CHILD WELFARE REFORM IN WISCONSIN

Considerations from Human Service Agencies

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ABSTRACT

The Family First Prevention and Services Act (FFPSA), and implementation of the Youth Assessment and Screening Instrument (YASI), provide unique opportunities for Wisconsin to assess and intentionally expand its service array to meet the needs of children and families. This report reflects the best thinking of WAFCA member agencies at this time, based on the information that has been shared out through federal and state channels, relevant research, and our membership expertise in the field.

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Introduction

Now is in an exciting time for child welfare and youth justice in Wisconsin. A time to examine what's working, and what's not. A time to look forward and envision possibilities. A time to elevate children, youth and family voice in our work. And a time to do better because we know better.

The Family First Prevention and Services Act (FFPSA), and the implementation of the Youth Assessment and Screening Instrument (YASI), provide unique opportunities for Wisconsin to assess and intentionally expand its service array to meet the needs of children and families. A diverse array of services available in all regions of the state will be needed. Collaborative relationships between state, local and tribal governments, the provider community and family stakeholders will be crucial to achieve the desired results both the FFPSA and YASI strive for in serving children, youth and families.

As the Department of Children and Families (DCF) plans to shift the system to one that is more preventative and strengths-based, focused on safely supporting children and families in their homes, WAFCA members are responding to the changing landscape. Over several months WAFCA members convened to learn, ponder and brainstorm about the future of child welfare (which refers to both Child Protective Services and Youth Justice herein) in our state.

This report reflects the best thinking of WAFCA member agencies at this time, based on the information that has been shared out through federal and state channels, relevant research, and our membership expertise in the field. We submit these thoughts in hopes that our collective thinking will assist DCF planning efforts and we look forward to increased opportunities for joint brainstorming and collective decision-making as we continue down a path toward reforms that deliver better outcomes for Wisconsin children and families.

Respectfully submitted,

Your WAFCA Partners

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definitions

When implementing the Family First Prevention Services Act (herein, Family First), the federal government was intentionally vague in some areas. In fact, the Commissioner of the Children's Bureau stated, *"Our approach to FFPSA implementation allows for as much flexibility as the statute permits. We do not intend to regulate definitions of key concepts beyond what is in the statute, such as 'candidate,' 'imminent risk of foster care entry,' and 'risk of sex trafficking.' We will also strive to provide maximum flexibility to states and tribes in claiming funding for prevention services."* As a result, Wisconsin has an opportunity to do some collective thinking around what these terms mean to us. Below are recommendations for the Department of Children and Families to consider as you work to clarify these terms for incorporation into state statutes, administrative code, and policy.

candidate

There are many factors that place individuals at "imminent risk" for entering foster care. The federal government has approved plans[1] with very broad interpretations of the word "imminent", which opens the door for Wisconsin to study the *factors* that contribute to individuals entering the child welfare system and serve individuals who may or may not come to the direct attention of Child Protective Services (CPS) currently. WAFCA members propose that the following be considered "candidates for foster care", and thereby be eligible for prevention services. Inclusion of the recommendations below does not mean that all will be served; offers of service can be declined. Inclusion of these families would simply position the state to fully shift to a child welfare system focused on strengthening families, while generating some new federal match to offset the cost of prevention services for many of the families listed.

1. Families with prior CPS referrals for whom a recent CPS referral was made and screened out.
2. Families for whom a recent CPS investigation occurred and was closed.
3. Families served through Intensive In-Home Services.
4. Families with prior CPS referrals for whom a delinquency or truancy referral was made and closed.
5. Families with a child who recently exited foster care (CPS/YJ) by reunification, guardianship, or adoption.
6. Families with a juvenile court proceeding that has closed within the past 6 months.
7. Families with a child born with a positive toxicology screening and/or a parent with intensive substance use disorder needs.
8. Families with a child in foster care who has siblings residing at home.
9. Families with a child who has been identified as being at-risk of experiencing trafficking.
10. Families with a child in voluntary kinship.
11. Families with parents/caregivers who aged out of foster care.
12. Families receiving services through a Domestic Violence Shelter.
13. Families or youth experiencing housing instability or homelessness.
14. Families with a parent or child with a developmental disability and/or intensive mental health needs.
15. Pregnant or parenting youth in/exited from foster care (CPS or YJ).

[1] Family First Prevention Services Act: Candidacy by Jurisdiction. (2020, January). Retrieved from https://familyfirstact.org/sites/default/files/Jurisdictional%20Family%20First%20Candidacy%20Definitions%201-27-20%20Submitted%20States.pdf

trauma-informed treatment model

Family First provides that a Quality Residential Treatment Program (QRTP) must have "…a Trauma-Informed Treatment Model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and, with respect to a child, is able to implement the treatment identified for the child…". Another section of Family First provides more context for what constitutes "trauma-informed" when it states that those specific services must be "…provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing."

WAFCA members reviewed this language and propose the following recommendation for a Wisconsin definition.

