DEVELOPING A THERAPEUTIC SUPPORT SERVICE

Cliff Davis
Human Service Collaborative
Washington, DC

In partnership with the
Connecticut Center for Effective Practice of the
Child Health & Development Institute of Connecticut

Connecticut Center for Effective Practice

Child Health and Development Institute of Connecticut, Inc.

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Section 1. Introduction

This report was developed for the Connecticut Department of Children and Families, through a partnership between the Child Health and Development Institute of Connecticut and the Human Service Collaborative. The report informs the Department's efforts to build an effective system of care for children with serious emotional disturbances and their families, focused particularly on the development of effective mentoring interventions. All recommendations contained herein are the author's; the Department determines how to best use public funds to appropriately serve children and their families.

A. Assignment

The assignment guiding this project: *to assist the Connecticut Department of Children and Families to develop a "Therapeutic Support Service" to be accessible as appropriate to the CT KidCare population of children with serious emotional disturbances and their families.* An individual mentoring model stands at the core of the Therapeutic Support Service. Important parameters for this work included: *to develop a service that will meet operational requirements under the State Medicaid Managed Care Program*; and *to strongly link the work of this service to the therapeutic goals and objectives of each child's unique and individualized service plan*.

This report describes how such a service is articulated in other service environments, identifies effective practices, and proposes an operational model for delivering this service in CT's system of care.

B. Methodology

This assignment was carried out in two primary stages. First, exploration of existing services similar to the therapeutic support service described above took place through internet searching and phone or email contact with a variety of relevant sources. Service and Medicaid information about individual states is widely available on the internet, as are publications and other resources relevant to this assignment. Technical assistance centers, training consortia, and organizations specifically supporting mentoring were contacted, seeking relevant information.

Second, the information obtained through research was reviewed, sorted and organized to identify what was most relevant to this assignment. A great deal of the information gathered is not directly referenced in this report because much of it was either irrelevant to Connecticut's specific needs or duplicative to information that is contained herein.

There is undoubtedly additional information available in the broad service community that was not accessed in conducting this project. Any failure to include all relevant information is the result of limited time and imagination on the part of the author. Information about programming in the following states was explored for this project: Arizona, California, Connecticut, Florida, Georgia, Illinois, Maine, Maryland, Massachusetts, New Mexico, New York, Ohio, Oregon, Pennsylvania, Texas, Vermont, and Washington.

C. Outline of the document

This document is organized as follows:

I. Introduction, including the Assignment, Methodology, and Report Outline
II. A Brief Discussion of Mentoring, including history, best practices, and resources
III. Definition of Therapeutic Support Service (core finding)
IV. Findings and Recommendations for the service (service definition; service population focus; linkage to service plan; appropriate service providers; supervision; recruitment, selection and matching of individual providers; training approach and curricula; quality assurance and documentation practices; and funding)

Section 2. Discussion of Mentoring

[The discussion in this section is based on information obtained from a variety of sources, including especially websites for the Connecticut Mentoring Partnership and the Big Brother/Big Sister Program.]

At the core of the Therapeutic Support Service will be an *individualized mentoring relationship* between professional, adult mentors and children and adolescents with serious emotional disturbances. The term "mentoring" is generally used to refer to a sustained, supportive relationship between one person and another. The "mentor" in this model is an adult with specific personal or relationship skills and a willingness to commit personal resources to a relationship that is intended primarily to benefit the other person, although most mentors would indicate that they gain from their giving. The "mentee" is a person, most commonly a young person, identified because of stressors or difficulties in their lives, with a need for support as they work to improve their life, coping or relationship skills. The intended outcomes for youth mentees generally fall into three categories: educational achievement; health and safety issues; and social and emotional development.

Specific to Connecticut's needs, the mentoring relationship is intended to take place between a qualified, committed adult and a young person experiencing a serious emotional disturbance. The trained, paid mentor will serve as a potential friend, confidant and supporter to the mentee, furthering the therapeutic goals in the youth's service plan and encouraging the mentee to experience new life opportunities in new ways. The mentor will make use of natural opportunities to assist the young person to function appropriately at home, at school, and in the community.

A. Brief History of Mentoring

Mentoring has existed as long as there have been adults taking young people "under their wing" and offering them guidance and support beyond that received from their families. Mentorship within particular vocations and for spiritual guidance has long had a place within developing societies. More organized mentoring emerged in the early 20th Century, as caring individuals connected with community settlement houses and faith communities formed relationships with persons in the neighborhood, including youth, supporting and guiding them towards success in life. The ingredients for these early mentoring approaches were a youth in need, however that need might manifest, an adult willing to give time and energy to a person not bound to them through familial or business ties, and the circumstances that

brought them together. Such relationships were always informal, expressed uniquely as the product of interactions between the two participants.

America's system of orphanages also served as a proving ground for mentoring, with community members meeting and assisting children being reared within an institutional environment, again with the loosest of organization, monitoring, or evaluation. Members of community and faith organizations saw a ready need among children living in orphanages or children's homes and provided mentoring to many. The well-known Big Brother/Big Sister Program (BB/BS) is a successful example of mentoring being organized and nurtured into something beyond individual, informal relationships in the post-orphanage era. While the mentoring relationship remained informal and emphasized the adult roles of friend, confidant and supporter, the BB/BS program brought structure to the organizing tasks of recruitment, training, matching, support, supervision, and evaluation. It is a testament to the simplicity of the mentoring model that programs like BB/BS and others flourish in most communities across the country, supported by a variety of national and state organizations and state and local infrastructures.

B. Best Practices; Populations Served

In recent years, the general mentoring model has been adapted to better serve specific, targeted populations, such as the child welfare and juvenile justice populations, and children and youth receiving services through the mental health, substance abuse and/or developmental disabilities systems. Mentoring models have evolved beyond the individual relationship approach, now actively including **traditional mentoring** (one adult to one young person), **group mentoring** (one adult to up to four young people), **team mentoring** (several adults working with small groups of young people, in which the adult to youth ratio is not greater than 1:4), **peer mentoring** (caring youth mentoring other youth), and **e-mentoring** (mentoring via e-mail and the Internet). Evaluation components have been built into several model designs, enabling serious study of the strategies that lead to the best outcomes for mentees under a variety of circumstances and approaches. Special studies have examined the impact of mentoring on the population of children with parents in prison and of school-based mentoring, where the relationship takes place within the operations of the child's school.

Positive outcomes are documented for children as a consequence of mentoring relationships. Mentees in various studies can be shown to have fewer missed school days, higher matriculation rates into higher education, more positive attitudes about schooling, lower incidence of initiating substance abuse, slightly reduced rates of criminal behaviors, and some increase in communication with parents. The programs that demonstrated these results emphasized careful selection and training of mentors, strong supervision and support of mentors, and long-term mentoring relationships.

