transitioning from one activity to the next • Fighting with peers or adults • Changes in school performance • Wanting to be left alone • Eating much more or less than peers • Getting into trouble at home or school • Frequent headaches or stomachaches with no apparent cause • Behaviors common to younger children (thumb sucking, bed wetting, fear of the dark) 	<ul style="list-style-type: none"> • Talking about the trauma constantly, or denying that it happened • Refusal to follow rules, or talking back frequently • Being tired all the time, sleeping much more (or less) than peers, nightmares • Risky behaviors • Fighting • Not wanting to spend time with friends • Using drugs or alcohol, running away from home, or getting into trouble with the law

¹ Content in the table is adapted from Safe Start Center. (n.d.). Tips for Staff and Advocates Working With Children: Polyvictimization. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, available at http://ojjdp.gov/programs/safestart/TipSheetFor_Polyvictimization.pdf.

There is considerable research on the overlap between trauma and behavioral health⁶:

Table 1
Symptoms that Overlap with Child Trauma and Mental Illness (AACAP, 2010)

Mental Illness	Overlapping Symptoms	Trauma
1. Bipolar disorder	Hyperarousal and other anxiety symptoms mimicking hypomania; traumatic reenactment mimicking aggressive or hypersexual behavior; and maladaptive attempts at cognitive coping mimicking pseudo-manic statements	Child trauma
2. Attention deficit/hyperactivity disorder	Restless, hyperactive, disorganized, and/or agitated activity; difficulty sleeping, poor concentration, and hypervigilant motor activity	Child trauma
3. Oppositional defiant disorder	A predominance of angry outbursts and irritability	Child trauma
4. Panic disorder	Striking anxiety and psychological and physiologic distress on exposure to trauma reminders and avoidance of talking about the trauma	Child trauma
5. Anxiety disorder, including social anxiety, obsessive-compulsive disorder, generalized anxiety disorder, or phobia	Avoidance of feared stimuli, physiologic and psychological hyperarousal on exposure to feared stimuli, sleep problems, hypervigilance, and increased startle reaction	Child trauma
6. Major depressive disorder	Self-injurious behaviors as avoidant coping with trauma reminders, social withdrawal, affective numbing, and/or sleep difficulties	Child trauma
7. Substance abuse disorder	Drugs and/or alcohol used to numb or avoid trauma reminders	Child trauma
8. Psychotic disorder	Severely agitated, hypervigilance, flashbacks, sleep disturbance, numbing, and/or social withdrawal, unusual perceptions, impairment of sensorium, and fluctuating levels of consciousness	Child trauma

The proposed tiers for treatment foster care are listed on the following pages. In an effort to move away from vague descriptions or unclear expectations, there are timeframes listed for appointments, meetings, etc. These timeframes are not intended to be restrictive; rather they are intended to help caregivers understand what might be needed by them in order to care for the child. We also recognize that these proposed tiers are really an initial starting place for foster care transformation and that the implementation of the proposed tiers will require further discussion from key stakeholders.

⁶ Griffin, Gene & McClelland, Gary & Holzberg, Mark & Stolbach, Bradley & Maj, Nicole & Kiesel, Cassandra. (2011). Addressing the Impact of Trauma Before Diagnosing Mental Illness in Child Welfare. Child welfare. 90. 69-89.

Proposed Tiers

Family Foster Care (Non-Treatment/Traditional)⁷

The following domains describe youth fit within Family Foster Care (Traditional).

- **Development:** Motor, language, cognitive and social/emotional skills that are above what is considered for their chronological age-level or are consistent with their chronological age level; or are slightly delayed in one or more area.
- **Education:** Is working above appropriate grade level or exceeds expectations of their special education individualized education plan (IEP); or is working at appropriate grade level or meets expectations of their special education IEP with assistance from parental figure.
- **Identity:** Reflects a strong sense of identity and demonstrates an overall positive self-image. They can talk about their connection and familiarity with their cultural customs and practices. Socializing with others connected with the community is a source of comfort and strength.
- **Behavioral Health:** Overall emotional/coping skills are within normal range and generally has positive behavior in dealing with crises and trauma, disappointment and daily challenges. Youth is able to develop and maintain healthy relationships. Youth is able to identify the need for, seek and accept guidance. Youth may have mild mental health needs that are managed by primary physician through medication and through therapy, if needed.
- **Physical Health:** Demonstrates general good health and has no known or minor health care needs that do not limit activities. Receives medical care as needed for health care needs, injuries, and preventative medical/dental/vision care, including immunizations.
- **Substance Use:** Youth does not use alcohol or other drugs and avoids peer/social activities involving drugs and alcohol or chooses not to use substances despite peer pressure/opportunities to do so.
- **Delinquency:** There is no indication of criminal/delinquent behavior.
- **Guidance and Structure:** Youth usually follows the rules and expectations, accepts guidance and adjusts to new situations.

Skills Needed by Caregivers include:

- **Home Environment:** Provides a loving, nurturing home, and respects youth's culture and experiences, encourages family communication in the home and provides guidance to help youth develop healthy peer friendships. Is aware of youth's emotions, takes time to help talk about their feelings, while respecting culture and experiences. Provides developmentally appropriate guidance, supervision, and discipline. Sets limits to keep youth safe and helps them learn to behave appropriately at home, with peers, using technology, and in the community.
- **Education:** Ensures youth's school enrollment and attendance, provides school supplies, supports them to complete homework and attends school meetings. Supports youth's educational and vocational interests, and actively promotes post-secondary planning in the home. Attends youth's school conferences/meetings and communicates with teachers and other education professionals.
- **Identity:** Demonstrates respect for youth's identity and their community. Caregiver makes efforts to increase cultural awareness and takes the responsibility to show and teach youth about their family history, including their birth family's culture and community. This includes ensuring the youth can participate in culturally appropriate events. Ensures youth has items and information needed to maintain skin and hair care. Demonstrates awareness and makes efforts to keep youth emotionally and physically safe from intolerance in the home and community.
- **Physical Health:** Coordinates and participates in medical appointments for routine care, including dental and vision appointments for youth. Caregiver provides basic daily care and needed medication, and shares

⁷ Family Foster Care (Traditional) corresponds with items considered "basic" in the Minnesota Assessment of Parenting for Children and Youth (MAPCY); use of the items within this tool is considered a draft and is part of a larger conversation with the Minnesota Department of Human Services.

developmentally appropriate health information with youth. Maintains a written record of youth's medical history including proper medication management.

- **Behavioral Health:** Is aware of youth's emotions, takes time to help talk about their feelings, while respecting culture and experiences. Provides developmentally appropriate guidance, supervision, and discipline. Schedules and takes youth to therapy appointments outside of the home, if needed, typically spending no more than 4 to 5 hours at appointments.
- **Development:** Pays attention to youth's skills, tracks progress and helps them learn to cook, do laundry, manage money, obtain and keep a job and other activities that meet adolescent developmental milestones and prepares youth for the transition to adulthood. Ensures youth is able to participate in normalcy activities by encouraging involvement and ensuring youth is able to participate (i.e. transportation, fees, permission slips)
- **Family Connections:** Supports family and/or sibling visits or contacts, helps youth prepare for visits, and helps them with any reactions. Shares information about youth with parents, siblings or other relatives to maintain the parental responsibilities or to preserve connections. This includes informing parents and family about upcoming appointments and activities for the youth and encouraging family participation as allowed by the custodial agency. Respects and values youth's connections to parents or relatives when visits or contact are infrequent, unpredictable, or do not occur. Caregiver shares information with the youth about their family to preserve connections and family history.
- **Placement Experience Acceptance:** Accepts as youth returning to their home after a trial home visit or reunification with parent or relative that included a youth experiencing physical abuse,
- sexual abuse or neglect. (*Youth is returning to the same caregiver that previously cared for them*). Accepts a youth returning to their home after a pre-adoptive or pre-kinship placement disruption. (*Youth is returning to the same caregiver that previously cared for them*)
- **Older Youth:** Provides youth ages 14 to 19 with appropriate independence and support that allows them flexibility to make their own choices, while providing guidance needed to maintain household routine and mutual respect

Treatment Foster Care, Tier One⁸

The following domains describe youth who fit within Tier One, the first level of treatment foster care.

- **Development and functioning:** Motor, language, cognitive, and social/emotional skills are delayed for most chronological age-level expectations. Youth has minor to moderate developmental delay or autistic behaviors. This includes: Gross or fine motor, language, social and cognitive skills and minor autistic-like behaviors.
- **Education:** Is working below appropriate grade level in at least one, but not more than half of academic subject areas, and/or struggles to meet expectations of their special education IEP.
- **Identity:** Reflects a conflicted identity or a poor self-image that is atypical for their age, adversely affecting their interest in developing familiarity with cultural customs or practices, and with others connected with their community.
- **Behavioral Health:** Difficulties in coping with situational stress, crisis or problems that frequently impair their functioning in home or in the community. Youth displays frequent behaviors or mental health symptoms that are atypical for the adolescent developmental stage and are not believed to be due to medical problems. These include but are not limited to eating/sleeping problems, toileting problems (e.g. encopresis, enuresis), depression, inappropriate sexual behavior, self-injury, mood disorders, running away, somatic complaints, hostile behaviors (biting, fighting, severe tantrums), sustained attachment issues or apathy.