> A "Trauma-Informed Treatment Model" refers to an organizational culture and treatment framework that demonstrate an understanding of the effects of trauma, employ principles of a trauma-informed approach, and utilize interventions that address trauma's consequences and facilitate healing. The organizational culture should include peer support, youth and parent voice. The treatment framework should acknowledge the universality of trauma, while employing person-centered treatment and services.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has also provided a framework for a trauma informed model. There are six key principles of a trauma-informed approach according to SAMHSA:

1. Safety
2. Trustworthiness & Transparency
3. Peer Support
4. Collaboration & Mutuality
5. Empowerment, Voice & Choice
6. Cultural, Historical, & Gender Issues[2]

WAFCA recommends the use of the SAMHSA framework in the Department's definition or guidance to help ensure those connected to the system have a shared understanding of what trauma-informed care looks like in practice.

clinical/nursing

Family First requires a QRTP to have "…registered or licensed nursing and licensed clinical staff on-site and available 24/7 in accordance with a QRTP's trauma-informed treatment model." Guidance released clarifies that "Clinical staff can include social workers, therapists, psychologists, and other professionals providing care and interventions for a child." It also provides that an agency may employ or contract with clinical staff to treat children and youth.[3] WAFCA recommends that the DCF definition includes all clinical staff identified in the guidance and specifically states that an agency may employ or contract with nursing and clinical staff.

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[2] SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. (2014, July). Retrieved from https://store.samhsa.gov/system/files/sma14-4884.pdf

[3] Implementing the Family First Prevention Services Act: A Technical Guide for Agencies, Policymakers, and Other Stakeholders. Retrieved from https://www.childrensdefense.org/wp-content/uploads/2020/01/FFPSA-Guide.pdf

service array

Wisconsin's service array is insufficient. Many portions of Wisconsin's service continuum are not capable of meeting the *current* needs of children and families being served through the child welfare system, let alone the future needs of kids and families following FFPSA and YASI implementation. Some portions of the continuum have not yet been created, which gives us space to innovate, but it doesn't help us fill the gap we are facing in our "we need it now" reality. Many of the services needed to fulfill the continuum do not fall under DCF's purview. A workgroup with representatives from DCF, other state agencies, counties, tribes, and providers focused on developing a comprehensive plan with benchmarks for continuum growth may be needed. For the purpose of this paper, we will focus on portions of the continuum that DCF oversees and will refer to placement settings as services.

To promote common language and understanding, we believe that each service should have an identified purpose and ideally be represented in each region of the state. Below are elements of the current service array that our member agencies are connected to and that DCF will need in order to implement Family First and YASI. The purpose of each has been defined through our lens and may not be how others view each part of the continuum. Ensuring all connected to the system have the same understanding of the intended purpose of each service would be valuable.

SERVICE	PURPOSE
Prevention	To keep children from entering the child welfare system.
Diversion	To keep children and/or families from progressing deeper into the system.
In-home	To strengthen families and keep children from being placed in out-of-home care.
Shelter Care	To provide short-term care for youth.
Foster Home (Level 1/2)	To provide a family-based placement resource for children and youth, emphasizing placements with kin and fictive kin whenever possible.
Foster Home (Level 3/4)	To provide a family-based placement resource for children and youth requiring more intensive treatment/services.
Foster Home (Level 5)	To provide a home-like setting for children with life-long care and/or specialized treatment needs.
Group Home	To provide a home-like setting for youth who do not wish/are not ready to be placed in a family-based setting and/or require more intensive support and services.
Residential Care Center	To provide a therapeutic placement resource for children unable to reside in the community due to intensive treatment needs.
Qualified Res. Tx Program (QRTP)* and/or Psychiatric Res. Tx Facility**	To provide a clinical placement resource for children unable to reside in the community due to intensive treatment needs that result from serious emotional or behavioral disorders or disturbances, or other cognitive/mental health needs.

*A clinical diagnosis is not needed; IV-E reimbursable. If an agency that operates a QRTP program has more than 16 children under the umbrella of the agency who have a diagnosed mental illness, Center for Medicaid Services considers the agency to be an Institute for Mental Disease.[4]
**Requires a mental health diagnosis for admission; Medicaid reimbursable.

[4] CMS Technical Assistance Questions and Answers. (2019, September). Retrieved from https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/faq092019.pdf

The chart below highlights the current uses (known to WAFCA) of the various parts of the service continuum and describes the current capacity of each service within our state. Given the various uses of each service type, WAFCA advocates for continuum growth and quality improvement investments, rather than removal of resources along the continuum.