Training approaches and curricula are accessible from a number of organizations, including approaches embedded with evaluation tools. Formal mentoring support infrastructures have been developed at the state and national levels, most now organized through a national network of mentoring partnerships (including Connecticut's Mentoring Partnership). The national focus does not single out children with serious emotional disturbances but includes children from high-risk, high-need groups. Several states now employ different approaches to include mentoring as one tool in their service infrastructure, including the ability to recoup federal reimbursement through the Medicaid program for therapeutic services provided to target populations, such as children and youth with serious emotional disturbances.

C. Resources

National Mentoring Partnership
Alexandria, VA
http://www.mentoring.org/
This national organization links all community and state mentoring organizations into a loose infrastructure, enabling the sharing of information throughout the network.

Dr. Susan Weinberger, Mentor Consulting Group, Connecticut
DrMentor@aol.com
Dr. Weinberger is a leader in the National Mentoring Partnership and a recognized expert in the mentoring field.

Connecticut Mentoring Partnership
http://www.preventionworksct.org/
This organization is the Connecticut chapter of the national mentoring partnership and is led by Dr. Weinberger.

Public/Private Ventures
http://www.ppv.org
This organization has published a variety of support tools for the broad field of mentoring and has conducted and published evaluation studies of mentoring approaches.

Section 3. Definition of Therapeutic Support Service

Therapeutic Support Service, as used in this report, is the delivery of behavioral guidance, advocacy and education interventions by trained adults to support skill-building in children and adolescents with serious emotional disturbances, in partnership with the youth, family and other key caregivers, and in furtherance of the therapeutic goals and objectives of the child's individualized service plan. This definition is discussed further in Section IV.B.2. – Service Elements and Recommendations.

Several important elements are critical to successful implementation of the service, and each element is discussed following the discussion of the definition. At initial implementation, the *population focus* for this service will be children and adolescents with identified serious emotional disturbances. As experience is gained in delivering and managing the service, the population focus may be broadened to include children and adolescents at risk of developing serious emotional disturbances. The State will define requirements for the *training and qualifications of mentors and individual agencies* providing this service; each agency will manage and document the training and qualification of mentors who are their employees. Employing agencies will provide adequate *supervision and support* to mentors. Agency *documentation* processes will be developed and monitored within the agency's *quality management policies*, and reported within State quality assurance requirements.

Section 4. Findings and Recommendations

A. Core Findings

The research in this project revealed that Connecticut has articulated a therapeutic support service built on an individual mentoring model that is assessed as equal to or better than other service models in operation across the country. It is noted that the elements of the Connecticut service model are not currently being implemented. The majority of states for which information was explored in this project do not have a well-defined service that meets Connecticut's parameters or that fully describes the service in which Connecticut is interested. System of care development is uneven across the states, and there is not yet widespread or uniform implementation of mentoring or therapeutic supports for children with serious emotional disturbances, although that approach is being utilized in many states and communities following a variety of models.

The best example of a well-constructed model for this service is contained in a Connecticut document entitled, "The Core Contract Part III – Therapeutic Mentoring" (hereafter referred to as "Core Contract"), dated October 26, 2004, which outlines operational details of implementing this service. Additional meaningful detail is contained in a Connecticut document entitled, "Mentoring: Therapeutic and One to One Supports, Proposed Guidelines for Future Programming, DRAFT," developed by the Mentoring Subcommittee of the Children's Behavioral Health Advisory Council (hereafter referred to as "CBHAC document") and dated June 15, 2006. Finally, individuals engaged in the delivery of this service across the country consistently referred to the expertise of Dr. Susan Weinberger of Connecticut's Mentor Consulting Group. These three information sources contributed strongly to the development of the recommendations in this report.

Medicaid service manuals and state service regulations for a host of other states were explored in this project. Language found in those manuals and regulations was consistently vaguer and less well-defined than the language presented in the Connecticut documents. The Maine model for Children's Behavioral Health Services is the most complete relevant service model found, other than the Connecticut model. Examples of Maine's approach are given below in a number of recommendations for the sake of comparison and in support of the recommended approach. The Georgia model for Community Support Services is also referenced, although less often, for similar reasons. Most language found in other state systems is not referenced in this report because it is not relevant to the report's purpose. It is noted that contacts in several other states referred the author back to Connecticut's language, or offered ideas and phrases supportive of Connecticut's approach.

B. Findings

The Findings section of this report is organized as follows:

1) The key language found in the Connecticut Core Contract is reorganized and presented as a clear and comprehensive model for implementing the Therapeutic Support Service.

2) Individual service elements are addressed through recommendations that build on the model articulated in the Core Contract, supplemented by information from other sources, as noted under each recommendation. Each Recommendation is followed by "Discussion", "Examples", and "Conclusion" sections.

1) Connecticut Core Contract Language

The following three pages contain a reorganized and slightly edited version of the content of the "Core Contract Part III – Therapeutic Mentoring," as referenced above. The service name has been changed in this report to Therapeutic Support Service. No language content was changed, but phrasing and organization has been altered from the published version, with headings inserted by the author. The remaining material in the contract language not referenced in this summary may be relevant and might be utilized in new rules; however, what follows is the core information in that contract language about the service and service provision expectations.

Core Contract Part III – Therapeutic Mentoring

A. Overarching Goal of Therapeutic Support Service (TSS; previously called "Therapeutic Mentoring"): "This service should aid in facilitating the discharge of youth from a more restrictive setting (e.g., residential) or assist in maintaining youth safely in their community."

B. The purposes of TSS:

"to provide interactional activities that focus on increasing self-esteem, habilitation, resiliency, the development and improvement of social skills and peer relations, and promoting age appropriate behaviors in normative, non-clinical settings through a one-to-one relationship with a trained, supervised, caring adult mentor; and

to provide guidance, advocacy and education to youth with complex behavioral health needs through the use of structured, home and community-based interactions and activities."

C. Through TSS youth will:

"receive help to explore and enjoy recreational activities, identify career options, and evaluate educational alternatives; and

experience a relationship with a mature, responsible person who can be a role model and resource that can offer the youth support, guidance, strength and reassurance."

D. The types of goals planned for individual youth under TSS will be:

- "Empowering and providing youth with the skills to realize positive long-term outcomes with respect to home, community, career, peer, and education/academic interactions;
- Enabling youth to effectively manage and/or lessen negative behaviors;
- Promoting and enhancing psycho-social resiliency;
- Assisting youth with the identification of and lasting affiliation with appropriate community activities to support the youth during the service period and after termination (e.g., development of an age appropriate hobby, interest, or skill; and formal connection to one or more natural community support systems); and
- Linking with other service components and systems to ensure that therapeutic mentoring is informed by the youth's clinical and SOC Individualized Service Plan goals."

