Family First Prevention Services Act
PL 115-123
Stakeholder Informational Meeting Highlights

The Family First Prevention Services Act (FFPSA) was signed into law as part of the Bipartisan Budget Act on February 9, 2018. This act reforms the federal child welfare financing streams, Title IV-E and Title IV-B of the Social Security Act, to provide services to families who are at risk of entering the child welfare system.

North Dakota Department of Human Services (NDDHS) is responsible to implement the federal regulations resulting from FFPSA, manage the Title IV-E State Plan, and administer funding to support these efforts. The department will host Stakeholder Informational Meetings the 3rd Wednesday of each month during 2019. The purpose of the monthly meetings is to engage with Stakeholders and inform on progress, while soliciting feedback and comments related to FFPSA implementation.

DATE	July 17, 2019
FACILITATORS	Kelsey Bless – Children and Family Services Division Dawn Pearson - Children and Family Services Division
TOPIC	Rules Updates (QRTP, SIL, Family Licensing)

Highlights of FFPSA Call:

- Family First Stakeholder calls continue to be scheduled through December 2019, cancelation of meetings will be posted online on the website. Please watch for updates on the CFS website https://www.nd.gov/dhs/services/childfamily/family-first.html

July 17	North Dakota Administrative Code comments and Qualified Residential Treatment Program (QRTP) capacity
August 21	Qualified Individual Process for Qualified Residential Treatment Program (QRTP) placement
September 18	Foster care candidacy and prevention plan updates
October 16	Review of Family First Prevention Services Act implementation
November 20	TBA
December 18	TBA

- Title IV-E State Plan will be submitted to the Children's Bureau in September 2019
- DHS continues efforts to review the reinvention of Title IV-E funds for the prevention plan. The momentum of the FFPSA Prevention Plan has started in great volume and will be discussed in September.
- ND Administrative Code – drafted and the department received various comments regarding the chapters. Reminder of the chapters revised or created:
    - NDAC 75-03-14 Foster Care Licensing rules
    - NDAC 75-03-15 QRTP Rates
    - NDAC 75-03-16 will be repealed
    - NDAC 75-03-40 QRTP rules
    - NDAC 75-03-41 Supervised Independent Living rules

Since this call the administrative rules have been finalized with the Attorney Generals office and are being published for full approval and review by the Legislative Rules committee. **The legislative rules committee hearing will be held on September 4th in the State Capitol.**

Bed Capacity for ND come October 1, 2019

Effective October 1, 2019, NDCC 50-11 eliminates the use of the current Residential Child Care Facility (RCCF) licensed level of care and implements new regulations for QRTPs and SILs noted above. PL 115-123 requires many standards for a QRTP including but not limited to: national accreditation, trauma informed treatment and six months post discharge aftercare supports. Below is a chart of the RCCF providers planning to transition into the QRTP level of care:

ND Qualified Residential Treatment Program capacity is expected to be:

Anticipated QRTP ND Licensed Facilities	Current Licensed RCCF Beds	ESTIMATED QRTP BEDS	Notes on Accreditation
DBGR - Fargo Youth Home	10	10 Female/Male Ages 10 to 19	Nationally Accredited
DBGR - Minot Campus	30	30 F– 10/M – 20 Ages 10 to 19	Nationally Accredited
Home on the Range	36	36 Female/Male Ages 12 to 19	Nationally Accredited
Pride HOPE Home	6	6 Female/Male Age 9 to 14	Nationally Accredited
Prairie Learning Center	24	24 Males Ages 12 to 19	*Pending - TBD*
Charles Hall Youth Services	16	16 Female/Male Ages 10 to 19	*Pending – estimated August 2019*
TOTAL QRTP BEDS	122		

***** Since this call, Charles Hall received nationally accreditation! Their facility is positioned to gain the QRTP license effective October 1, 2019.**

Trends founds in the comments from QRTP rules (NDAC 75-03-40):

1. Restraint
    a. Further defined after receiving comments
    b. Mechanical restraints will not be allowed
    c. Drug restraint will not be allowed
    d. Prone restraint will not be allowed
2. Seclusion
    a. Further defined after receiving comments
3. Discipline
    a. Further defined after receiving comments
    b. Timeout is voluntary
    c. Discipline is now referred to as Behavior Management
4. Locked Unit
    a. Further defined after receiving comments
    b. Doctors order required
    c. This call allowed for stakeholder feedback to offer suggestions for a new name
    d. Changed title to “Special Care Unit”.