⁸ Tier One corresponds with items considered "significant" in the Minnesota Assessment of Parenting for Children and Youth (MAPCY); use of the items within this tool is considered a draft and is part of a larger conversation with the Minnesota Department of Human Services.

- Physical Health: Has a chronic condition, illness and/or physical disability that limits some activities. A condition requires regular professional medical services, professional and routine interventions that may be provided by caregiver after minimal instruction. May have behaviors similar to those listed in the BH domain, but these behaviors may be due to a medical issue.
- Substance Use: Youth's use of alcohol or other drugs results in disruptive behaviors and discord in school/community/family/work relationships. Use may have grown to include multiple drugs.
- Delinquency: Youth has engaged in occasional, nonviolent delinquent behavior and may have been placed on probation within the past two years.
- Guidance and Structure: Youth's daily behaviors or conditions often restricts or prevents them from participating in age-appropriate activities in the home or community.

Skills Needed by Caregivers include:

- Placement Experience Acceptance: Accepts a youth returning to their home after more than 30 days of hospitalization. Caregiver engaged with the youth and visited during the hospitalization to develop a relationship and learn about the youth's needs or accepts as youth returning to their home after a trial home visit or reunification with parent or relative that included a youth experiencing physical abuse, sexual abuse or neglect. (*Youth is returning to the same caregiver that previously cared for them*). Accepts a youth returning to their home after a pre-adoptive or pre-kinship placement disruption. (*Youth is returning to the same caregiver that previously cared for them*). Accepts a youth returning to their home after a short stay (72 hours to 59 days) in residential treatment, correctional program, or hospitalization. Caregiver remained engaged with youth during treatment, and youth is returning to the same caregiver(s) that previously cared for them.
- Home Environment, Supervision, Guidance and Structure: Identify interactions in the home that include physical conflicts among children/youth living in the home and makes adjustments to parental attention in order to safely maintain and teach healthy family interactions. Guidance and structure may include the use of alarms on doors/windows, visual monitors or other safety devices required to ensure the safety of youth and others in the home. Provides adult supervision to assure the youth's safety, and the safety of others in the home and community. Provides individual care and attention for a youth who has either: episodes of intense distress not typical for their age, or a serious medical condition, illness, disability, or complex medical needs. Meets regularly with culturally appropriate behavioral or mental health professional or corrections officer to adapt their parenting to implement a specific plan of supervision, guidance and structure to reduce or safely manage youth's disruptive behavior(s) in the home and community, when required in the case or treatment plan.
- Education: Supports educational success and attendance for youth who has current issues such as school suspension, is involved with a truancy program, school phobia, or had other serious school attendance issues. This includes disruptive behaviors that require caregiver's regular (more than weekly) intervention at the school with youth.
- Identity: Demonstrates and mentors youth to develop skills to safely negotiate difficulties in diverse settings at school, in the neighborhood, within social network communities and in public. Regularly coordinates, attends or hosts cultural community events to help youth establish, develop, and maintain connections to their culture that builds their identity. Caregiver can identify the frequency of specific events and how they support youth's identity development. Encourages and supports normalcy activities as a part of daily routine.
- Health (Physical and Behavioral): Is required to complete training from a medical professional to provide specific medical treatments and monitor medical equipment in the home for the youth's care. Supports youth's mental health needs by participating in on-going family therapy, or meeting with a culturally appropriate mental health professional to improve caregiver's family communication. Caregiver puts into action specific parental strategies in the home, which are directed by a culturally appropriate mental health professional. Puts into action in the home a specific continuing care plan for youth's medical care and/or developmental needs designed by a physician or other qualified medical, mental health, or behavioral health professional. The plan includes monitoring specific health concerns or developmental

lags, monitoring and supervising medication and reporting progress to a health professional. This may include care for youth being treated for encopresis or enuresis.

- Provides substantial daily basic care assistance that is not typical for a youth, such as feeding, diapering, bathing and mobility assistance. Youth has a diagnosed health problem/condition that requires some intervention; however, can be addressed with no or limited/minimal caregiver training.
- Takes youth to medical and/or therapy appointments outside the home several times a month, possibly doing some or all of the scheduling. Requiring more than 6 hours of the caregiver's time each month to take the youth and attend the appointments.
- Actively participates with in-home professional services several times a month. Caregiver is present during the service and engaged with the professional and youth. Requires more than 8 hours of the caregiver's time each month.
- Provides on-going round-trip transportation, 8 or more times a month, to help youth hold a job, or participate in other activities that prepares them for the transition to adulthood.
- **Family Connections:** Supports family and/or sibling visits or contacts, helps youth prepare for visits, and helps them with any reactions. Shares information about youth with parents, siblings or other relatives to maintain the parental responsibilities or to preserve connections. This includes informing parents and family about upcoming appointments and activities for the youth and encouraging family participation as allowed by the custodial agency. Respects and values youth's connections to parents or relatives when visits or contact are infrequent, unpredictable, or do not occur. Caregiver shares information with the youth about their family to preserve connections and family history. Supervises regular face-to-face visits with youth's parents or other adult relatives unless a relationship is deemed unsafe. Actively assists youth with unusually intense reactions related to regular visitation
 - Formally engages or participates in therapy with youth's parent(s), prospective adoptive parents or relative custodians, having regular contact with them, perhaps weekly or more often.
 -
 - Drives or goes with youth to visit parent(s), siblings, relatives or kin.
- **Respite:** Youth may be receiving services that provide the caregiver with the relief from parenting duties while family/friends or other professional services care for a youth's needs. These parental relief services include respite, personal care attendant services, in-home nursing, waived service provider, or other designated service provider. This may include up to anywhere from 8-14 hours a week, in addition to one respite weekend a month.
- **Older Youth:** Provides youth ages 14 to 19 with appropriate independence and support that allows them flexibility to make their own choices, while providing guidance needed to maintain household routine and mutual respect. Provides care to youth aged 18 to 21 who have mentally or physically handicap and assist in transitioning them into the adult system.

Treatment Foster Care, Tier Two

The following domains describe youth who fit within Tier Two of treatment foster care.

- **Development and functioning:** Motor, language, cognitive, and social/emotional skills are two to three age levels behind chronological age-level expectations. This includes: Gross or fine motor, language, cognitive and social/emotional skills, severe autistic behaviors. These major developmental delays impact a youth's ability to perform many of the daily living tasks in the home consistent with their age.
- **Education:** Is working below grade level in more than half of academic subject areas, and/or does not meet expectations of their special education IEP.
- **Identity:** Reflects a damaged identity or absence of an identity that contributes to self-destructive behaviors or relationships. A youth's damaged self-image is evident in their current social behaviors that currently seeks to damage or disengage relationships.
- **Behavioral Health:** Displays an established history of one or both of the following:

- One or more areas of functioning is currently severely impaired due to chronic/severe mental health symptoms or behaviors that are a risk to self or others, such as fire-setting, suicidal (life-threatening), or violent behavior towards people and/or animals, including sexually dangerous behaviors.
- Youth has been involved in violent or repeated serious nonviolent delinquent behaviors resulting in legal consequences, such as incarceration or probation.
- Physical Health: Has a serious health condition, illness, or disability that severely limits their daily functioning. The condition requires professional monitoring and extensive medical services, and care is provided by a professional and/or caregiver who has received substantial instruction.
- Substance Use: Chronic alcohol or other drug use results in severe disruption of functioning, such as a loss of relationships, job, school suspension/expulsion, problems with the law, and/or physical harm to self or others. Use may require medical intervention/treatment.
- Delinquency: Please see item two under Behavioral Health.
- Guidance and Structure: Youth's daily behaviors or conditions limits their functioning and affects their safety and other's safety.

Skills Needed by Caregivers include:

- Placement Experience Acceptance: Accepts youth returning to their home after 60 days or more in residential treatment, or other residential or correctional program or hospitalization. Caregiver(s) remained engaged with youth during treatment and they are returning to the same caregiver(s) that previously cared for them.
- Home Environment, Supervision, Guidance and Structure: Provides one-to-one supervision of youth or is responsible to ensure another adult provides one-to-one supervision in the home and community. Youth cannot be left alone in any room of in caregiver's home without a responsible adult present due to emotional functioning that is assessed to be a danger to self or others, or due to a medical condition requiring continuous supervision for a specific life-threatening condition or behavior. Identify dangerous interactions among children/youth in the home that are a safety risk. A mental health or social service professional has identified the safety risk and developed a written safety plan the caregivers follow to provide daily routine with intense parental attention to ensure safe sibling interaction among children/youth in the home and when they are in the community.
- Education: Supports youth in a home-based educational program who may have been expelled from school, involved in an alternative education program, or cannot attend a daily school program. (This does not include a homeschool program that a caregiver decided to provide or day treatment where education is a component of the daily program.)
- Identity: Caregivers have transformed their daily life to include youth's individual identity and community into caregiver's daily life. Normalcy activities as a part of daily routine are encouraged for opportunities to practice skills.
- Health (Physical and Behavioral): Transforms parenting to safely manage youth's complex behaviors or conditions that are a safety risk to self or others. This requires caregiver to have knowledge about youth's medical or mental health needs, adjust their parenting to meet individual health needs, and utilize community medical and mental health services to safely care for youth in the home. Additionally:
 - Provides all basic care that is not typical for a youth, such as feeding, diapering, bathing and mobility assistance. Youth may have a chronic condition, illness, or physical disability, limiting some of their daily activities (as listed previously).
 - Is required to complete training from a medical professional to provide specific medical treatments and monitor medical equipment in the home for the youth's care. Supports youth's mental health needs by participating in on-going family therapy, or meeting with a culturally appropriate mental health professional to improve caregiver's family communication. Caregiver puts into action specific parental strategies in the home, which are directed by a culturally appropriate mental health professional. Puts into action in the home a specific continuing care plan for youth's medical care and/or developmental needs designed by a physician or other

qualified medical, mental health or behavioral professional. The plan includes monitoring specific health concerns or developmental lags, monitoring and supervising medication and reporting progress to a health professional. This may include care for youth being treated for encopresis or enuresis.