E. The following are the types of service activities to be delivered under TSS:

- "Educational/Academic Achievement: Tutoring and academic assistance, identification of and linkage with educational resources, college preparation support, and educational entrance and application assistance;
- Career and Vocational Support: Assistance with career selection, career exploration, preparation and guidance;
- Health, Safety and Well-being: Support and general information to assist with the promotion of overall health, fitness, nutrition, safety and injury prevention;
- Social/Emotional Developmental: Imparting of mediation, self-advocacy and conflict resolution skills. Enhancing stress management, coping, problem solving, communication and interpersonal skills. Assistance with behavior management and psychosocial skill building;
- Recreational/Personal Enrichment: Identification of, linkage with and participation in recreational, volunteer and/or enrichment activities;
- Family Interaction and Support: Engaging in activities that include the family. Identification of resources and information for the parent and family that converge with the youth's mentoring goal plan. Provision of parent education and instructional modeling, as appropriate;
- Recognition and Appreciation Events: Regular acknowledgement of program, staff and youth accomplishments and successes. Recognition of "graduated" mentees, significant achievements, and exemplary mentors and their practices, etc."

F. Providers of TSS will:

"collaborate with and/or develop and maintain a demonstrable linkage with informal, concrete and natural supports (e.g., family groups, religious, fraternal, sorority, civic organizations, etc,) and services within their program catchment area(s) as a means to ensure that equity in client access, satisfaction and outcomes will occur;

provide evidence of functional relationships with informal, concrete and natural institutions and programs; utilize such providers as consultants, training resources, and avenues for community/neighborhood-based outreach and dissemination activities; and

actively participate in the Local System of Care/Community Collaborative(s) or such groups operating within the catchment area for this service."

G. Providers of TSS will provide pre-service training in the following areas to all direct service employees:

- "Blood born pathogen (universal precautions).
- CPR.
- Effective communication and limit setting.
- Crisis management/Behavioral interventions.
- Mandated reporting.
- Medication Administration.
- De-escalation, conflict resolution and crisis management techniques".

H. Providers of TSS will provide or arrange in-service training in the following areas to all direct service employees:

- "Overview of child and adolescent behavioral health (common diagnosis and associated behaviors, and common psychotropic medications).
- Recognition of child abuse and neglect.
- Interpersonal communication and effective listening.
- Social skills development.
- Limit setting and boundary establishment/maintenance.

- Agency policies and data keeping requirements.
- Impulse control and anger management.
- Child and adolescent development.
- Behavioral Management.
- College and vocational-education resources.
- Career preparation guidance.
- Community resources (traditional, non-traditional).
- Health promotion (e.g., suicide and injury prevention).
- Cross cultural competency".

I. Expectations around TSS service hours and caseloads:

- "A substantial time commitment by the mentor and the youth is required in order to better affect positive outcomes. The mentor and their matched youth shall meet for a period of no less than 6 -months for up to a maximum of 104 hours. Extensions of up to 3 -months may occur, at a maximum average of up to 12 hours per month. The regional Mental Health Program Director must approve extensions beyond 9 months or less than 6 months of the Therapeutic Mentoring service.
- The number of hours of direct contact between the mentor and the youth should typically range from (1 – 6 hours) a week, averaging up to 12-14 hours per month over the course of the 6-month period. The assignment of direct service hours and length of service should occur in partnership with the youth, their primary caregiver, and as appropriate their Clinician, DCF and Care Coordinator for the Systems of Care. The specific number of hours provided during a given week should be flexible and informed by the needs, goals and activities identified for the participating youth.
- Therapeutic mentors are to have a consistent presence in the life of the assigned youth(s) during the period of the service. Therefore, therapeutic mentors are to carry a caseload of up to 3 youth at a time, serving 4-6 youth annually."

J. Providers of TSS will meet the following supervision requirements for TSS workers:

- "A licensed individual with at least a master's degree in a human services field and no less than three (3) years experience in delivery of psychiatric services will be available for consultation and/or supervision to the TSS direct service staff, serving as the Program Clinical Supervisor.
- Each direct service staff person will receive no less than 1 hour of weekly individual supervision, with additional access to supervision provided as needed. Supervision and support to the direct service staff will also include monthly therapeutic mentor support group meetings, regular telephone contact, regular review and maintenance of mentoring activity logs, and regular dissemination of relevant information."

2) Service Elements and Recommendations

The model presented in the preceding section is the basis for recommendations on key service elements of Therapeutic Support Service; all recommendations are offered as amendments or improvements to that model.

SERVICE ELEMENT 1: SERVICE DEFINITION

Recommendation 1: Service Definition: "Therapeutic Support Service is the delivery of behavioral guidance, advocacy and education interventions by trained adults to support skill-building in children and adolescents with serious emotional disturbances, in partnership with the youth, family and other key caregivers, and in furtherance of the therapeutic goals and objectives of the child's individualized service plan."

Discussion: This language is taken directly from the CT Core Contract to create a short, informative service definition. It describes the type of intervention, the providers, the focus population, and key parameters, and links the service directly to the individualized service plan. This last element is important – effective care is driven by the care plan reflecting collaborative planning among the child or youth, the family/caregivers, and representatives of community services and supports relevant to the child and family's preferences and needs. It is not necessary to provide a listing of specific activities or service goals in the definition if the intervention is always driven by an appropriately-created care plan.

The Core Contract language emphasizes "facilitation of a discharge from a restrictive setting" and "maintaining youth safely in their community" (IV.B.1.A. above). The recommended service definition supports this goal, especially by linking the service to the therapeutic goals and objectives of the child's individualized service plan. The long-term service impact from use of this definition will be an increase in the system's ability to help address children's needs and improve the factors that contribute to those children remaining in their homes and communities.

All of the other guidelines proposed in the Core Contract can be connected to this definition.

Examples: Additional language in the Core Contract, as well as language in other states' service definitions, describes the desired goals of the service (e.g., "increased functioning"), activities characterizing the service (e.g, "acquisition of skills"), and the conditions surrounding provision of the service (e.g., "culturally competent"). Some even provide details about the documentation and billing of the service ("billed in quarter hour units").

Two examples of similar state language follow:

From the Maine Medicaid Benefits Manual

> **Children's Behavioral Health Services** shall mean those habilitative services provided to a child in his/her home or community setting which focus primarily on behavior management, increased skill development, and physical development activities. The goal of these services is a demonstrated increase in a child's level of function, increased skill development and a decrease in maladaptive behaviors.

This example includes a listing of specific activities provided under the service and a statement in support of goals that fit well under the language in Recommendation 1.

From the Georgia Providers Medicaid Manual [on-line URL]

> Community Support services consist of rehabilitative, environmental support and resources coordination considered essential to assist a child and family in gaining access to necessary services and in creating environments that promote resiliency and support the emotional and functional growth and development of the child. This service is provided to children in order to promote stability and build towards age-appropriate functioning in their daily environment.