SERVICE & CURRENT STATEWIDE CAPACITY*	CURRENT SERVICES AND/OR USES
Prevention *(TBD – DCF Prevention Scan underway; Insufficient/Not Yet Established (YJ))*	• Home visiting • Varies by county • Mental health and substance use prevention services included
Diversion *(Insufficient/Not Yet Established)*	• Varies by county
In-home *(Insufficient)*	• Varies by county • Mental health, family preservation, and disability services, among others
Shelter Care *(Sufficient; currently utilized for children who could be placed in other settings if there was more capacity)*	• Respite services • Short-term voluntary placement/ Temporary CHIPS/JIPS placement • Runaway and Homeless Shelter services • Delinquency sanctions/360 Programs
Foster Home (Level 1/2) *(Insufficient)*	• Respite services • Voluntary/CHIPS/JIPS/Delinquency placement • Concurrent adoptive resource
Foster Home (Level 3/4) *(Insufficient)*	• Respite services • Voluntary/CHIPS/JIPS/Delinquency placement • Concurrent adoptive resource • DHS 34 Crisis Services • Runaway and Homeless Shelter services
Foster Home (Level 5) *(Insufficient)*	• Respite services • Long-term CHIPS placement • Transition to adult services
Group Home *(Insufficient)*	• Respite services • Voluntary/CHIPS/JIPS/Delinquency placement • Delinquency sanctions • DHS 34 Crisis Services • Runaway and Homeless Youth Shelter Services • Pregnant/Parenting Youth Placement & Services • Supervised Independent Living Placement • Anti-human Trafficking Placement & Services
Residential Care Center *(Insufficient)*	• Respite/shelter services • Voluntary CHIPS/JIPS/Delinquency Placement • Anti-human Trafficking Placement & Services
Qualified Res. Tx Program (QRTP) and/or Psychiatric Res. Tx Facility *(Insufficient/Not Yet Established)*	N/A

*Capacity assessed via quantitative/qualitative data (i.e., the number of children placed out of state, Children with Complex Needs Workgroup recommendations, and conversations with human services agencies/licensed providers).

in-home caregivers

Implementation of Family First and DCF's vision of strengthening families is going to require Wisconsin to think differently about the availability/accessibility of community-based services, including the expansion of mobile units and telehealth opportunities. Different resources in out-of-home care will also be needed. All acknowledge that an increase in relative and fictive kin resources, as well as foster and treatment foster care parents (herein, "in-home caregivers"), will be needed to ensure more children are served in home-like settings, including children and youth with complex needs.

Wisconsin has well established recruitment strategies in place; however, our state is still lacking the capacity necessary to provide care and services to children in the most appropriate setting. In seeking to grow this portion of the continuum, it is important to understand whether Wisconsin has a recruitment issue, a retention issue, or both. Research published by Chapin Hall in 2018, although not specific to Wisconsin, seems to indicate there is a larger issue with retention rather than recruitment. Its study of nearly 15,000 unique foster homes concluded that the overall population was stable between the years of 2011 and 2016. The opening and closing of foster homes were offsetting. The reasons for closure primarily fell into two categories: homes closing due to changes in circumstances, personal, or family issues, and homes who were providing Kinship care.[5]

The Chapin Hall study reflects national AFCARS data that indicates that, "more than half of foster parents quit fostering within the first year."[6] Unfortunately, the reasons for quitting are rather vague in the Chapin Hall report. Another study completed by the Foster Care Institute provided more context for foster parents choosing to close their license. Below is a list of common reasons for closure:

- Suffering from feelings of grief and loss
- Lack of support from their case worker or agency
- Not included in the decision making for the child placed in their home
- Insufficient training to be effective
- Insufficient training and resources for foster parent burnout and grief
- Caseworkers did not provide necessary and honest information needed to properly care for the child placed in their home[7]

The reasons for closure identified by the Foster Care Institute study resonated with WAFCA members. In addition to what was noted in the study, member agencies cited a general undercurrent best articulated as a lack of respect for the caregivers doing the work and a disregard for/minimization of the challenging work being done. This undercurrent is believed to stem from the overarching way Wisconsin supports and reimburses foster parents and, in some instances, fails to engage with them as true members of a child's team.

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[5] The Dynamics of Foster Home Recruitment and Retention. (2018, September). Retrieved from https://www.chapinhall.org/wp-content/uploads/Foster-Home-Report-Final_FCDA_October2018.pdf

[6] NCFA Responds to New Foster Care Stats. (2018, November). Retrieved from https://www.adoptioncouncil.org/blog/2018/11/ncfa-responds-to-new-foster-care-stats

[7] Foster Parent Retention Revisited. (2017, February). Retrieved from https://www.fosterfocusmag.com/articles/foster-parent-retention-revisited

WAFCA members believe philosophical, structural, and financial changes are needed in order to grow our in-home caregiver resources. The following are recommendations for ways to improve the overall system for in-home caregivers and move towards attaining the vision set forth by Family First and DCF.