- Takes youth to medical and/or therapy appointments outside the home several times a month, possibly doing some or all of the scheduling. Requiring more than 12 hours of the caregiver's time each month to take the youth and attend the appointments.
- Actively participates with in-home professional services several times a month. Caregiver is present during the service and engaged with the professional and youth. Requires more than 16 hours of the caregiver's time each month.
- Provides on-going round-trip transportation, 16 or more times a month, to help youth hold a job, or participate in other activities that prepares them for the transition to adulthood.
- **Family Connections:** Contact with the youth's parents or other relatives is complex and difficult, but caregiver(s) safely maintains a relationship and contact with youth's family by exercising sound judgment. Additionally,
 - Formally engages or participates in therapy with youth's parent(s), prospective adoptive parents, or relative custodians, having contact with them several times a week.
 - Is responsible to supervise regular face-to-face visits with youth's parents or other adult relatives
 - Actively assists youth with unusually intense reactions related to regular visitation.
 - Drives or goes with youth to visit parent(s), siblings, relatives or kin
- **Respite:** Youth may be receiving services that provide the caregiver with the relief from parenting duties while family/friends or other professional services care for a youth's needs. These parental relief services include respite, personal care attendant services, in-home nursing, waived service provider or other designated service provider. This may include 15-28 hours or more in a week, in addition to one respite weekend a month.

Older Youth: Provides youth ages 14 to 19 with appropriate independence and support that allows them flexibility to make their own choices, while providing guidance needed to maintain household routine and mutual respect. Provides care to youth aged 18 to 21 who have a mental or physical handicap and assist in transitioning them into the adult system.

Treatment Foster Care, Tier Three⁹

The following domains describe youth who fit within Tier Three of treatment foster care.

- **Development and functioning:** Motor, language, cognitive and social/emotional skills are more than three age levels and/or "severely" behind chronological age-level expectations. This includes: Gross or fine motor, language, cognitive and social/emotional skills, severe autistic behaviors. These major developmental delays impact a youth's ability to perform all, or nearly all, daily living tasks in the home consistent with their age.
- **Education:** Is working below grade level in all, or nearly all, of academic subject areas, and/or does not meet expectations of their special education IEP.
- **Identity:** Reflects a damaged identity or absence of an identity that contributes to self-destructive behaviors or relationships. A youth's damaged self-image is evident in their current social behaviors that currently seeks to damage or disengage relationships.
- **Behavioral Health:** Displays an established history of one or both of the following:

⁹ Tier Three corresponds with items considered "exceptional" in the Minnesota Assessment of Parenting for Children and Youth (MAPCY); use of the items within this tool is considered a draft and is part of a larger conversation with the Minnesota Department of Human Services.

- The majority areas of functioning are currently severely impaired due to chronic/severe mental health symptoms or behaviors that are a risk to self or others, such as fire-setting, suicidal (life-threatening), or violent behavior towards people and/or animals, including sexually dangerous behaviors.
- Youth has been involved in violent or repeated serious nonviolent delinquent behaviors resulting in legal consequences, such as incarceration or probation. Youth may still display such violent and/or serious nonviolent delinquent behaviors in the home, at school, etc. Youth safety is primary concern of supervision at all times. Youth may have a history and/or current problems with law enforcement.
- **Physical Health:** Has a serious health condition, illness or disability that severely limits their daily functioning. The condition requires professional monitoring and extensive medical services, and care is provided by a professional and/or caregiver who has received substantial instruction. Youth may be completely reliant on professional monitoring and extensive medical services for the majority of the day.
- **Substance Use:** Chronic alcohol or other drug use results in severe disruption of functioning, such as a loss of relationships, job, school suspension/expulsion, problems with the law, and/or physical harm to self or others. Use likely requires medical intervention/treatment as substance use/abuse may still be occurring.
- **Delinquency:** Please see item two under Behavioral Health.
- **Guidance and Structure:** Youth's daily behaviors or conditions severely limits their functioning and affects their safety and other's safety. At all, or mostly all times, safety is an urgent concern and/or consideration for caregivers.

Skills Needed by Caregivers include:

- **Placement Experience Acceptance:** Accepts youth returning to their home after 90 days or more in residential treatment, or other residential or correctional program or hospitalization. Caregiver(s) remained engaged with youth during treatment and they are returning to the same caregiver(s) that previously cared for them.
- **Home Environment, Supervision, Guidance and Structure:** Provides one-to-one supervision of youth or is responsible to ensure another adult provides one-to-one supervision in the home and community. Youth cannot be left alone in any room of in caregiver's home without a responsible adult present due to emotional functioning that is assessed to be a danger to self or others, or due to a medical condition requiring continuous supervision for a specific life-threatening condition or behavior. Identify dangerous interactions among children/youth in the home that are a safety risk. A mental health or social service professional has identified the safety risk and developed a written safety plan the caregivers follow to provide daily routine with intense parental attention to ensure safe sibling interaction among children/youth in the home and when they are in the community.
- **Education:** Supports youth in a home-based educational program who may have been expelled from school, involved in an alternative education program, or cannot attend a daily school program. (This does not include a homeschool program that a caregiver decided to provide or day treatment where education is a component of the daily program.)
- **Identity:** Caregivers have transformed their daily life to include youth's individual identity and community into caregiver's daily life. Helps child repair and build their damaged identity. Caregiver can list the substantial, deliberate parenting actions they take to nurture child's pride in their identity, and involvement in group activities that build positive self-image. Normalcy activities take a concentrated effort to assure community involvement and require support to allow for engagement skill practice, and coaching.
- **Health (Physical and Behavioral):** Transforms parenting to safely manage youth's complex behaviors or conditions that are a safety risk to self or others. This requires caregiver to have knowledge about youth's medical or mental health needs, adjust their parenting to meet individual health needs, and utilize community medical and mental health services to safely care for youth in the home. Additionally:
 - Provides all basic care that is not typical for a youth, such as feeding, diapering, bathing and mobility assistance.

- Is required to complete training from a medical professional to provide specific medical treatments and monitor medical equipment in the home for the youth's care. Supports youth's mental health needs by participating in on-going family therapy, or meeting with a culturally appropriate mental health professional to improve caregiver's family communication. Caregiver puts into action specific parental strategies in the home, which are directed by a culturally appropriate mental health professional. Puts into action in the home a specific continuing care plan for youth's medical care and/or developmental needs designed by a physician or other qualified medical, mental health or behavioral professional. The plan includes monitoring specific health concerns or developmental lags, monitoring and supervising medication and reporting progress to a health professional. This may include care for youth being treated for encopresis or enuresis.
- Takes youth to medical and/or therapy appointments outside the home several times a month, possibly doing some or all of the scheduling. Requiring more than 16 hours of the caregiver's time each month to take the youth and attend the appointments.
- Actively participates with in-home professional services several times a month. Caregiver is present during the service and engaged with the professional and youth. Requires more than 20 hours of the caregiver's time each month.
- Provides substantial daily basic care assistance that is not typical for a youth, such as feeding, diapering, bathing and mobility assistance.
- Provides on-going round-trip transportation, 20 or more times a month, to help youth hold a job, or participate in other activities that prepares them for the transition to adulthood.
- **Family Connections:** Contact with the youth's parents or other relatives is complex and difficult, but caregiver(s) safely maintains a relationship and contact with youth's family by exercising sound judgment. Additionally,
 - Formally engages or participates in therapy with youth's parent(s), prospective adoptive parents or relative custodians, having contact with them several times a week.
 - Is responsible to supervise regular face-to-face visits with youth's parents or other adult relatives
 - Actively assists youth with unusually intense reactions related to regular visitation.
 - Drives or goes with youth to visit parent(s), siblings, relatives or kin.
- **Respite:** Youth may be receiving services that provide the caregiver with the relief from parenting duties while family/friends or other professional services care for a youth's needs. These parental relief services include respite, personal care attendant services, in-home nursing, waived service provider or other designated service provider. This may include 29 hours or more in a week, in addition to one respite weekend a month.
- **Older Youth:** Provides youth ages 14 to 19 with appropriate independence and support that allows them flexibility to make their own choices, while providing guidance needed to maintain household routine and mutual respect. Provides care to youth aged 18 to 21 who have a mentally or physically handicap and assist in transitioning them into the adult system.

Other Considerations for Tier Placement¹⁰

These considerations may allow for placement in a higher tier. As these criteria outline specific characteristics of youth, they may qualify youth for placement in a higher tier.

Placement History: Please check one option that best describes the youth's placement experience.

During their lifetime a youth has been placed in two or fewer foster family or facility placements.

During their lifetime, a youth has experienced one or more of the following:

- a. Has been placed in three to five foster families or facility placements, or

¹⁰ The MAPCY has several items that may allow for placement in a higher tier or an increase in payment for care.