This example describes a broader service than proposed for Therapeutic Support Service in this report, although the desired interventions could be offered under this broad service description. In particular, this definition emphasizes the role of resource coordination in providing the service which is not being proposed in Connecticut's service model.

To give better understanding to the activities of TSS Workers, the Core Contract language lists specific *service activities to be delivered under TSS* (section IV.B.1.E.). The list includes the following categories of activities: Educational/Academic Achievement; Career and Vocational Support; Health, Safety and Well-being; Social/Emotional Developmental; Recreational/Personal Enrichment; Family Interaction and Support; Recognition and Appreciation Events. This list clearly links the service to activities that may address a broad range of needs, allowing flexibility for local teams to set distinct and unique goals for each child and adolescent.

For comparison, the following list of service objectives is provided from Georgia's service system. It appears that Objectives 1-7 and 9 in this list would be a different way of presenting the same activities described in IV.B.1.E. Objective 8 focuses on resource coordination, a duty not included in the recommended definition. Objectives 10 and 11 may be seen as defining coordination or monitoring responsibilities that may compromise a child's trust in the mentoring relationship, which lies at the core of the Therapeutic Support Service. Objectives 8, 10, and 11 are shown below only to give the full picture of Georgia's approach.

From the Georgia Providers Medicaid Manual

Objectives possible for specific activities under Community Support Services:

1) Identification, with the child/youth, of strengths which may aid him or her in achieving resilience, as well as barriers that impede the development of skills necessary for age-appropriate functioning in school, with peers, and with family;
2) Support to facilitate enhanced natural and age-appropriate supports (including support/assistance with defining what wellness means to the child in order to assist that child/youth with recovery-based goal setting and attainment);
3) Assistance in the development of interpersonal, community coping and functional skills (including adaptation to home, school and healthy social environments);
4) Encouraging the development and eventual succession of natural supports in school and other social environments;
5) Assistance in the acquisition of skills for the child/youth to self-recognize emotional triggers and to self-manage behaviors related to the child's identified emotional disturbance;
6) Assistance with personal development and school performance;
7) Assistance in enhancing social and coping skills that ameliorate life stresses resulting from the child's emotional disturbance;
8) Service and resource coordination to assist the child/youth and family in gaining access to necessary rehabilitative, medical, social and other services and supports;
9) Assistance to children/youth and other supporting natural resources with illness understanding and self-management; and
10) Any necessary monitoring and follow-up to determine if the services accessed have adequately met the individual's needs.
11) Identification, with the child/youth/family, of risk indicators related to substance related disorder relapse, and strategies to prevent relapse.

Conclusion: The recommended definition is useful and concise. It helps all stakeholders hold a common understanding of the service while allowing flexibility for individual care planning teams to plan the interventions most likely to be effective and supportive for each child. The list of service activities under TSS offers an additional, concise explanation of the activities envisioned under this service. The Core Contract language is recommended as more useful than alternate language from other states.

SERVICE ELEMENT 2: POPULATION FOCUS

Recommendation 2: Population Focus for Therapeutic Support Service: This service is intended to serve children and youth who meet Connecticut's definition of serious emotional disturbance, as demonstrated by a placement in a restrictive, facility-based treatment program or active risk of such a placement, or as determined by a Community Collaborative.

Discussion: Recommendation 1 clearly indicates that this service is intended to be delivered to children with serious emotional disturbances. The overarching purpose statement pulled from the Core Contract language addresses the population – "facilitating the discharge from a more restrictive setting or maintaining youth safely in their community" – with a focus on youth who are in or at risk of placement in residential treatment programs. Currently such youth may be referred to as "Level 3 children". Involvement with a local Community Collaborative is viewed as likely or necessary for a child with this level of seriousness, so this recommendation supports maintaining that linkage to local infrastructures.

The CBHAC Proposed Guidelines document recommends that the service not be open exclusively to the children with the most serious disturbances (i.e., accessible by children at risk of a serious disturbance) and suggests a more specific population focus – "youth with SED that are particularly difficult to engage in traditional mental health services, yet are interested in and give voluntary consent to developing a relationship with a healthy adult role model." That draft goes on to suggest priority be given to "children 6-21 with severe disorders, with co-morbid conditions, significant histories of trauma, attachment difficulties and/or placements, risky behaviors, or multiple and frequent hospitalization. At this time, it is recommended that the focus remain limited to children with serious emotional disturbances. Future experience with this service may lead to an expansion of service access to children and youth with less serious emotional disturbances, preventing the emergence of more serious disturbances.

Examples: For comparison, Maine rules set two population criteria, as follows:

From the Maine Medicaid Benefits Manual

All children must meet criteria #1 and #2 below:

1. The child has an Axis I or Axis II diagnosis as defined in the most recent edition of the DSM or in the 0-3 National Center for Clinical Infant Programs Diagnostic Classifications of Mental Health and Developmental Disabilities of Infancy and Early Childhood Manual.
2. Exhibit behaviors which cannot be managed by the parent, or guardian, or puts them at risk for an out-of-home placement.

The first Maine criterion is a broader statement than proposed at this time for Connecticut, including both Axes I and II not using any qualifier such as "severe" or "serious". It maintains a focus on the population of children with identified diagnoses. The second criterion appears

to focus on one cause of potential placements but not the wider set of contributing factors (e.g., difficulty managing behavior in school). One goal of the proposed service would be to increase parents' success in managing the child's behavior, thus decreasing the risk for placement.

The Georgia definition of "Target Population", shown below, identifies a number of diagnostic categories of children, without functionally tying the service to the Individualized Care Plan (although the Georgia rules make that tie elsewhere).

From the Georgia Providers Medicaid Manual

Target Population Children and Adolescents with one of the following:
Mental Health Diagnosis
Substance Related Disorder
Co-Occurring Substance-Related Disorder and Mental Health Diagnosis,
Co-Occurring Mental Health Diagnosis and Mental Retardation/Developmental Disabilities
Co-Occurring Substance-Related Disorder and Mental Retardation/ Developmental Disabilities

Conclusion: Directing this service towards children and youth with the most serious functional impairments from their recognized disturbances makes the best use of finite public resources. "Level 3 Children" in Connecticut appear to meet this parameter. Linking such children to the local Community Collaborative ensures consideration of all resources in service planning and delivery. In the future, when this service is established and demonstrating efficacy, it could be expanded to a wider pool of children in need, perhaps incorporating some of the CBHAC recommendations.

SERVICE ELEMENT 3: LINKAGE TO THE CARE OR SERVICE PLAN

Recommendation 3: Linkage to the Care or Service Plan: Therapeutic Support Service will only be possible where the child's' individualized planning team identifies the specific therapeutic goals and objectives to be accomplished by the service. The individualized service plan will document how the service is linked to those goals and objectives and articulate specific outcome indicators that will be used to measure goal achievement over time. The service plan will be subject to necessary sign-off and approval requirements and will be tracked through the agency's quality assurance processes.