- Acknowledge that in-home caregivers are people first. They have emotions, they need support, and they need positive, constructive feedback. They are allowed to become frustrated, make mistakes, and be forgiven for those mistakes.
- Respect in-home caregivers as true members of the team. If they can be trusted with the care of a child, they can be trusted with information. Share information with them and listen when they share as well.
- Require timely responses to requests for information or service from in-home caregivers.
- Allow private Child Placing Agencies (CPAs) to pay their licensed caregivers directly OR assure timely and accurate payment to all in-home caregivers.
- Reimburse in-home caregivers according to the type of service you are expecting them to provide, not only the child's level of need.
- Establish a baseline that in-home caregivers serving children with complex needs are not expected to hold other employment. Allowing it via an exception does not honor the amount of time, energy, and self-sacrifice it takes to adequately care for the child.
- If foster care payments are viewed as reimbursement for the care of the child, then we must expand our definition of "care" to include the cost of human beings doing the work as happens in all other out-of-home care placement settings.
- Do not decrease foster parent payment because a child has improved. In no other sector do people experience a decline in compensation for doing good work.
- Provide BadgerCare+ coverage for in-home caregivers who need it.
- Create more resources for respite, training, mentoring, group support, and childcare during training, meetings, etc.
- Provide support, training, and resources for building relationships with biological family.
- Create advanced caregiver training to encourage highly trained caregivers and areas of specialization to better serve youth with complex needs.
- Have children in out-of-home care identified as a priority services population. There should be no waitlist for children in out-of-home care who need mental health services, including crisis services and respite.

Systemic change for in-home caregivers brings us one step closer to responding to the federal and state changes currently in motion. Similar systemic changes will be needed for the WAFCA member CPAs responsible for recruiting, licensing, and supporting in-home caregivers, and other licensed congregate care providers if we are going to be able to "right size" our service array and not lose capacity overall. Licensing rules and regulations currently do not allow agencies to be nimble and relocate or reorganize to address emerging needs under Family First. For example, 48.66(1)(c) currently does not allow for a license transfer to occur from entity to entity or from premises to premises. We recommend modifications to existing law to ease the process for providers to relocate, reorganize and/or merge. (See Attachment 1)

other home-like settings

Finally, Wisconsin's service array will not be complete without congregate care settings. It is WAFCA's position that not all congregate care settings need to be QRTP certified. Family First affirms this position by carving out specific settings that will remain IV-E reimbursable in spite of not having the QRTP designation. WAFCA recommends that in addition to those carve-outs, DCF exempt congregate care providers operating shelter care facilities from obtaining the QRTP certification. Group homes serving LGBTQ youth, runaway and homeless youth, and those providing for other cultural needs (as defined by the Department) or serving rural areas of the state should also be exempt from the QRTP certification requirement. There are group homes that provide home-like settings and rely on community-based services for the young people in their care. While it would be reasonable to expect those facilities to have a trauma-informed treatment model, requiring clinical services and/or nursing to be present in the home is unnecessary. And while exempting these facilities will mean that those resources are not IV-E reimbursable after the initial 14-day placement period under Family First, the stability in placement and better outcomes for specific young people should take priority.

qualified residential treatment programs

Many WAFCA members are preparing to apply to operate a QRTP. WAFCA members pursuing QRTP certification indicate that the following would assist them in successfully operating such a program:

- Permitting video recording in common areas, exits, and hallways. Video recording is allowed in other states and provides increased training opportunities and proper resolution of most incidents. (See Attachment 2)
- Streamlined training for the congregate care workforce, including training in DCF rules and Evidence-based Practices.
- Deemed status, which would affirm that the accreditation required in order to become a QRTP not only meets but exceeds the state's minimum licensing requirements resulting in reduced need for licensing oversight at time of license renewal. License renewal should be synced with accreditation renewal, if possible. (See Attachment 3)
- Stronger liability protections. (See Attachment 4)
- Improved DCF licensing/provider relationship to move toward a quality improvement model.

Eventually, a new client rights rule would benefit DCF licensed agencies, but we recognize that there will be enough to do to make the transition to Family First. Acting on the above recommendations would be a great start.

Many WAFCA members are eager to develop and implement some of the requirements of a QRTP, such as family engagement and aftercare services, but are hesitant to do so in the absence of clearer information on improvements to county/tribal/state case management collaborations and better funding models. Developing portions of a program only to have them change after policies and procedures are developed and staff are trained is not feasible. Providing these services without having a mechanism to be reimbursed for them also creates an issue. Overall, WAFCA members believe their staff will enjoy assisting with family connections and maintaining relationships with a youth and family following discharge. In order to put together solid plans for doing so, a workgroup comprised of counties, tribes, providers, DCF, DHS, youth, and families would be beneficial.

With regard to some of the specific requirements for QRTPS, WAFCA offers the recommendations below.

aftercare

- Aftercare costs should be determined by the provider agency based on individual child and family needs. Not all families will need/receive the same level of service.
- Aftercare services should be flexible and allow for variations in service delivery (in person, via phone or other forms of technology, etc.).
- A decision needs to be made regarding who is responsible for aftercare, and the decision must apply to all placements. Agencies are unable to staff appropriately if the choice for who participates in aftercare is left up to each individual purchaser. Some counties may want their CCS or CST program to serve the child once reunified. This is one item a workgroup could tackle together.
- Aftercare implies services provided to the family post-discharge, while skill building with the parents typically happens throughout placement. DCF will need to provide a way to capture the staff time and resources that go into this work or determine that the agency will set their own rates for services to the family.
- Aftercare utilizing evidence-based practices should be considered a prevention service.