- b. Has re-entered foster care after reunification or trial home visits.

___ During their lifetime, a youth experienced one or more of the following:

- a. Has been placed into six or eight foster families or facility placements, or
- b. Has experienced a disrupted pre-adoptive placement, or
- c. Has reentered foster care after adoption or court-ordered relative custody arrangement.

___ During their lifetime, a youth experienced one or more of these needs:

- a. Has been placed in nine or more foster families or facility placements, or
- b. Has experienced a legally dissolved adoption or court-ordered relative custody arrangement.

Family Connections: Please check one option that best describes the youth's placement experience:

- ___ Has supportive relationships, positive interactions with parents, siblings, relatives, or kin.
- ___ Has positive interactions with parents, siblings, relatives, or kin, despite some lapses of contact with family; or youth has no contact with parents, siblings, relatives or kin.
- ___ Visits parents, siblings, relatives, or kin, but these visits are difficult for them. Youth's experiences have significantly affected their interactions with parents, siblings, relative, or kin.
- ___ Visits parents, siblings, relatives, or kin, but these visits are traumatic for them. These experiences have severely impeded their sense of safety and security.
- ___ Has no contact with primary family.

Home Environment: Please check one option that best describes the dynamics in the caregiver's home.

- ___ Youth is the only youth living in the home.
- ___ Youth is placed with one sibling, and/or caregiver is parenting other children/youth in the home.
- ___ Youth is placed with two siblings and a caregiver is parenting other children/youth in the home.
- ___ Youth is placed with three or more siblings and caregiver is parenting other children/youth in the home, or youth is a minor parent placed with their child in caregiver's home.

School Transportation: Please check one option that best describes a school transportation situation that allows a youth to keep attending the same school where no transportation is available.

- ___ Time to drive youth to school takes longer than 30 minutes, but 60 minutes or less a day.
- ___ Time to drive youth to school takes longer than 60 minutes, but less than 90 minutes a day.
- ___ Time to drive youth to school takes longer than 90 minutes a day

Determining Tier Placement

The determination of placement within the tiers is designed to be flexible to accommodate various level of care tools that counties and agencies may already have in place or are considering. In general, the tiers should be a best match, meaning a child fits the majority of characteristics detailed within the tier. In some states like California or Minnesota, there is a specific scoring protocol to determine a tier. In nearly all states reviewed during the stakeholder meetings, there was built in flexibility for waivers or overrides of the criteria to allow for a higher tier placement based on clinical insight and/or the insight of the child welfare organization.

Payment Considerations

This report recommends the establishment of foster care per diems based on the level of care provided, that is consistent across the state. Currently, Ohio has not set rates as some other states have done, resulting in great variation between the counties. We recommend that a workgroup be established to further study this topic and examine a standard set of per diem ranges for traditional foster care as well as the three tiers of treatment foster care that is consistent across the state. These ranges should consider actual cost of living, including costs associated with the expected care needs of the child.

The stakeholder group examined payment data from Ohio and payment data from states where rates were established and published. Included in this section is a summary of information on maintenance payments in Ohio to demonstrate the current variation and inconsistency. Comparison data for other states was compiled by IHS and is included in their brief.

Payment Ranges: Payment calculations were based on data from actual expenditures recorded between January 2019 and July 31, 2019. During this time period, there were some counties who did not have a recorded expenditure in some categories. These calculations are meant as a guide for consistency across counties. Measures of central tendency are provided for each category.

Terminology:

- **Mean:** average across all counties reporting an expenditure.
- **Median:** midpoint of all recorded expenditures.
- **Mode:** most frequent amount expended.
- **Range:** lowest expenditure to highest expenditure

Category 1: Lowest Per Diem

Range: \$6.25 to \$75.00

Daily Rates	30 days Lowest Per Diem
Mean: \$26.81	Mean: \$804.30
Median: \$24.00	Median: \$720.00
Mode: \$25.00	Mode: \$750.00

Category 2: Highest Per Diem

There were two payments considerably larger than the others and may be considered as outliers. As such, there are two sets of calculations for this category. The main figure that changed between the two calculations is the mean/average.

All data (with outliers)	Data (without outliers)	30 days Highest Per Diem
Range: \$35.00 to \$561.92	Range: \$35.00 to \$200.00	Mean: \$2,998.20 Median: \$3,000.00 Mode: \$3,000
Mean: \$108.13	Mean: \$99.94	
Median: \$100.00	Median: \$100.00	
Mode: \$100.00	Mode: \$100.00	

Categories Beyond the Regular Rate Per Diems:

Category 3: Special Needs	Category 4: Exceptional Needs	Category 5: Intensive Needs
Range: \$71.86 to \$338.04 Mean: \$127.32 Median: \$122.67 Mode: \$150.00	Range: \$48.00 to \$423.00 Mean: \$147.54 Median: \$138.14 Mode: \$150.00	Range: \$76.14 to \$304.00 Mean: \$158.62 Median: \$150.00 Mode: \$150.00
30 days: Mean: \$3,819.60 Median: \$3,680.10 Mode: \$4,500.00	30 days: Mean: \$4,426.20 Median: \$4,144.20 Mode: 4,450.00	30 days: Mean: \$4,758.60 Median: \$4,500.00 Mode: \$4,500.00

Professionalization Considerations

This report recommends that the conversation about the professionalization of foster parents continue, likely another workgroup dedicated solely to this topic. Professionalization is not synonymous with employment; rather professionalization should be focused on role definition, skill expectation, training needs, and mentorship. In the short-term, the training requirements current in the ORC are as follows:

CURRENT TRAINING REQUIREMENTS PER ORC: In terms of current training requirements all the draft tiers for treatment foster care would fall into **SPECIALIZED** and would need to complete the following hour requirements:

Pre-adoptive infant foster home:

- 12 hours of pre-service training
- 24 hours of ongoing training per certification period

Family foster home:

- 36 hours of pre-service training
- 40 hours of ongoing training per certification period

Specialized foster home:

- 36 hours of pre-service training (plus additional topics on behavioral intervention, education, advocacy and CPR/First Aid certification)
- 60 hours of ongoing training per certification period

There is current legislation pending to change the training requirements in the revised code. Changes under HB 8: <https://legiscan.com/OH/bill/HB8/2019>, which amends sections 2151.353, 5103.031, 5103.032, 5103.033, 5103.035, 5103.038, 5103.0313, 5103.0314, 5103.0316, 5103.0317, and 5103.31 and to repeal sections 5103.039 and 5103.0311 of the Revised Code regarding foster caregiver training.

In summary, this bill will remove the training requirements to which we are currently bound from law and move them to rule instead. The ORC recommendations in the bill are a result of the Foster Care Advisory Group (FCAG). After the law gets change, the plan would be to look at the following recommendations from that group:

- Decrease the number of pre-service training hours and re-focus pre-service training on the readiness of prospective foster caregivers.
- Restructure ongoing training for new foster caregivers.
- Restructure ongoing training for foster caregivers who have completed their initial certification period.
- Permit more alternative training formats for foster caregivers.
- Expand specialized training for foster caregivers caring for drug-impacted children.

This group supports the training recommendations put forth by the Foster Care Advisory Group Final Report in May of 2018. It is also recommended to examine training for lower tiers versus higher tiers with a focus on skill-building.. Lower tiers may see a decrease in training requirements from the current levels.

As the determination of training requirements unfolds with the possible passage of HB8, it is important to consider the topics for training that may be required. Suggestions include training on issues that are likely to impact the youth, including: grief and loss, complex trauma, attachment and dissociation, and self-harming behavior. Topics for training that impact caregivers include: compassion fatigue, vicarious trauma, and self-care.

Recruitment Considerations: PCSAO’s Children’s Continuum of Care Reform Plan, Strategy #2 is focused on Foster Care Services. Within this strategy there are three areas of focus: (A) Develop statewide foster parent recruitment and retention assistance; (B) Modernize Ohio’s foster care system; and (C) Establish a new exit from foster care to permanency with the Kinship Guardianship Assistance Program (KGAP), with certain conditions. As we have worked on item B in this workgroup, we are aware of the interconnection with item A related to recruitment and retention. For the purposes of this document, we will reference PCSAO’s CCCR Plan and the strategies put forth to assist the recruitment and retention efforts.

Building a Community of Care between the Foster Parent Community: The need for a community of care between foster parents was a topic that came up as a value for treatment foster care and continue to come up as a necessary component of quality care, support, retention and recruitment. Stakeholders with lived experience as foster parents vocalized the importance of being able to call upon other foster parents to solve problems that arise in the home, and to provide one another guidance and support. The mentorship of one another was also a benefit of this community of care. In addition to creating a community among parents, the need for true community support arose in the discussion, including examples of faith-based support networks and other community collaboratives were discussed. This sense of community support, along with true crisis support from the treatment foster care organization and the county agency is essential to helping parents feel valued and feel safe. The retention of parents may be positively impacted by community support, making it a worthwhile part of the discussion on treatment foster care.

Next Steps

In addition to the expectations for caregivers, it will be important to list out the expectations for the agency to allow the caregiver to know what to anticipate in their relationship with the agency. For example, the frequency of case worker visits, crisis supports, etc. Detailing these expectations helps with role confusion and with building that sense for trust and teamwork. Next steps will also include ongoing discussions as indicated in the recommendations for payment and for professionalization. These topics are both quite complicated and will require facilitated dialogues dedicated to each topic. Additionally, the implementation of the tiers, including scoring the tiers, using assessments and level of care tools, and assisting counties and agencies in the implementation is a logical next step. As these discussions on treatment foster care continue, we suggest determining the core components of quality for treatment foster care, similar to the work that was done by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2013. These core features will help to enhance the quality of care, including the use of data-driven models or evidence-informed practices.