Discussion: The needs of "Level 3" children are complex. Therapeutic Support Service is one tool that can work in concert with other interventions to address the highest priority needs of each child, but it must be strongly and clearly linked to any and all other interventions being made to help the child and family. Care planning teams will need to recognize when TSS can be used as an effective component of a child's care and integrate it into other services and supports. The State and individual agencies will need to focus quality management activities on the service planning process to monitor appropriate development and certification (sign-off by appropriately-credentialed professionals) of care plans.

Use of formal care plan development and monitoring processes assures that the TSS, when offered, will be documented as medically necessary in the care plan, and system QA will monitor the completeness and accuracy of such documentation. Involvement by the

respective Community Collaborative will increase the likelihood of appropriate team-based care planning for each child.

The care plan also represents an unofficial contract between a family and child and the public helping system. It represents a process of shared commitments to the child by the family and the system, and it sets expectations the family and child can monitor during their time in service from the public system. The care plan is a critical focus for system quality management practices.

Examples: For comparison, the Maine definition of an Individual Treatment Plan follows. The definition describes the components and requirements of such a plan, with an emphasis on the list of professionals eligible to create such a care plan. The definition ends by re-emphasizing the importance of family involvement in developing a care plan for their child.

From the Maine Medicaid Benefits Manual

> **Individual Treatment Plan (ITP)** shall mean the plan of mental health care based on an assessment of a child and his/her family circumstances (if appropriate), made by a psychiatrist, physician, psychologist, licensed clinical social worker, licensed master social worker clinical conditional within the scope of his/her license, licensed clinical professional counselor, licensed clinical professional counselor conditional, advanced practice psychiatric and mental health nurse, and registered nurse certified in the field of mental health of a child's need for mental health treatment or rehabilitation, with the exception of emergency and crisis resolution services. This plan shall specify the service components to be provided, who will be accountable for provision of the service, the frequency and duration of each service component, the expected duration of treatment, and the expected short and long-range treatment and/or rehabilitative goals or outcome of services. The plan shall be developed in consultation with the family.
>
> A treatment plan for Children's Behavioral Health Services must: Identify behavioral health treatment needs, delineate all specific services to be provided, indicate the frequency and duration of each service, identify the mental health personnel who provide the service, and establish the goals and expected outcomes of each service.

Conclusion: The Maine definition for an Individual Treatment Plan strongly supports the linkage between care planning and the delivery of a service such as TSS, as advocated in this recommendation. The State must establish and monitor effective quality management practices to ensure that this service is delivered as intended – as described in a recipient's care plan. (See Recommendation 9 below.)

SERVICE ELEMENT 4: APPROPRIATE PROVIDERS OF SERVICE

Recommendation 4: TSS Service Providers: Existing or new service agencies will be certified to deliver Therapeutic Support Service. The service will be delivered by TSS Workers who meet State-determined qualifications and training requirements. TSS agencies will hire staff and be responsible for training, supervision, monitoring, and support of TSS Workers, following State rules as recommended in this report.

Discussion: The Core Contract language gives explicit direction to agencies providing TSS about the environment within which the service will be delivered:

> "collaborate with and/or develop and maintain a demonstrable linkage with informal, concrete and natural supports (e.g., family groups, religious, fraternal, sorority, civic organizations, etc,) and services within their program catchment area(s) as a means to ensure that equity in client access, satisfaction and outcomes will occur;
>
> provide evidence of functional relationships with informal, concrete and natural institutions and programs; utilize such providers as consultants, training resources, and avenues for community/neighborhood-based outreach and dissemination activities; and
>
> actively participate in the Local System of Care/Community Collaborative(s) or such groups operating within the catchment area for this service."

Service delivery agencies in active partnerships with other entities are well-poised to deliver this service and meet those three requirements: 1) linkage to informal, natural supports; 2) functional relationships with appropriate entities to monitor and improve services; and 3) participate in the Local System of Care and/or Community Collaborative within the child's community.

The Core Contract goes further in identifying specific *pre-service training requirements* (blood born pathogens, CPR, effective communication and limit setting, crisis management/behavioral interventions, mandated reporting, medication administration, and de-escalation, conflict resolution and crisis management techniques) and *in-service training requirements* (overview of child and adolescent behavioral health, recognition of child abuse and neglect, interpersonal communication and effective listening, social skills development, limit setting and boundary establishment/maintenance, agency policies and data keeping requirements, impulse control and anger management, child and adolescent development, behavioral management, college and vocational-education resources, career preparation guidance, community resources, health promotion, and cross cultural competency). These training content requirements define the competencies of TSS Workers. In the model being recommended, TSS agencies would ensure and document that TSS Workers receive this mandated training. A certification process would be established to document the qualifications and training of TSS Workers throughout the State.

Examples: Maine's service is structured to make use of two levels of certification. The Behavioral Specialist I position requires minimal qualifications, as long as appropriate training is provided. The Behavioral Specialist I must be actively monitored and supervised by a Behavioral Specialist II, and the service language lists the licensed professionals eligible to be a Behavioral Specialist II.

From the Maine Medicaid Benefits Manual

> **Professional and Other Qualified Staff in Children's Behavioral Health Services**
> Children's Behavioral Health Services may be provided by approved individuals as indicated in A and B below.
>
> [All such staff] is required to undergo, at the provider's expense, motor vehicle, child protective and Bureau of Identification background checks and demonstrate professional or other adequate liability insurance coverage. Repeat background checks are required every three (3) years.

A. Behavioral Specialist I

A Behavioral Specialist I provides direct care behavioral health services. He/she must be an individual eighteen (18) years of age or older. Minimum requirements include a high school diploma or equivalent, and relevant life experience. Relevant life experience can include, but is not limited to, post high school or equivalent education or other specialized training; paid or volunteer work; care for a family member. Providers may use their professional judgment in determining whether the individual has relevant life experience to meet this criterion.

A Behavioral Specialist I is required to be certified by the Department of Behavioral and Developmental Services.

Family members are not eligible for reimbursement as a Behavioral Specialist I. Family means any of the following: husband or wife, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild, spouse of grandparent or grandchild or any person sharing a common abode as part of a single family unit. If the Behavioral Specialist I has a personal relationship with the member (other than one of the relationships listed above), the Behavioral Specialist II will use his/her professional judgment in the clinical supervision of the Behavioral Specialist I to determine the ability of the Behavioral Specialist I to professionally provide services to the member.