assessment

- WAFCA supports the use of the Child and Adolescent Needs and Strengths (CANS) assessment, in conjunction with other assessments, to determine whether QRTP placement is appropriate.
- WAFCA requests a study of how the CANS determines the Level of Care (LOC) for a child with significant development or cognitive needs, as those providing care for individuals with disabilities see inaccurate LOCs for children presenting with these needs.
- WAFCA recommends that completion of the CANS for this specific purpose be delegated to a CANS superuser (would need to be created) within each county or region to better ensure it is administered to fidelity and without bias, as seems to be intended by the Family First requirement for an independent qualified individual administering the assessments.
- WAFCA recommends the creation of a multi-disciplinary team, inclusive of members from various state agencies that serve children and/or families with complex trauma histories, mental health diagnoses, social emotional/behavioral needs, and cognitive/developmental disabilities. The team would be responsible for reviewing disputes that may arise from the QRTP assessment; providing consultation to counties, tribes, and providers regarding the most complex children, youth and families being served; and maintaining data regarding consultation to identify system gaps and inform service array enhancement/expansion.

nursing/clinical staff

- WAFCA recommends that agencies identify within their policies and procedures when and how nursing and clinical staff will be relied upon within the scope of a child's treatment.

family participation

- Clarity around the role of providers in facilitating outreach to the family members of the child, including siblings, is needed. In some cases, it could be duplicative of what county case workers would be doing.

- Family interaction plans are established by the county. Including providers in the development of these plans should be required in order to ensure they are aware of and can support the plans as developed.
- Like aftercare, family participation may be more successful if it is consistently defined from county to county and provider to provider. The workgroup proposed above could address this as well.

determining quality

Continued reform and improvement in Wisconsin's child welfare system are needed. At this stage, the timing of such reform and the areas of focus are being driven in large part by Family First. The framework that Family First is built around hones in on three essential principles: 1) Helping families whose children are at risk of removal stay together safely; 2) Ensuring that children in foster care can live with a family; and 3) Improving access to high quality residential treatment.[8] While Family First provides some minimal standards for quality, we believe this is an opportunity to explore what we in Wisconsin believe constitutes quality as it relates to our child and family serving agencies.

WAFCA members believe that it is crucial that we engage in the work of defining quality together and again recommends the formation of a workgroup comprised of counties, tribes, providers, DCF, DHS, youth and families. The workgroup would ideally focus on defining quality as it pertains to out-of-home care; however, it would be prudent to include agencies in the prevention and in-home services space as well. We envision the following questions and areas of exploration being tackled by this workgroup.

- The larger question of "what constitutes quality", both anecdotally and according to specific evidence.
- What drivers of quality belong in the minimum standards?
- How do certain variables, such as workforce, location, and payment rates influence the quality of a program?
- While standards (administrative code requirements) will vary, can/should quality measures be relatively consistent across the continuum?
- What role do evidence-based practices play in establishing a quality program?
- The evaluation and reporting of quality metrics.
- The inclusion of satisfaction surveys and/or other feedback loops for children and families receiving services, as well as purchasers and providers of the service.

If we truly want to expand and improve our service continuum to achieve increased quality and effectiveness, there are specific conversations that WAFCA members believe would be beneficial. In 2017, the Alliance for Strong Families and Communities ("Alliance") and the American Public Human Services Association (APHSA) commissioned Oliver Wyman and SeaChange Capital Partners to conduct the National Imperative Study.[9] Over the course of 9 months, they analyzed tax returns for nearly 45,000 human services community-based organizations (CBOs), surveyed executives and leaders from CBOs, public sector agencies, private

[8] Implementing the Family First Prevention Services Act: A Technical Guide for Agencies, Policymakers, and Other Stakeholders. Retrieved from https://www.childrensdefense.org/wp-content/uploads/2020/01/FFPSA-Guide.pdf

[9] A National Imperative: Joining Forces to Strengthen Human Services in America – 2018. (2018, January). Retrieved from https://www.alliance1.org/web/resources/pubs/national-imperative-joining-forces-strengthen-human-services-america.aspx

foundations, and other stakeholder groups, and engaged a national advisory council whose members came from nonprofit human services agencies, government, the private sector, and academia. The findings of the study and the subsequent recommendations or "North Stars" resonated with WAFCA members.

A key finding of the study, likely felt by counties and tribes doing human services work as well, was that CBOs were unable to realize their full potential because of specific roadblocks and challenges faced, including:

- Public perception – the unfortunate labeling of nonprofits as charities that are ineffective and poorly managed, serving the community via handouts rather than being a valuable member of the human services field capable of providing impactful care and facilitating meaningful change.
- Financial stress – constraints imposed by government contracts, private philanthropy, regulations and other legal matters, as well as underdeveloped financial risk management systems.
- Operational shortcomings – lack of integration into the larger human services infrastructure, limited data sharing, low collaboration, and difficulty in measuring outcomes.
- Capacity limitations – lack of access to capital for investment in technology and talent.

To address these challenges, the study recommended five "north star" initiatives that WAFCA has modified in an effort to provide a road map for potential child welfare partner conversations. The recommendations that follow would significantly shift the future of service delivery in Wisconsin and, we believe, would produce the increased "quality" being sought.