Appendix A: Stakeholder Workgroup List

First Name:	Organization:	Title:
Crystal Allen	Casey Family Programs	Senior Consultant
Juliana Barton	Lived Experience	
Scott Boone	Knox County JFS	Assistant Director
Elisha Cangelosi	Franklin County Children Services	Clinical Director
Angela Cochran	Trumbull County Children Services	Recovery Coach
Chelsea Cordonnier	Governor's Office of Children's Initiatives	
Teri DeVoe	Foster Caregiver	Foster Caregiver
Dot Erickson-Anderson	Ohio Family Care Association	Family Representative
Sara Faison	Clermont County CPS	Foster Care Supervisor
Jacqueline Fletcher	Cuyahoga Co. Div. of Children & Family Services	Program Administrator
Bryan Forney	Focus on Youth, Inc.	CEO
Jeffrey Greene	St. Vincent Family Center	VP of Residential, Foster Care and Med
Kelley Gruber	Institute for Human Services	Training Manager
Shannon Harnichar	Cadence Care Network	Program & Compliance Officer
Teresa Lampl	The Ohio Council of BH and Family Services Providers	CEO
Sharon Marconi	National Youth Advocate Program	Executive Director
Linda McKnight	Franklin County Children Services	Assoc. Dir. of Placements
Mark Mecum	Ohio Children's Alliance	CEO
Matt Mitchell	Pressley Ridge	Executive Director of Ohio
Bobbi Pedersen	Foster Caregiver	Foster Caregiver
Deanna Prezioso	Trumbull County Children Services	Trumbull Co. Children Services
Pamela Priddy	NECCO	Chief Strategy Officer
Robin Reese	Lucas County Children Services	Lucas County Children Services
Kristin Ross	Lorain County Children Services	
Donna Seed	Lucas County Children Services	Director of Social Services
Samantha Shafer	Integrated Services for BH	Integrated Services for BH
Tara Shook	ODJFS-OFC	Section Chief, Substitute Care
Colleen Tucker	ODJFS-OFC	
Marisa Weisel	Ohio Department of Medicaid	
Kim Wilhelm	Licking County Job & Family Services	Protective Services Administrator
Crystal Williams	ODJFS Office of Families and Children	FFPSA Coordinator

Appendix B: ACYF Well-Being Framework

The following page provides the ACYF Well-Being Framework which was issued on April 14, 2012 by the Administration for Children and Families. The purpose of this Information Memorandum (ACYF-CB-IM-12-04) was,

“To explain the Administration on Children, Youth and Families priority to promote social and emotional well-being for children and youth receiving child welfare services, and to encourage child welfare agencies to focus on improving the behavioral and social-emotional outcomes for children who have experienced abuse and/or neglect.” (p. 1)

The Information Memorandum goes on to explain,

“There are many frameworks for understanding well-being of children and youth. While these frameworks differ in minor ways, they generally identify similar domains and definitions of well-being. In an effort to understand what well-being looks like and how to support it for young people who have experienced maltreatment, ACYF has adapted a framework by Lou, Anthony, Stone, Vu, & Austin (2008). The framework identifies four basic domains of well-being: (a) cognitive functioning, (b) physical health and development, (c) behavioral/emotional functioning, and (d) social functioning. Aspects of healthy functioning within each domain are expected to vary according to the age or developmental status of children or youth.* The framework also takes into account contextual factors, both internal and external to children, that may influence well-being. These include environmental supports, such as family income and community organization, as well as personal characteristics, such as temperament, identity development, and genetic and neurobiological influences.”

** Within each developmental category, refinement is possible; for example, for older youth, job readiness and independent living skills are markers of well-being during the transition to adulthood.*

Appendix 1: ACYF Well-Being Framework

	Intermediate Outcome Domains		Well-Being Outcome Domains			
	Environmental Supports	Personal Characteristics	Cognitive Functioning	Physical Health and Development	Emotional/Behavioral Functioning	Social Functioning
Infancy (0-2)	Family income, family social capital, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Temperament, cognitive ability	Language development	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior
Early Childhood (3-5)	Family income, family social capital, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Temperament, cognitive ability	Language development, pre-academic skills (e.g., numeracy), approaches to learning, problem-solving skills	Normative standards for growth and development, gross motor and fine motor skills, overall health, BMI	Self-control, self-esteem, emotional management and expression, internalizing and externalizing behaviors, trauma symptoms	Social competencies, attachment and caregiver relationships, adaptive behavior
Middle Childhood (6-12)	Family income, family social capital, social support, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Identity development, self-concept, self-esteem, self-efficacy, cognitive ability	Academic achievement, school engagement, school attachment, problem-solving skills, decision-making	Normative standards for growth and development, overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competencies, social connections and relationships, social skills, adaptive behavior
Adolescence (13-18)	Family income, family social capital, social support, community factors (e.g., institutional resources, collective socialization, community organization, neighborhood SES)	Identity development, self-concept, self-esteem, self-efficacy, cognitive ability	Academic achievement, school engagement, school attachment, problem solving skills, decision-making	Overall health, BMI, risk-avoidance behavior related to health	Emotional intelligence, self-efficacy, motivation, self-control, prosocial behavior, positive outlook, coping, internalizing and externalizing behaviors, trauma symptoms	Social competence, social connections and relationships, social skills, adaptive behavior
<i>Social and Emotional Well-Being Domains</i>						

Appendix C: Previous Versions of the Tiers

The first version of the tiers was presented at the August Stakeholder meeting. Feedback was gathered and modifications were made.

The second version of the tiers was presented at the September Stakeholder meeting. Feedback was gathered via a survey and modifications were made.

Tiers, Version One

Score	Placement Criteria			Placement Options		
	Level of Need		Level of Care (Overview)	Foster Care	Group Home	Residential
Behaviors	Traits	Services Provided by Treatment Family				
5-18*	Age-appropriate Minor or transient episodes of emotional, behavioral, or physical problems	Fall within normal-mild developmental levels	Meet basic and developmental needs (B&D) including accompanying to appointments and increased school involvement	Child specific and/or Basic (Tier 1)		
19-20	Mild-moderate impulsive behaviors and/or hyperactivity <i>Special Education**</i>	Mild-moderate developmental delays	B&D plus: Accompanying to appointments, increased school involvement, assisting to implement treatment plan	Moderate (Tier 2)	Group Home	
21-22	Moderate-severe impulsive behaviors and/or hyperactivity	Moderate-severe developmental delays	B&D and Moderate plus: Observes/ documents behavioral/emotional functioning and behavior patterns; facilitates educational program and behavioral change; foster parent is part of treatment team	Specialized (Tier 3)		
23-24	Severe impulsive behaviors and/or hyperactivity Delinquency	Severe developmental delays Medical conditions needing attention	B&D, Moderate, and Specialized plus: emphasis on helping child to function in less restrictive environment, adapting home environment to meet child's needs	Exceptional (Tier 4)		Residential
25+	The following behaviors automatically place a child at the Intensive level: Adjudicated violent offenses, significant property damage, and/or sex offenders/perpetrators; Commercial Sexual Exploitation of Children (CSEC); Runaway; Aggressive and assaultive; Fire setting; Gang activity; Animal cruelty; Three or more placements due to the child's behavior	The following traits automatically place a child at the Intensive level: Eating disorder; Severe mental health issues (including suicidal ideation); Substance use/abuse; Habitual Truancy; Psychiatric Hospitalization(s)	B&D, Moderate-Exceptional plus: 1 foster parent/approved adult with child at all times	Intensive (Tier 5)		

* If have total score of 18, but child has a score of 5 in Beh/Emotional or Health—LOC Rate can be “leveled up” (scores are derived from the California matrix)** Several agencies advocate that every child in foster care have an IEP and are thus involved in Special Education **Placement Options:** Gray Shading: Placement of children at this level is not appropriate; Black Shading: Step-down level to be used for transition planning to a less restrictive placement setting

*Underlined language is for additional LOC tasks provided by foster family/parent as score increases within each domain

Level of Care Specifics Across Domains (Condensed Version of CA Matrix)