B. Behavioral Specialist ll

A Behavioral Specialist II performs consultations, clinical assessments and evaluations when a higher level professional is required by the treatment plan. In addition, a Behavioral Specialist II oversees and coordinates the work the Behavioral Specialist I is performing with the child and family. A Behavioral Specialist II must be a licensed psychiatrist, physician, psychologist, licensed clinical social worker, advanced practice psychiatric and mental health nurse, registered nurse certified in the specialized field of mental health of a child's need for mental health treatment or rehabilitation with the exception of emergency and crisis resolution services, licensed master social worker clinical conditional, licensed clinical professional counselor, or licensed clinical professional counselor conditional.

All professional staff may provide services only to the extent permitted by licensure provisions. The provider must comply with all licensing requirements for Children's Behavioral Health Services.

The language above specifically excludes family members of the child, especially close family living in the same household as the child, from becoming TSS Workers, but leaves to the supervisor's judgment whether other persons naturally in the child's life might be qualified to provide TSS. The Behavioral Specialist II can also provide TSS directly to children, to the extent permitted by the individual's professional license.

The Maine approach is different than that requested by Connecticut, in which mentoring is provided by more skilled and/or qualified professionals. Without question, mentoring a child with a serious emotional disturbance may require professional understanding of the child and

the treatment approach being utilized. The State is encouraged to explore a credentialing process that includes but goes beyond professional mentors, making use of certain individuals with life skills that make them effective mentors, even though they may lack educational and/or license-based qualifications.

Georgia lists specific requirements for practitioners of Community Support services, as shown below. This model allows a licensed person (MHP or SAM) to provide the service independently and a less-qualified person to provide the service under the supervision of a licensed professional.

From the Georgia Providers Medicaid Manual

B. Staffing Requirements

1. The following practitioners may provide Community Support services:
   - Mental Health Professional (MHP)
   - Substance Abuse Manager (SAM)
2. Under the supervision of a Physician, an MHP, or a SAM, the following staff may also provide Community Support:
   - Certified Peer Specialists
   - Paraprofessional staff

This model, like Maine's, emphasizes the use of peers and paraprofessionals to deliver the support service, as long as they are appropriately trained and supervised.

Conclusion: Connecticut has asked that this service be delivered by professional providers. The Core Contract clearly describes the training and competencies needed by TSS Workers. The State will establish a credentialing process to certify individuals with adequate qualifications and training to provide TSS. As experience with this service is gained, Connecticut may choose to allow certification of TSS Workers with less professional experience but relevant life experience.

SERVICE ELEMENT 5: SUPERVISION

Recommendation 5: Supervision: TSS Workers should receive a minimum of 4 hours of clinical supervision per month, preferably on a weekly basis. Part-time TSS Workers should receive the same rate of supervision, prorated to their work hours. TSS Supervisors will be appropriately licensed professionals and agency position descriptions will include supervision of TSS Workers as a primary job duty. Supervision will be documented and reviewed in the agency's quality assurance processes.

Discussion: Supervision is an essential component of effective functioning by the persons who deliver services and supports directly to children and their families. Supervision was repeatedly cited by contacts during this project as the most critical element in effective delivery of the service. The ability of TSS Workers to act in support of care plan goals and objectives will develop over time in the context of effective supervision. The ability of a TSS agency to provide effective services and supports will develop over time in the context of functional quality management practices, including regular review of fidelity to the service model followed by the agency.

The Core Contract language indicates that, "A licensed individual with at least a master's degree in a human services field and no less than three (3) years experience in delivery of

psychiatric services will be available for consultation and/or supervision to the TSS direct service staff, serving as the Program Clinical Supervisor."

The Core Contract goes on to set specific parameters for supervision. "Each direct service staff person will receive no less than 1 hour of weekly individual supervision, with additional access to supervision provided as needed. Supervision and support to the direct service staff will also include monthly therapeutic mentor support group meetings, regular telephone contact, regular review and maintenance of mentoring activity logs, and regular dissemination of relevant information."

Recommendation 5 sets a minimum amount of supervision for TSS Workers and links supervision to professional training and licensure and to the agency's quality management system. The Core Contract language about license, education and experience may be appropriate in Connecticut. Support groups could be an effective tool, if the employing agency chooses to implement that form of support. Telephone accessibility, review and maintenance of mentoring activity logs, and reporting on the service all fall within the expectations of supervision.

The CBHAC document includes recommendations about supervision that support Recommendation 5. Staff providing what that document calls "therapeutic mentoring" must receive clinical and administrative supervision from an experienced Master's prepared mental health professional. Supervision must be regular or on-going, and the supervisor must be available for emergency consultation. This group's recommendation emphasizes the supervisor's role in maintaining fidelity to the service model being administered.

Example: The following language supports Recommendation 5 and comes from the Maine service model. The Behavioral Specialist positions are discussed earlier in this Report.

From the Maine Medicaid Benefits Manual

> A Behavioral Specialist I must have a minimum of four (4) hours per month of clinical supervision by a Behavioral Specialist II. For Behavioral Specialist I staff who work less than full time, requisite clinical supervision will be prorated, with a minimum requirement of one hour per month.

Conclusion: As TSS is implemented, Connecticut should make supervision expectations clear and enforceable. TSS Workers must have access to regular supervision through the TSS agency, and agency quality management practices must monitor that aspect of the service.

SERVICE ELEMENT 6: RECRUITMENT, SELECTION AND MATCHING OF INDIVIDUAL PROVIDERS

Recommendation 6: Recruitment, Selection and Matching: TSS agencies will be responsible for recruitment, selection, and preparation of TSS Workers, as well as for making appropriate matches between TSS Workers and children and adolescents whose service plans call for this service. The State will establish rules describing the qualifications of TSS Workers and requiring background checks. TSS agencies will implement policies describing how matches are accomplished within the service, including a listing of specific factors or characteristics used in the matching process.

Discussion: A review of the current mentoring literature reveals an emphasis on the recruitment, selection and matching processes utilized by a mentoring program. The TSS is intended initially to be provided to children affected by serious emotional disturbances, and individuals must be recruited for their ability to offer therapeutic supports to children whose therapeutic needs may not be simple. As stated earlier, Connecticut is requesting a professionalized approach to delivery of TSS, so TSS Workers may be recruited from existing service provision roles to add a mentoring relationship to their activities.

Following this recommendation, TSS agencies would establish policies describing the process used to recruit TSS Workers and match them with children needing the service. The strengths and interests of the youth and his/her family would be used for matching, along with the interests and particular capabilities of the TSS Worker.

Current mentoring literature emphasizes contacts with three distinct types of organizations to identify and recruit mentors: institutions of higher education, faith-based organizations, and senior groups. While recruiting mentors, these large, general groupings may prove helpful, but involvement in any of these groups will not ensure knowledge about the impact of a serious emotional disturbance on a child and family.