1) Focus on a common set of outcomes rather than services delivered and core measures with accountability, full funding, incentives, disincentives, and flexibility.
    - It is WAFCA's position that the core measures should not be based on what our current system (eWiSACWIS) is capable of doing or permanency alone. Ideally, we would be discussing things that tie back to identified treatment needs, child and family improvements, etc. These would not be dictated by the state but developed in partnership with purchasers, providers, and receivers of service. In addition, we would advocate for contextual information to be gathered to supplement outcome information. Reasons for not achieving the expected results (such as a child being discharged from services prior to completing programming) should be gathered as well. Finally, we would encourage family *and* child focused outcomes, as services have implications for both.
2) Better data sharing and analysis, technology, agility and adaptability, and knowledge and leadership exchange.
    - It would be helpful to discuss the pros/cons associated with our current system, potentially in connection to conversations about a "Provider Portal". We should prioritize development of a mechanism for providers to enter information into a system that the state and providers can both pull information from. Stakeholders should regularly review data together as part of a knowledge/leadership exchange.
3) Establish strategic partnerships to change how members of the ecosystem work with each other and leverage assets to achieve better outcomes, reduce costs and redundancy, and foster innovation.
    - Among the assets of private providers in the human services system is the capacity to be nimble and the ability to leverage charitable support. By establishing the partnerships, and truly valuing them, we believe 1 and 2 above can be achieved, and will ultimately result in greater efficiencies, increased creativity and improved outcomes.

As indicated by the North Stars, it is critically important to consider roles, responsibilities, and relationships as they pertain to whatever quality improvement strategies we may pursue. Clear expectations, honoring the expertise of all team players, sharing decision-making power and risk (both outcome wise and financially) will not only help us reform our system, but will facilitate the trusting partnership needed to ensure the system is serving the best interests of our kids and families.

funding reform

As is the case with most reform efforts, adequate funding will be key. WAFCA shares the initial stated intent of DCF to build the system we want and then figure out how to fund it. Too often funding restrictions and/or challenges stifle conversation, creativity, and innovation. The changes Family First and DCF envision will require shared costs between state agencies and increased state investment, especially on the front end. It will be critical for us to take the long view, including projected cost savings following successful implementation, in order to ease concerns regarding the initial investment. Cost savings should be viewed through a public health lens, and we should invest early in systems to track the return on investment.

The system cannot make a shift if we stay narrowly focused on daily rates and eligibility for federal reimbursement. We are reforming the human services ecosystem and that requires us all to engage in some reframing to acknowledge the interdependence of private and public partners. We all must be invested in the financial health and stability of all components. The ecosystem cannot flourish if some of the building blocks are weak and under resourced. That's true for providers and it's true for state, county and tribal partners, as well.

As things currently sit, providers do not have reserve funds to support a pivot and start expanding their workforce or, in some cases, shift their workforce to community-based or in-home service delivery while still providing congregate care services. A number of providers report an inability to fully recover their allowable costs, let alone acquiring allowable profit/reserves that could be utilized to plan for the changes that are coming, invest in innovation, increase staff salaries, hiring or training, and/or modify or obtain space to deliver services. As a result, both short and long-term funding strategies will be needed in order to build and sustain our desired system.

In the short-term, WAFCA members advocate for the following:

- A per diem rate based on the total allowable costs as reflected through the annual audits and costs projected by the agency. Agencies will submit their cost and service report; however, agencies will also have the option to submit an alternative calculation based on their agency projections. Most rate regulation processes could remain the same (e.g., DCF calculating a maximum rate, providers submitting a rate request). The primary change would be that, within reason, agencies would be able to obtain their requested rate. An agency's costs would be deemed their costs of operating and their daily rate set accordingly.
- An investment in in-home caregiver retention, such as merit increases or annual increases in recognition of foster parent anniversaries.
- A solution that ensures timely and accurate in-home caregiver payments.
- Competitive innovation grants funded with a portion of the $8.7 million awarded to Wisconsin through the Family First Transition Act to support:

  - Expansion of community-based/in-home child welfare practices and services likely to be included in the state's prevention plan.
  - Costs associated with new service development (aftercare), accreditation, and physical plant modifications needed for agencies applying for QRTP certification.
  - Workforce investments, such as training and employee/agency growth in new areas of the state.
  - The development of more resources for respite, grief counseling, post-adoption support, and expansion of support groups for in-home caregivers.
  - The development of advanced foster parent training to create a pool of highly trained foster parents and areas of specialization to better serve youth with complex needs.

- The state must offset some of the costs of services for counties and tribes. Whether through an increase in the Child and Family Allocation, additional Medicaid funding, a separate legislative budget request, or some other mechanism, state investment must occur. Provider agencies, counties, and tribes have absorbed the majority of the financial costs and risks associated with out-of-home care expenses in particular. Where state investment has been made (Milwaukee), the data shows a return on investment. For example, Milwaukee has not seen a caseload spike, unlike the counties in the balance of the state.