The Department appreciates the comments from stakeholders and has reviewed and revised the sections related to restraint, seclusion and locked unit. The Department has financially supported training for the current residential facilities in the six core strategies for reducing seclusion and restraint facilitated by the National Association of State Mental Health Program Directors (NASMHPD) and trauma informed Building Bridges Initiative funded by Substance Abuse Mental Health Services Administration (SAMHSA). The six core strategies, which current residential facilities utilize as a foundation of change

and engagement include:

1. Leadership toward organizational change;
2. Use of data to inform practice;
3. Workforce development;
4. Use of seclusion and restraint prevention tools;
5. Consumer roles in inpatient/residential settings; and
6. Implementation of debriefing techniques.

The Department's mission is to provide quality, efficient, and effective human services, which improve the lives of people. The Department believes that safety is paramount and the six core strategies offer a foundation to ensure that a facility is equipped to develop a culture of safety and security to all residents and staff while minimizing the need to engage in physical restraint or seclusion. The proposed administrative rules indicate that facility staff must be trained in non-violent crisis intervention, which offers de-escalation techniques as the primary source of engagement to prevent restraint for a child escalating and facility staff are properly trained in techniques if restraint is needed as a last resort. The Department will continue to support the philosophy of the six core strategies to reduce restraint and seclusion and maintain a culture of de-escalation.

The Department originally proposed a locked unit as an option for a facility to utilize only if their facility buildings and grounds allowed for a dedicated therapeutic space or unit for a child to temporarily work with clinical staff to regulate behaviors in a restrictive secure environment. The interpretations of locked unit from the commenters posed great variability and was not consistent with the vision of the Department. The locked unit has been renamed to "special care unit" which means a separate secure area of the facility designated as a protective environment in which treatment and services are provided to residents. The unit is secured by means of a key lock that prevents residents from leaving at will, much like a memory care wing of a nursing home. A special care unit is not seclusion, but rather a fully operational separate space located within the facility for residents in need of more intense supervision. The special care unit is not a requirement of a facility, rather an option permitted with additional licensing approval from the Department. After further review and communications with commenters both internal and external to the Department and current residential child care facilities; the Department has revised the definitions of "restraint" and "seclusion" and sections 75-03-40-44, 75-03-40-45, and 75-03-40-46 to was completely revised.

Q & A

What agency will be replacing Provider Audit's function for the QRTP rate setting?

Until further notice, Children and Family Services will be the facility contact for rates.

With more children being served in the community, are there any funds for facilities to support mentoring or in- home service delivery for the provider in efforts to maintain children in lower levels of care?

At this time, CFS does not have an answer specific to the funding request. However, if an agency identifies a model of practice that will complement the system and support children and families, you may pitch your idea and costs for service to the Department at any time.

What agency will be setting the rates for Supervised Independent Living agencies?

Children and Family Services negotiates rates for all SIL's via the NDAC 75-03-41.

Seclusion or placement into the "Special Care Unit" noted in QRTP rules will need an physician's order, how will this work for Physician's not directly affiliated with the licensed QRTP? We believe this is difficult as the Physician's do not oversee the care of child onsite, staff engaging in the supervision of the children, etc?

Children and Families does not have the answer regarding the liability of the Physician ordering a child into the special care unit or seclusion. Prescribing doctors should be informed of the treatment and onsite cares available to meet the needs of children they are familiar with.

With the system of juvenile justice not serving these kids, the psychiatric hospitals not serving these kids, psychiatric residential treatment facilities (PRTF) not serving these kids, the state hospital not serving these kids, etc. How are we in the community supposed to meet the capacity of need for all children in need of "acute psychiatric behavior management" when refused by medical placements. Please add my comments to your notes as these topics need to be addressed and children in the system need the Department, Psychiatrists, Medical Providers, and community providers to come together and discuss how to meet their needs and ensure safety for all parties ongoing.

We will keep these comments regarding the system, and will share with others at NDDHS.

Will the "locked unit" or "special care unit" be isolated to one child at a time or can multiple residents be placed there at one time?

Such decisions will be less prescribed by Children and Family Services and more defined in facility policy by the provider as a business model/practice. The special care unit was not intended to be for one child at a time, it could accommodate more than one child at a time.

Will the "locked unit" or "special care unit" be isolated to one area of the facility/buildings and grounds…. Can we allow the residents to engage in therapeutic interventions across campus throughout the day? child at a time or can multiple residents be placed there at one time?

Such decisions will be less prescribed by Children and Family Services and more defined in facility policy by the provider as a business model/practice. It is assumed that groups or treatment may be offered outside of the secure area where the children placed in that level of QRTP care are not intermixed with QRTP clients in the general population,

I encourage the Department to revisit the title of "locked unit" and be sensitive to the fact we are working with children and families.

Children and Family Services will revisit the title.

NEXT MEETING:

August 21, 2019 1:00-2:00PM

TOPIC: Qualified Individual Process for

Qualified Residential Treatment Program (QRTP) placement