Conclusion: Recruitment and matching of TSS Workers with children will be a TSS agency responsibility, meeting standards defined by the State and with ongoing monitoring through the agency and system quality management processes. This particular aspect of the TSS should be targeted by system research and evaluation strategies, ensuring that experience with the service will lead to improved implementation and impact.

SERVICE ELEMENT 7: SERVICE CAPACITY (CASELOAD)

Recommendation 7: Service Capacity: TSS Workers will strive to establish ongoing relationships with mentees that last 6 months or more. TSS Workers will commit approximately 12 hours per month to a mentee relationship. TSS Workers will work with a maximum of 3 mentees at a time

Discussion: This recommendation sets very specific numerical guidelines for the work of TSS Workers which reflect Core Contract language, expectations in similar services by other states, and current mentoring literature. The guidelines are specifically designed for the model Connecticut desires to implement where TSS Workers are likely to be professionals working in a variety of system roles. The guidelines limit TSS Workers to a maximum of approximately 40 hours per month (3 mentees times 12 hours/month for each), plus time for training, supervision, and documentation.

The Core Contract prioritized “the substantial time commitment by the mentor and the youth in order to better affect positive outcomes. The mentor and mentee shall meet for a period of no less than 6 -months for up to a maximum of 104 hours.” That language emphasizes the need for a TSS Worker to commit adequate time to the building of a relationship with a mentee.

The Core Contract also sets ongoing time expectations: “The number of hours of direct contact between the mentor and the youth should typically range from (1 – 6 hours) a week, averaging up to 12-14 hours per month over the course of the 6-month period. The specific

number of hours provided during a given week should be flexible and informed by the needs, goals and activities identified for the participating youth." This language offers a range for weekly contact (1-6 hours) and a monthly average (12-14 hours) over 6 months, while anchoring the service in the needs, goals and activities planned for the youth.

The Core Contract also recommends a specific caseload size: "Therapeutic mentors are to have a consistent presence in the life of the assigned youth(s) during the period of the service. Therefore, therapeutic mentors are to carry a caseload of up to 3 youth at a time, serving 4-6 youth annually." This limit on the number of therapeutic relationships for a TSS Worker is intended to ensure that a child receiving the service gets adequate time and attention from the Worker.

Conclusion: The relationship between the TSS Worker and a child with a serious emotional disturbance is intended to be an intense, meaningful relationship. Each will be highly individualized in response to the unique strengths and needs of the child and the unique interests and capabilities of the Worker. The guidelines in this recommendation are designed to ensure that each relationship receives adequate attention and energy to give it the best chance of bringing therapeutic benefit to the child.

SERVICE ELEMENT 8: TRAINING APPROACH AND CURRICULA

Recommendation 8: Training Approach and Curricula: DCF will engage in a planning relationship with Dr. Susan Weinberger, Mentor Consulting Group, to develop and implement a TSS training curriculum to prepare TSS Workers in Connecticut's TSS service, emphasizing a professionalized mentor pool and requirements for operating within the CT KidCare environment. All TSS Workers will receive a minimum of 40 hours of pre-service training, except where credit is earned through relevant professional training.

Discussion: A variety of curricula have been created to support various models of mentoring (see http://mt.org/publications/index.htm). The greatest value appears to come from curricula that are designed to achieve the goals of a specific mentoring organization or program. Said differently, each curriculum appears to work best where it was created to work. In the field of training mentors, the majority of contacts in this project referred to Dr. Weinberger (whose email address is "DrMentor") as the expert in this field. Because Dr. Weinberger lives in Connecticut and has a long-term relationship with DCF, it makes sense to work with her to develop and implement appropriate training for TSS. The chosen population focus of children and adolescents with serious emotional disturbances may require adjustment of existing training approaches, but Dr. Weinberger appears to be appropriately skilled to make such adjustments.

The Core Contract includes listings of areas that must be covered by pre-service and in-service training of TSS Workers. (*pre-service training requirements* (blood born pathogens, CPR, effective communication and limit setting, crisis management/behavioral interventions, mandated reporting, medication administration, and de-escalation, conflict resolution and crisis management techniques) and *in-service training requirements* (overview of child and adolescent behavioral health, recognition of child abuse and neglect, interpersonal communication and effective listening, social skills development, limit setting and boundary establishment/maintenance, agency policies and data keeping requirements, impulse control and anger management, child and adolescent development, behavioral management, college and vocational-education resources, career preparation guidance, community

resources, health promotion, and cross cultural competency)). Those content areas define a training curriculum that could be utilized to prepare TSS Workers. The State could establish and mandate such a curriculum, or merely set the requirements of training and allow each provider agency to establish a training program that meets those requirements. As a consequence of the research conducted in this project, Recommendation 7 suggests working with Dr. Weinberger, a nationally recognized expert in mentoring, to develop a standardized curriculum that would be utilized by provider agencies to prepare mentors to provide TSS.

The CBHAC document also articulates specific training content for TSS Workers. Mandatory topics under those recommendations would include: child psychopathology, childhood development, relationship building, communication and conflict resolution skills, assertiveness training, counseling skills, mandated reporting of abuse/neglect, system of care and KidCare philosophies, CPR/First Aid, client advocacy skills, life skills, social skills, and cultural competency. The document identifies additional areas for mentor training: effects of trauma on childhood development, suicide and risk assessment, safety planning, gender and sexual identification differences, professional boundaries within a non-traditional therapeutic relationship, knowledge in conducting child specific team meetings, and training in the identified "evidence-based, best practice" model.

These recommendations for training content are comprehensive and may exceed the reality of what is possible to cover in preparatory training for TSS Workers. In particular, "counseling skills, suicide and risk assessment, and knowledge in conducting child specific team meetings" may exceed the reasonable expectations of what a TSS Worker can accomplish, given that the mentor is not viewed as delivering therapy services.

Examples: For comparison, the following curriculum content is provided to demonstrate the required training to meet Maine's regulations for Behavioral Health Specialists.

From the Maine Behavioral Health Professional Training Curriculum Content
prepared by the Maine Behavioral Health Sciences Institute

1. Introduction to Behavioral Health Professional (4 hours)
   This module sets the tone for the modules that follow by addressing why children and families need the services of a Behavioral Health Professional (BHP). This module includes information about the inherent value placed on children, families, and people with disabilities; the roles and responsibilities of the BHP; the legal and regulatory requirements governing the delivery of these services; professional boundaries; and problem solving.
2. Working in the Home Setting (4-5 hours)
   This module addresses the basic competencies necessary for working respectfully and effectively with a child and family in their home. Topics included in this module are setting and maintaining personal and professional boundaries, respecting privacy, sensitivity to cultural differences, dynamics of working with families who face multiple challenges, relaxation techniques, stress management and reduction, conflict resolution, and supervision.
3. Typical Child and Family Development and Child Pathology (6 hours)
   This module serves as an introduction to the typical developmental milestones of children and families. It also introduces mental health diagnoses of children that are commonly encountered by the BHP. It includes strategies likely to be found in individual treatment plans and the role of medications. This module also gives a strategy for formulating a case summary.
4. Trauma (4-5 hours)

The Behavioral Health Professional needs to have an understanding of the effects of trauma. This module is intended to provide the Behavioral Health Professional with an introduction to the identification of trauma and strategies for working with children who have been traumatized.