Score	Educational	Physical	Permanency/Family Services	Score	Behavioral/ Emotional	Health
1	Provides age/ developmentally appropriate support	Provides age and developmentally appropriate support for physical hygiene and life skills	Arranges/facilitates child/ family-focused community/ cultural engagement activity 1x/week and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for 2 hours/week	1	Provides direct supervision to age and developmentally appropriate supports and/or arranges/consults with therapist 1x/month	Arranges routine health-related schedule
2	Provides assistance beyond basic activities 2 additional hours per week	Provides supervision/ verbal cueing/physical assistance for at least 1 ADL/IADL* beyond age/developmentally appropriate and/or arranges developmental/ physical/ occupational therapy max. 1x/month	Arranges/facilitates child/ family-focused community/ cultural engagement activity 2x/week and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for 4 hours/week	4	<u>Redirects</u> beyond what is age/developmentally appropriate at least 2 days/week and/or arranges/consults with therapist 2x/month	Arranges appointments 2x/year
3	Provides assistance beyond basic activities 4 additional hours per week	Provides supervision/ verbal cueing/physical assistance for at least 2 ADL/IADL beyond age/developmentally appropriate and/or arranges developmental/ physical/ occupational therapy at least 3x/month	Arranges/facilitates child/ family-focused community/ cultural engagement activity 3x/week and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for 6 hours/week	5	<u>Implements therapeutic intervention plan</u> and/or arranges/consults with therapist 3x/month and/or <u>provides structure support for stressors w/ moderate symptoms</u>	Arranges appointments 3-11 times per year, and/or observes/records medication effects for administering of 1 medication daily
4	Provides assistance beyond basic activities 6 additional hours per week	<u>Implements and monitors a plan</u> of supervision/ verbal cueing/physical assistance for at least 3 ADL/IADL beyond age/developmentally appropriate and/or arranges developmental/ physical/ occupational therapy at least 4x/month	Arranges/facilitates child/ family-focused community/ cultural engagement activity 4x/week and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for 8 hours/week	6	Implements therapeutic intervention plan and/or arranges/consults w/ therapist 4x/month and/or provides structure support for stressors w/ <u>severe symptoms; supervision during waking and limited night hours</u>	Arranges appointments 12 times per year, and/or observes/records medication effects for administering of <u>multiple medications</u> daily
5	Provides assistance beyond basic activities 8 additional hours per week	Provides supervision/ verbal cueing/physical assistance for at least 6 ADL/IADL beyond age/developmentally appropriate and/or arranges developmental/ physical/ occupational therapy at least 6x/month	Arranges/facilitates child/ family-focused community/ cultural engagement activity 5x/week and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for 10 hours/week and/or <u>youth who are chronic/terminally ill</u>	7	Helps <u>develop</u> and implement <u>daily</u> therapeutic intervention and/or engages in/supports WRAP or TBS and/or arranges/provides 24 hr. <u>observation</u>	Provides care to child w/ <u>severe medical/ developmental diagnosis</u>

*ADL = Activities of Daily Living (i.e. walking, bathing, grooming); IADL = Instrumental Activities of Daily Living (i.e. shopping, meal prep etc.)

Level 1: Basic/Traditional Family Foster Care (Non-Treatment)

Level of Need			
Score	Behaviors		Traits
	Internalizing	Externalizing	
5-18*	Age-appropriate internalizing behaviors Minor or transient episodes of internalizing behaviors including but not limited to: <i>Depression, anxiety, social withdrawal, feelings of loneliness or guilt, feelings of sadness, nervousness and irritability, fearfulness, difficulty concentrating, negative self-talk</i>	Age-appropriate externalizing behaviors Minor or transient episodes of emotional, behavioral, or physical problems including but not limited to: <i>Aggression, disruption, acting out, destruction of property</i>	Fall within normal-mild developmental levels

* If have total score of 18, but child has a score of 5 in Behavioral/Emotional or Health—LOC Rate can be “leveled up”

Level of Care Needed from FC Family (Overview)				
Educational	Physical	Permanency/Family Services	Behavioral/Emotional	Health
Provides age and developmentally appropriate educational support Examples include: Assist with homework; Attend parent teacher conferences/school meetings; manage school-related expenses	Provides age and developmentally appropriate support for physical hygiene, life skills	Provides child with safe, nurturing family setting with opportunity for normalcy Arranges/facilitates child/family-focused community/cultural engagement activity 1x/week and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for 2 hours/week	Provides age and behaviorally appropriate supervision needs	Transport and attend health-related appointments, allow birth family to participate in medical appointments

Level 2: Treatment Foster Care

Level of Need			
Score	Behaviors		Traits
	Internalizing	Externalizing	
19-20	Mild-moderate internalizing behaviors including but not limited to: <i>Depression, anxiety, social withdrawal, feelings of loneliness or guilt, feelings of sadness, nervousness and irritability, fearfulness, difficulty concentrating, negative self-talk</i>	Mild-moderate impulsive behaviors, hyperactivity and/or episodes of emotional, behavioral, or physical problems including but not limited to: <i>Aggression, disruption, acting out, destruction of property</i>	Mild-moderate developmental delays Special Education

Level of Care Needed from TFC Family (Overview)				
Educational	Physical	Permanency/Family Services	Behavioral/Emotional	Health
Level 1 plus: Additional school/educational involvement of approximately 2 hours.	Level 1 plus: Cueing or supervision for 1-2 activities of daily living (i.e. Bathing, grooming, dressing) or instrumental activities of daily living (i.e. shopping, managing medications, completing basic homework)	Level 1 plus: Arranges/facilitates child/family-focused community/cultural engagement activity 1-2 times week and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for 2-4 hours per week	Arranges or consults with therapist 2-3 times a month May assist in implementing treatment plan as outlined by the child/youth's therapist and/or redirects, prompts, and/or diffuses beyond age/developmentally appropriate at least 2 days pe week May provide enhanced supervision	Level 1 plus: Arranges as needed appointments up to 6 times per year and/or observes, records, and reports effects and administers 1 daily medication

Level 3: Specialized Treatment Foster Care

Level of Need			
Score	Behaviors		Traits
	Internalizing	Externalizing	
21-22	Moderate-severe internalizing behaviors including but not limited to: <i>Depression, anxiety, social withdrawal, feelings of loneliness or guilt, feelings of sadness, nervousness and irritability, fearfulness, difficulty concentrating, negative self-talk</i>	Moderate-severe impulsive behaviors, hyperactivity and/or episodes of emotional, behavioral, or physical problems including but not limited to: <i>Aggression, disruption, acting out, destruction of property</i>	Moderate-severe developmental delays

Level of Care Needed from TFC Family (Overview)

Educational	Physical	Permanency/Family Services	Behavioral/Emotional	Health
Level 1 plus: Additional school/educational involvement of approximately 2-4 hours.	Level 1 plus: Cueing or supervision for 2-3 activities of daily living (i.e. Bathing, grooming, dressing) or instrumental activities of daily living (i.e. shopping, managing medications, completing basic homework)	Level 1 plus: Arranges/facilitates child/family-focused community/cultural engagement activity 2-3 times week and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for 4-6 hours per week	Arranges or consults with therapist 3-4 times a month and/or Implements treatment plan as outlined by the child/youth's therapist and/or plan 3-4 days per week Provides observation during waking hours, and may provide limited night supervision such as episodic check ins	Level 1 plus: Arranges as needed appointments 7-11 times per year and/or Observes, records, and reports effects and administers 1 daily medication

Level 4: Exceptional Treatment Foster Care

Level of Need			
Score	Behaviors		Traits
	Internalizing	Externalizing	
23-24	Severe internalizing behaviors including but not limited to: <i>Depression, anxiety, social withdrawal, feelings of loneliness or guilt, feelings of sadness, nervousness and irritability, fearfulness, difficulty concentrating, negative self-talk</i>	Severe impulsive behaviors, hyperactivity and/or episodes of emotional, behavioral, or physical problems including but not limited to: <i>Aggression, disruption, acting out, destruction of property</i>	Severe developmental delays Medical conditions needing attention

Level of Care Needed from TFC Family (Overview)

Educational	Physical	Permanency/Family Services	Behavioral/Emotional	Health
Level 1 plus: Additional school/educational involvement of approximately 4-6 hours.	Level 1 plus: Cueing or supervision for 3-5 activities of daily living (i.e. Bathing, grooming, dressing) or instrumental activities of daily living (i.e. shopping, managing medications, completing basic homework)	Level 1 plus: Arranges/facilitates child/family-focused community/cultural engagement activity 3-4 times week and/or Participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for 6-8 hours per week	Arranges or consults with therapist at least 5-6 times per month and/or Implements treatment plan as outlined by the child/youth's therapist and/or plan 4-6 days per week Provides observation during waking hours and limited night supervision such as episodic check ins	Level 1 plus: Arranges as needed appointments 12 times per year and/or Observes, records, and reports effects and administers multiple medications

Level 5: Intensive Treatment Foster Care

Level of Need			
Score	Behaviors		Traits
	Internalizing	Externalizing	
25+	Severe/extreme internalizing behaviors including but not limited to: <i>Depression, anxiety, social withdrawal, feelings of loneliness or guilt, feelings of sadness, nervousness and irritability, fearfulness, difficulty concentrating, negative self-talk</i>	The following behaviors automatically place a child at the Intensive level: <i>Adjudicated violent offenses, significant property damage, and/or sex offenders/perpetrators; aggressive and assaultive; fire setting; gang activity; animal cruelty</i>	<i>The following traits automatically place a child at the Intensive level: Eating disorder; Severe mental health issues (including suicidal ideation); Substance use/abuse; Psychiatric Hospitalization(s)</i>

Level of Care Needed from TFC Family (Overview)				
Educational	Physical	Permanency/Family Services	Behavioral/Emotional	Health
Level 1 plus: Additional school/educational involvement of approximately 6-8 hours.	Level 1 plus: Cueing or supervision for 6+ activities of daily living (i.e. Bathing, grooming, dressing) or instrumental activities of daily living (i.e. shopping, managing medications, completing basic homework)	Level 1 plus: Arranges/facilitates child/family-focused community/cultural engagement activity 5-7 times week and/or Participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for 8-10 hours per week	Helps develop and implement daily therapeutic intervention plan and/or Is engaged in and supports WRAP or TBS Arranges or provides 24-hour observation/line-of-sight. May require assistance in providing supervision.	Level 1 plus: Provides care to a child who has been diagnosed with a severe medical and/or developmental diagnosis