In the long-term, WAFCA strongly advocates for replacing the current process utilized to establish rates with one that:

- Funds holistic services that promote individual and family engagement and treatment rather than beds or days in care.
- Provides consistent, tiered payment to in-home caregivers based on their level of competency and contributions to a child's treatment and supports ongoing caregiver participation even as children temporarily receive treatment in other settings.
- Funds services infrastructure versus individuals. The current exceptional/extraordinary rate process does not support development of the caregiver workforce needed to serve children with complex needs.
- Utilizes incentives related to outcome achievement and holds teams (including case workers, care providers, treatment providers, etc.) accountable for durable results with children and families.
- Creates shared risk between state, county, tribal and provider partners, integrates quality data, and considers risk adjustment.
- Invests in a highly competent and experienced child and family serving workforce in both the private and public sector. Ongoing case management of families at risk of a removal is complex engagement work requiring advanced practitioners.

closing

Providers want Wisconsin to capitalize on this opportunity to reform and improve our systems so that more children and families receive the right service/support at the right time. "Right support, right time" may mean a referral to residential as a first response, not a last resort. "Right support, right time" will also require that our sector engage more intentionally across systems to support the basic needs of families including, quality health care access and quality early care and education. This is an opportunity to identify and get behind key

investments that will lift families up and strengthen the health of our human services ecosystem across the private and public sector.

We are "all in" on investing in prevention and early intervention with families. As we continue to move forward, we are also acutely aware that we have a responsibility to sustain a broad continuum of resources. We will continue to have children who need an out-of-home resource, families with complex trauma, and adolescents facing serious emotional and mental health challenges. We cannot advance our care delivery system without the support of those in our current out-of-home care array - our relative caregivers and foster parents, youth care workers, group home operators, and residential service providers. Their work is valuable, and we need to engage their passion and expertise.

We are committed to partnering to move forward and see many hopeful signs that our government partners share this commitment and are taking the lead to move the system in a new direction. Cross-system collaborations will be most effective when local communities have the support and tools to engage in critical conversations between invested and impacted stakeholders. A shared understanding amongst child welfare, health care, law enforcement, judges, mental health providers, schools, community leaders, and families is essential to the success of the reform. We believe we can go further faster together when our joint efforts are built on a foundation of trust, shared values, and hope for Wisconsin's children and families.

Thank you for considering this contribution to a much larger conversation. We look forward to continuing to work together to address the questions and challenges that lie ahead.

Attachment 1: Licensing Transfer and Agency Relocation

With the implementation of the Family First Prevention and Services Act, agencies may need to merge and/or acquisitions may need to occur. As currently written, 48.66(1)(c) will require all agencies seeking to merge or acquire other businesses to go through the process of obtaining a new license; a process that will be overly burdensome for both DCF and private providers.

At minimum, WAFCA recommends the following statutory changes:

1) **Amend 48.66(1)(c)** by striking the last sentence:

   A license issued under par. (a) or (b), other than a license to operate a foster home or secured residential care center for children and youth, is valid until revoked or suspended. A license issued under this subsection to operate a foster home or secured residential care center for children and youth may be for any term not to exceed 2 years from the date of issuance. ~~No license issued under par. (a) or (b) is transferable.~~

2) **Create 48.66(1)(d)** and subsections that read:

   (1)(d) Licenses issued under par. (a) or (b) may only be transferred in one of the following circumstances.

   1. To a person or entity issued a current license under par. (a) or (b), excluding probationary licenses granted under 48.69, after ensuring any sanction or penalty under 48.715 has been resolved, including payment of any forfeiture under s. 48.715 (3) (a) or penalty under s. 48.76. The only provision of the license under 48.70(1) that may change in the transfer is the name of the person or entity licensed.

   2. When a licensed child placing agency as defined in DCF 54.01(4)(d) notifies the department of a change in the location of the premises identified on the license. The only provision of the license under 48.70(1) that may change in the transfer is the location of the premises.

In addition to the above statutory changes, WAFCA would advocate for an amendment to DCF 54.02(3)(e), which would require a CPA seeking to relocate or merge to submit the following with the application:

1. Copies of the annual reports published since the last license was issued.
2. The budget for the current fiscal year and the most recent financial audit.
3. A list of the current members of the board of directors and its committees.
4. The number, names, qualifications, and classifications of current staff.
5. A copy of the current staff organization chart.
6. A description of any program review and evaluation and changes in program content and purpose which have occurred since the last license was issued.
7. If the expiring license is provisional, a statement showing whether the requirements on which a provisional license was based have been met, or if not, plans for meeting them.
8. A copy of any revisions of personnel practices that have been made since the last license was issued.
9. Upon the request of the department, a copy of the current staff development and in-service training plan.

As written, the requirements are burdensome and unreasonable for a change in premises. There are no physical space requirements within the rule. It seems most reasonable to require the CPA to notice the department 30 days prior to a change in premises and provide a plan that details how the agency will remain in compliance with DCF 54.06(2)(b) which states, "All records shall be kept in a safe place protected from fire damage, theft and unauthorized scrutiny." The department has the right to complete an inspection at any time, as noted in DCF 54.06(4). If desired, a mandatory inspection within 30 days of the move to ensure the plan submitted has been implemented would be reasonable as well.