5. Individual Treatment Plan (2.3 hours)
   This module addresses the basic competencies necessary for the Behavioral Health Professional to function as a member of the team that develops and implements the Individual Treatment Plan (ITP). The treatment planning model, reading and interpreting treatment plans, recording, reporting, and observation and identification of strengths and needs are all topics included in this module.
6. Communication Skills (4-5 hours)
   The Behavioral Health Professional needs to be skilled in listening to others and in clearly and accurately communicating their ideas verbally as well as in writing. This module addresses the particular issues of using these skills within a home environment.
7. Principles of Behavior (6-7 hours)
   Each Behavioral Health Professional (BHP) needs to have a basic foundation in understanding, predicting, and managing behavior safely. This module is intended to prepare the BHP to objectively observe behavior, teach appropriate behavioral skills and manage challenging behaviors safely.
8. Principles of Family Functioning (8 hours)
   The Behavioral Health Professional needs to have a basic understanding of the underlying dynamic of family functioning. This module is intended to prepare the BHP to objectively observe the family's functioning, teach effective parenting and behavioral management skills.
9. Principles of Instruction (3-4 hours)
   The Behavioral Health Professional (BHP) teaches children and families and youth without permanency a variety of skills, from the most basic activities of daily living to more sophisticated behavioral and adult skills. This module addresses the basic competencies necessary to succeed in teaching the skills a child or youth needs to achieve the goals identified in the ITP.
10. Using Community Resources (3-4 hours)
    The Behavioral Health Professional needs to be active in facilitating integration into the community. This module introduces the concept of community as well as strategies for using community resources and integrating the child into the community.
11. First Aid/CPR/Bloodborne Pathogen Training (7 Hours)
    The Behavioral Health Professional needs to demonstrate basic competencies in emergency procedures, including infant/child CPR.

There is clear overlap in the training areas covered by the Core Contract, the CBHAC document, and Maine's BHP Training Curriculum. Together they outline possible content for a standardized training curriculum for all of Connecticut's TSS Workers.

Conclusion: This content from Maine's Behavioral Health Specialist suggests 51-58 hours of training for TSS Workers covering a wide range of subjects. The list is similar to and supportive of the areas listed in the Core Contract language, and it strongly supports the approach described in Recommendation 8. Rather than rely on this report to establish the content for training TSS Workers, Connecticut ought to take advantage of the recognized expertise of Dr. Weinberger in this particular field to design and implement appropriate training.

SERVICE ELEMENT 9: QUALITY ASSURANCE PRACTICES

Recommendation 9: Quality Assurance Practices: TSS will be implemented in a quality management service environment that emphasizes constant improvement in service impact on recipients of service. Service documentation policies will be established to ensure accurate monitoring within agency and system quality management processes, all of which will include participation by family/caregivers and children served.

Discussion: TSS will be provided in a manner that promotes appropriate review and monitoring through agency- and system-wide quality management practices. Such practices will be built upon existing quality assurance requirements, to the extent possible, but may also require changes in current quality assurance practices. The overall goal is to learn from effective practices that positively impact child and family needs. The system, at agency and statewide levels, will ensure that caregivers and youth have input in all quality management functions.

Each TSS Worker, supervisor, and agency will benefit from system feedback about strategies designed to fulfill the service mission. Agencies will ensure that TSS Workers and supervisors carefully document all service activities and participate meaningfully in agency quality management practices. DCF will establish and maintain a state-level quality management system to receive data from and support agency service delivery improvement practices.

The State's role in quality management is crucial to system functioning. DCF must commit resources to maintaining quality improvement standards and practices, including state-level staff to support agency quality practices, to monitor QM findings at the system level, and to apply learning through the quality process to system improvement. Although this report strongly supports the use of the language from the Core Contract, this project revealed that the State had no system in place to monitor implementation of the terms therein. State leadership is necessary to effectively utilize quality management practices at the community, agency, and individual child levels.

Examples: This language from the Maine Medicaid Benefits Manual offers a typical example of language used to describe quality assurance implementation requirements.

From the Maine Medicaid Benefits Manual

> Periodic review of cases to assure quality and appropriateness of care will be conducted in accordance with the quality assurance protocols established by the Department of Behavioral and Developmental Services. Reviews will be in writing, signed and dated by the reviewers, and included in the clinical record.

It is noted that this language describes a minimal, if traditional, approach to quality assurance practices, limiting them to "quality and appropriateness of care." Connecticut will need to go beyond this minimal approach, establishing practice expectations and putting in place a State infrastructure to monitor and support the fulfillment of those practice expectations.

Conclusion: Quality management practices are necessary at the agency and statewide levels. Quality management for TSS will be most effective within the context of system QA practices that inform individual agencies and workers about their impact and ensure that agency managers use QA data in decision-making. Such quality management practices will ensure that the service can be applied uniquely and effectively for each child, maintaining

flexibility in the design of individual service plans. TSS cannot be viewed as a unique service with unique or distinct operational requirements; it must be designed to work within the current Connecticut service regulatory context.

SERVICE ELEMENT 10: FUNDING SUPPORT UNDER KIDCARE

Recommendation 10: Funding Support under CT Community KidCare: The State will establish a uniform fee-for-service payment rate for TSS that recognizes the full cost to agencies of implementing the service. In particular, the rate must ensure that appropriate training, support, and supervision of TSS Workers takes place in all provider agencies.

Discussion: Ideally, this project would have discovered a range of typical rates for the TSS service in comparable service environments, allowing Connecticut to set a rate consistent with prevailing practice. However, no service fully comparable to the model Connecticut desires to implement was found, except in Connecticut, and so rate comparisons are impossible.

It is recognized that the model described in this report is a more professionalized model than any similar service being implemented elsewhere, which suggests a higher per-unit cost than paid in other service environments. It is also recognized that, generally, reimbursement approaches do not fully recognize the cost to agencies for training, support, and supervision of a service. Training, support and supervision are critical to the effectiveness of TSS, as proposed in this report, and therefore must be fully supported as a reimbursement structure is set in place for this service.

Conclusion: Implementation of TSS creates an opportunity for Connecticut to establish reimbursement strategies that recognize and support the full cost of system of care services. Agencies likely to provide TSS should be involved in discussions to establish a rate that makes the service competitively possible, and that rate should be re-examined each year. Agency involvement in pricing will be balanced by the implementation of system quality management practices that ensure appropriate delivery of the service.