Level of Care Specifics Across Domains (Condensed Version of CA Matrix)

Score	Educational	Physical	Permanency/Family Services	Score	Behavioral/ Emotional	Health
1	Provides age/ developmentally appropriate support	Provides age and developmentally appropriate support for physical hygiene and life skills	Arranges/facilitates child/ family-focused community/ cultural engagement activity 1x/week and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for 2 hours/week	1	Provides direct supervision to age and developmentally appropriate supports and/or arranges/consults with therapist 1x/month	Arranges routine health-related schedule
2	Provides assistance beyond basic activities <u>2</u> additional hours per week	Provides supervision/ verbal cueing/physical assistance for at least <u>1 ADL/IADL*</u> beyond age/developmentally appropriate and/or arranges developmental/ physical/ occupational therapy max. <u>1x/month</u>	Arranges/facilitates child/ family-focused community/ cultural engagement activity <u>2x/week</u> and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for <u>4 hours/week</u>	4	<u>Redirects</u> beyond what is age/developmentally appropriate at least 2 days/week and/or arranges/consults with therapist <u>2x/month</u>	Arranges appointments <u>2-6 times per year</u>
3	Provides assistance beyond basic activities <u>4</u> additional hours per week	Provides supervision/ verbal cueing/physical assistance for at least <u>2 ADL/IADL</u> beyond age/developmentally appropriate and/or arranges developmental/ physical/ occupational therapy at least <u>3x/month</u>	Arranges/facilitates child/ family-focused community/ cultural engagement activity <u>3x/week</u> and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for <u>6 hours/week</u>	5	<u>Implements therapeutic intervention plan</u> and/or arranges/consults with therapist <u>3x/month</u> and/or <u>provides structure support for stressors w/ moderate symptoms</u>	Arranges appointments <u>3-11</u> times per year, and/or observes/records medication effects for administering of <u>1 medication</u> daily
4	Provides assistance beyond basic activities <u>6</u> additional hours per week	<u>Implements and monitors a plan</u> of supervision/ verbal cueing/physical assistance for at least <u>3 ADL/IADL</u> beyond age/developmentally appropriate and/or arranges developmental/ physical/ occupational therapy at least <u>4x/month</u>	Arranges/facilitates child/ family-focused community/ cultural engagement activity <u>4x/week</u> and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for <u>8 hours/week</u>	6	Implements therapeutic intervention plan and/or arranges/consults w/ therapist <u>4x/month</u> and/or provides structure support for stressors w/ <u>severe symptoms</u> ; <u>supervision during waking and limited night hours</u>	Arranges appointments <u>12</u> times per year, and/or observes/records medication effects for administering of <u>multiple medications</u> daily
5	Provides assistance beyond basic activities <u>8</u> additional hours per week	Provides supervision/ verbal cueing/physical assistance for at least <u>6 ADL/IADL</u> beyond age/developmentally appropriate and/or arranges developmental/ physical/ occupational therapy at least <u>6x/month</u>	Arranges/facilitates child/ family-focused community/ cultural engagement activity <u>5x/week</u> and/or participates in mentoring/coaching birth parents implementing family visitation plans (FVP) for <u>10 hours/week and/or youth who are chronic/terminally ill</u>	7	Helps <u>develop</u> and implement <u>daily</u> therapeutic intervention and/or engages in/supports WRAP or TBS and/or arranges/provides <u>24 hr. observation</u>	Provides care to child w/ <u>severe medical/ developmental diagnosis</u>

Tiers Feedback Survey

Name:	
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General Questions:

In looking at the range of Tiers, especially tiers 3 through 5:

1. Do we have enough tiers to adequately represent the children served in child welfare?
___ Yes ___ No

Please explain:

2. Please rate your level of agreement with the description of Tier 3 by placing an X on the line below:

No agreement Some Agreement Considerable Agreement

Please add any information that would help improve your agreement, if needed:

3. Please rate your level of agreement with the description of Tier 4 by placing an X on the line below:

No agreement Some Agreement Considerable Agreement

Please add any information that would help improve your agreement, if needed:

4. Please rate your level of agreement with the description of Tier 5 by placing an X on the line below:

No agreement Some Agreement Considerable Agreement

Please add any information that would help improve your agreement, if needed:

Please provide us with any other information that you think we need to consider or re-consider related to Tiers 3, 4, or 5.

Appendix D: List of Briefs Developed by IHS

The Institute for Human Services gathered information to support the work of the stakeholder group. Information briefs developed by IHS included:

- Access, Efficiency, Effectiveness, and Satisfaction
- Child Needs Assessment
- County Comparisons
- Considerations and Recommendations: Phone Interviews with National CW Consultants
- Kinship-TFC
- Payment Rate Comparison
- Medicaid and TFC
- Foster Caregiver Payment
- Recruitment
- Professionalizing Foster Parents
- Relationship Triad (PCSA-Provider-Caregiver)
- TFC Caregiver Supports
- TTFC Outcomes
- Summary of Other Resources
- State Comparisons
- State Briefs:
 - California
 - Colorado
 - Maryland
 - Pennsylvania
 - Virginia

Appendix E: Detailed Meeting Notes

June 17, 2019

The first stakeholder meeting convened with a focus on acclimating the group to the purpose, goal, and general timeline for the TTFC project. The following were topics covered:

- ODJFS and the Office of Child Welfare Transformation was established by Gov. DeWine; this office is a partner with PCSAO on this project.
- The context and overview for the Continuum of Care Reform plan was provided by PCSAO.
 - There is significant alignment between the PCSAO Children's Continuum of Care Reform Plan (CCCR) and the Family First Prevention Services Act (FFPSA), including prevention/diversion service opportunities, aftercare for when a child returns home, more intensive levels of care, and the QRTP process.
- Trumbull County shared their cost-benefit analysis on the use of high-fidelity wrap-around (HFWA) with treatment foster care, compared to the use of residential treatment. They saved approximately \$2.5 million dollars. Trumbull refers to multi-system youth as "community youth" to emphasize the need for a community of care for wrap-around services.
- The current treatment foster care model in Ohio is not well-defined. Current evidence-based practices include Treatment Foster Care Oregon, which is challenging to implement. Most organizations are not using this type of evidence-based practice (EBP).
- The Foster Care Advisory Group recommendations were provided; there is an emphasis on changing the training requirements that are currently in Ohio Revised Code vs. under the jurisdiction of ODJFS.
- Tiered treatment foster care is happening in other states. The difference between a system based on Level of Need (LoN) vs. Level of Care (LoC) was discussed.

Values Discussion: The group engaged in a discussion on values. They were asked to respond to two questions: (1) What are the values of a tiered system?" and (2) What kinds of partners do we need to make it work?

Stakeholders identified the following **values**:

Theme 1: Well-being of Children:

- Reducing the movement in placement for children
- Keeping siblings together
- Helping children transition out of foster care

Theme 2: The Role and Expectations of Caregivers:

- Knowing what is expected of TFC providers and parents
- Increased trust between the agencies and parents
- Having a common language
- Consistency in the tiers or levels between counties
- Seeing caregivers as professionals, valuing and respecting caregivers, and valuing their need for self-care.
- Clear expectations and flexibility
- Performance-based measurements for caregivers
- Giving caregivers a voice
- Honesty and openness in communication from the beginning of the partnership
- Understanding the impact of trauma and the home

When asked what kinds of partners are needed to make Tiered Treatment Foster Care work, stakeholders identified several partners:

- Wraparound team (i.e. schools, churches, mentors, community centers, in-home/community-based services, behavioral health, medical providers, probation officers, crisis interventions)
- Representation of the community
- Compatible resources
- Primary family as a part of the community of care
- Collaboration and communication among partners

July 15, 2019

The second stakeholder meeting began with a review of the current treatment foster care model in Ohio. The model currently consists of pre-adoptive infant foster homes, family foster homes, and specialized foster homes. The majority of Ohio counties currently complete a level of care on children in placement, however there is great variance among all Ohio counties. The meeting then included a facilitated discussion on TTFC models in a small sample of other states.

- **West Virginia** currently employs a three-tier model, using the Child and Adolescent Needs and Strengths (CANS) as a Level of Care tool.
- **Wisconsin** is a county-administered child welfare system and employs a five-level model which includes specific training and experience required per tier. The model uses language consistent with a Level of Need model.
- **Oregon** has four tiers: base, enhanced supervision 1, 2, and 3. Oregon works with Behavioral Rehabilitation Services, a private entity for youth in need of BH services.
- **California** employs a level of care matrix tool, where LOC is determined based on individual care and supervision expectations for each child/youth based on domain scoring. The weighted matrix consists of five core domains: physical, behavioral/emotional, educational, health, and permanency/family services.
- **Kentucky** currently employs a five-tiered model but is in the process of transforming their model to be only three tiers.