It should be noted that even with the change in statute, the Department would still have discretion over what the child welfare licensing section would require in order to process the transfer and issue an amended license. In addition, the statutory change recommendation does not facilitate an easy transfer of a group home license to an existing RCC. WAFCA requests that the Division of Safety and Permanence obtain assistance from the DCF Office of Legal Counsel to explore potential statutory and/or administrative rule revisions needed to allow for any mergers/acquisitions that need to occur.

Attachment 2: Permitting Video Recording

Under current law, generally, an individual who is receiving services for mental illness, developmental disabilities, alcoholism, or drug dependency (patient) has a right not to be filmed or taped unless the patient signs an informed and voluntary consent. This includes an individual who is admitted to a treatment facility or detained, committed, or placed under the Children's Code. WAFCA advocates for revisions to state statute and administrative rules to allow a patient placed in a residential care center, group home, or shelter care facility licensed by the Department of Children and Families to be subject to video surveillance, or be filmed or taped without the patient's consent, in common areas and near exits. Recording would not be permitted in private spaces, such as patient bedrooms or bathrooms.

The following would be needed in addition to revisions to administrative code:

1) Create 48.67 (6) to read:

> 48.67 (6) That all child welfare agencies that operate a residential care center for children and youth, all group homes, and all shelter care facilities develop a plan for monitoring safety, which may include the use of video monitoring and recording in common areas and exits. The department shall promulgate rules governing the use of video monitoring and recording for safety purposes in a residential care center for children and youth, group home, or shelter care facility.

2) Amend 51.61 (1)(o) as follows:

> 51.61 (1)(o) Except as otherwise provided, have a right not to be filmed or taped, unless the patient signs an informed and voluntary consent that specifically authorizes a named individual or group to film or tape the patient for a particular purpose or project during a specified time period. The patient may specify in the consent periods during which, or situations in which, the patient may not be filmed or taped. If a patient is adjudicated incompetent, the consent shall be granted on behalf of the patient by the patient's guardian. A patient in Goodland Hall at the Mendota Mental Health Institute, a patient detained or committed under ch. 980, a patient placed in a residential care center, group home, or shelter care facility licensed under ch. 48, or a patient who is in the legal custody of or under the supervision of the department of corrections, may be subject to video surveillance or filmed or taped without the patient's consent, except that such a patient may not be filmed in patient bedrooms or bathrooms without the patient's consent unless the patient is engaged in dangerous or disruptive behavior. A treatment activity involving a patient committed or detained under ch. 980 may be filmed or taped if the purpose of the recording is to assess the quality of the treatment activity or to facilitate clinical supervision of the staff involved in the treatment activity.

Attachment 3: Deemed Status

Under current law, DCF licenses a range of out-of-home care providers. In addition, DCF regulates the rates for CPA, RCC, and GH settings (Wis Stats 49.343). Wis Stats 49.343 (b)6m requires DCF to consider accreditation as a factor in setting rates; however, in practice, accredited agencies do not receive any direct consideration of their accredited status in the rate setting process. The current statutes and rules governing out-of-home care settings do not provide any recognition for accreditation.

The new federal Family First Prevention Services Act establishes new expectations for certain out-of-home care providers to be nationally accredited, which will mean more organizations moving to accreditation. The statutory language proposed under 2015 AB 712 could be adapted to provide regulatory relief to accredited out-of-home care providers. Additional examples of recognition of accreditation may be found on the Council on Accreditation website and in the Wisconsin YoungStar program.

Attachment 4: Addressing Liability

Children and youth with complex needs and challenging behaviors who are placed in out-of-home care pose a significant liability risk (harm to self, others, community, etc.) to providers. Out-of-home care providers are not afforded the same liability protections as those granted to government and to other similar types of facilities, such as community-based residential facilities, nursing homes, etc. This risk exposure impacts provider liability insurance rates and impacts provider capacity to serve youth with challenging behaviors.

WAFCA recommends that the following also apply to RCCs, group homes, shelters and CPAs licensed under Wis. Stats., Ch. 48.60.

- **Non-economic damages cap.** Wis. Stats., Ch. 893.555(4) limits the total noneconomic damages arising from care and treatment performed by a long-term care provider to $750,000. Long-term care provider includes adult family homes, nursing homes, hospices, CBRF, and home health agencies.
- **Collateral Source Rule.** Wis. Stats., Ch. 893.555(8) permits long-term care providers to introduce evidence regarding collateral source payments to reduce their liability to an injured person.
- **Wisconsin's "I'm Sorry" Statute.** Wisconsin statutes allow health care providers to meet with families after an incident to discuss what happened without risk that the statement of apology may later be used as an admission of liability. A broad range of facilities and professionals are included under Wis. Stats., Ch. 904.14.
- **Peer Review Statute.** Wis. Stats., Ch. 146.38 provides for confidentiality of peer review findings intended to improve the quality of health care, assess utilization of services or deterring reasonable charges. The records of reviewers cannot be used in civil or criminal action against a health care provider. The same providers that are listed under the "I'm Sorry" statute are included under the peer review protections.