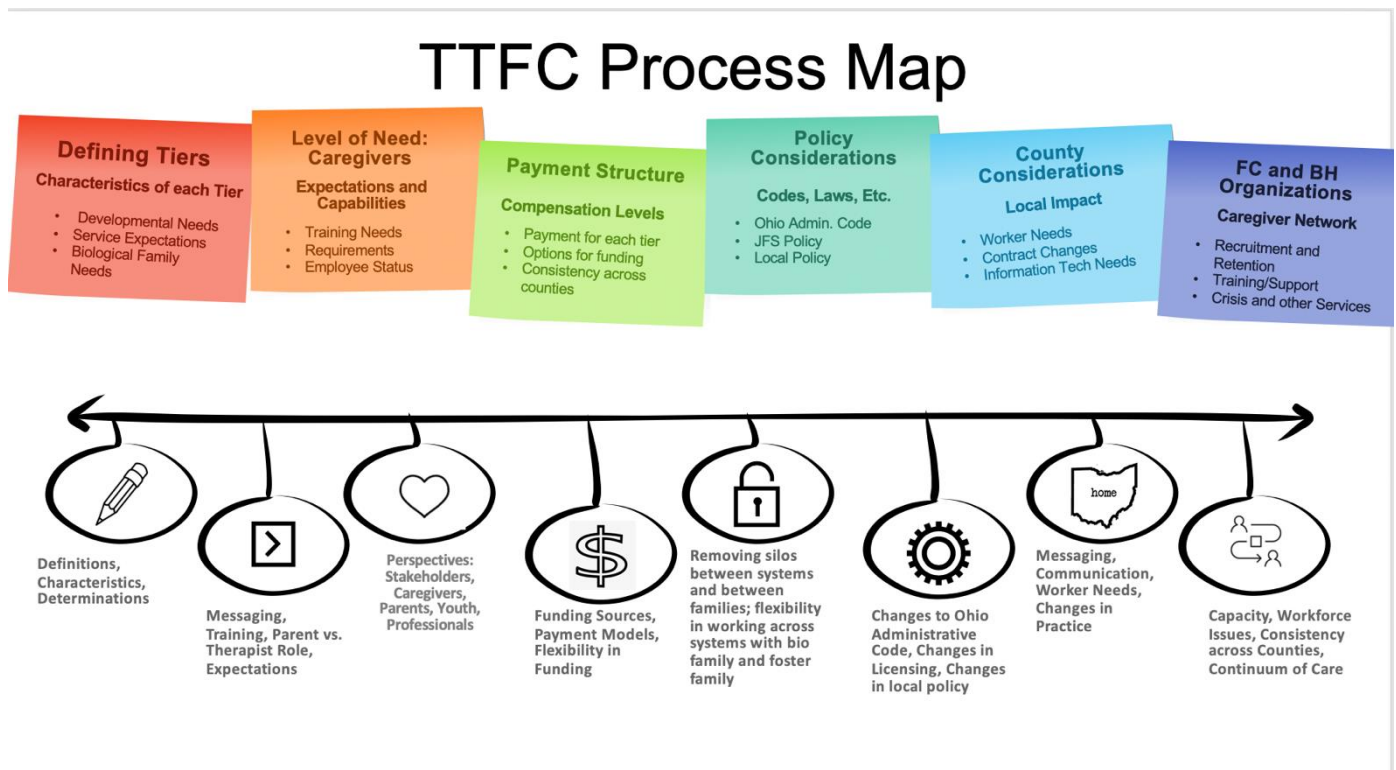
Major themes of this meeting include the need for support for foster parents, a true team approach, a need for trust, and feeling valued in order to have success in implementing a TTFC model in Ohio. Stakeholders engaged in a process mapping activity to ensure that all steps, pieces, policies, and processes were considered during the formation of a new TTFC model for Ohio. Stakeholders were encouraged to express their ideas, concerns, and key points that need to be considered when creating a tiered treatment model including, but not limited to payment, self-care for caregivers, the role of the biological family, etc. The process mapping activity allowed for a creative and thoughtful brainstorming session that generated a robust list of considerations.

August 19, 2019

The process mapping activity generated many ideas, which were synthesized and grouped into themes. Small group discussions were facilitated by the TTFC leadership team; stakeholders split into the following groups for discussion:

1. **Level of Need for Caregivers** (expectations and capabilities): Defining roles and expectations; relationship to biological parents and crisis support; proximity to services; payment and income and training needs; not overloading homes
2. **Payment Structure** (compensation levels): Assess current compensation levels and determine tier costs; payment strategies to preserve homes, Medicaid rates, funding continuum of care; sustainable business model, consistency across counties, education on accessing funds
3. **Policy Considerations** (codes, laws, etc.): Communication and messaging; role of public and private agencies; updated Ohio Administrative Code, creating legal flexibility; modernization of rules; impact of the Family First Prevention Services Act (FFPSA); licensing rules
4. **County Considerations** (local impact): Workforce issues and caseload structure; supervision and training needs; legal and service flexibility
5. **Foster Care and Behavioral Health Organizations** (caregiver network): Workforce issues; recruitment and retention; training needs, consistency across counties, payment rates; service capacity continuum of care; performance monitoring

Facilitators collected feedback from their small groups and reported out the main points that emerged.



Tiers, Version One¹¹: Mighty Crow presented the first version of tiers for review and feedback by the stakeholder group. The tiers were informed by the examples from California, Wisconsin, Kentucky and

¹¹ Version One is provided in the Appendices.

Nebraska, as well as information gathered on other states and from a review of the literature on TTFC. Version One employed a similar model to California's matrix for determining tiered placement; this matrix assigns points across domains of well-being. Stakeholders engaged in small-group discussion, facilitated by members of the TTFC leadership team. Groups were comprised of five to six people and all stakeholders were asked to provide their feedback on the drafted document. Discussion prompts included:

1. How well do the criteria fit each tier? What criteria might be missing?
2. How well do the tiers match the needs we are seeing in children?
3. How well do the tiers communicate to caregivers what to anticipate in caring for children?
4. What other considerations might we need to make with the draft tiers? What might be something we need to add or change?

Discussion among all groups was overall positive, with suggestions for improvements and clarifications needed across each tier. Stakeholders expressed the need for specific requirements for each level, ensuring that the tiers accurately capture the children entering the child welfare and foster care systems in the state of Ohio. The smaller groups reconvened and shared out to the larger stakeholder group, with time allotted for larger group discussion.

September 16, 2019

Tiers, Version Two¹²: In preparation for the September meeting of the tiered treatment foster care stakeholder group, Mighty Crow reviewed the feedback from the small and large group discussions from the previous meeting. Mighty Crow reformatted and edited the Version One and presented Version Two to the group. Stakeholders divided into small groups to review the four tiers of treatment foster care. As was done in previous meetings, small group discussions were facilitated by members of the leadership group. Facilitators collected feedback and then reported out to the larger group. Additionally, to ensure that all stakeholders had an opportunity to provide individualized feedback, Mighty Crow created a survey form that was provided to everyone in attendance. The surveys asked close and open-ended questions to stakeholders about their agreement with each tier and the factors that would increase their overall agreement. Feedback from the small groups and the surveys included:

1. Stakeholders reflected the need for more narrative explanation within the tiers.
2. Stakeholders requested adding in the role of trauma to youth and more detail on internalizing and externalizing behaviors.
3. Stakeholders wanted to see fewer tiers, likely moving from four tiers of treatment foster care to three tiers of treatment foster care.

Discussion on Professionalization: Kelley Gruber from the Institute for Human Services led a presentation on the topic of professionalization of foster care parents. Pros of professionalizing foster parents included employing higher skilled individuals, having better and easier recruitment, and showing value to the foster parents/caregivers. Cons of professionalizing foster parents included potentially negatively impacting the relationship between the caregiver and child(ren) in their care and a potential

¹² Version Two is provided in the Appendices.

negative impact on permanency. Concerns about making foster parents formal employees were expressed in the group discussion.

October 21, 2019

Tiers, Version Three: The team from Mighty Crow presented Version Three at the final TTFC Stakeholder group meeting. The overall format for the tiers shifted from a grid model to a narrative description. The narrative format incorporated the impact of trauma more explicitly and detailed the characteristics/qualities of both the child and caregiver within each tier. A total of three tiers of treatment foster care were presented, reduced from four tiers in Version Two. The following characteristics were narrated in each tier, utilizing language from the Minnesota Assessment of Parenting for Children and Youth (MAPCY):

Characteristics within Tiers for Children:	Expectations for Caregivers
Development	Home Environment
Education	Education
Identity	Identity
Behavioral Health	Behavioral Health
Physical Health	Physical Health
Substance Use	Family Connections
Delinquency	Considerations for Older Children
Guidance and Structure	Respite

Other considerations that may impact placement within tiers were also highlighted when thinking about implementation of the proposed tiered model: (a) Placement history, (b) Family connections, (c) Home environment, and (d) School transportation. Stakeholders received Version Three in advance of the meeting and were asked to review it prior to their arrival. An overview of Version Three was provided, followed by open discussion in the large group. After the overview of the tiers, the group reviewed a state-by-state comparison on payment ranges and the topic of training and recruitment for foster parents. Stakeholders were asked to submit written feedback on the tiers to Mighty Crow within ten working days of the meeting (10/31).

Meeting with Medicaid

Due to the complexity of payment, the leadership group convened meetings with staff from the Department of Medicaid to discuss Medicaid’s role and next steps in the tiered treatment foster care reform. Discussion on the need to ensure some level of consistency across all counties within the state occurred. Questions about identifying characteristics of the children currently in Ohio’s child welfare system and aligning the current population with the proposed tiers was determined as an important next step. The team from the Office of Child Welfare Transformation agreed to retrieve SACWIS data to help inform this discussion. At the time of this report, discussions with Medicaid will continue on the topic of payment for services within the tiers.

Resources

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