DFPS Rate Modernization

Foster Care Rate Modernization Report

PROVIDER SURVEY FINDINGS

March 2022

The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work

Research Team

Monica Faulkner, PhD, LMSW, Principal Investigator

Laura Marra, MSSW, Lead Researcher & Data Analyst

Kaitlyn Doerge, MSSW, Researcher

Swetha Nulu, MPH, Researcher

Kristene Blackstone, Consultant

Acknowledgements

The research team would like to thank the staff at the Texas Alliance for Child and Family Services and the Texas Network of Youth Services for their input and support. We also thank everyone who shared their time and expertise by participating in workshops and Ms. Audrey Deckinga for facilitating workshops. Finally, our sincere appreciation is extended to all the providers who completed a very long and detailed survey. Thank you for the work you do for our state.

Recommended Citation

Faulkner, M., Marra, L., Doerge, K., Nulu, S. & Blackstone, K. (2022). Foster Care Rate Modernization Report from Survey of Service Setting Costs. Texas Institute for Child and Family Wellbeing, The University of Texas at Austin.

About the Texas Institute for Child & Family Wellbeing

The Texas Institute for Child & Family Wellbeing (TXICFW) is a social work research institute within the Steve Hicks School of Social Work at The University of Texas at Austin. For over 10 years, TXICFW has used its research and training expertise to engage in a joint learning process with practitioners and agencies to build the foundational knowledge that best serves children and families. TXICFW's research focuses on improving outcomes for children and families in many areas, including school social work, child welfare, foster care, adoption, permanency, adolescent sexual health, child care, social work practices in healthcare, child maltreatment prevention, and immigration. TXICFW researchers have direct practice experience working with families in crisis and utilize this real-world experience to guide their research, evaluation, programming, and support services.

Executive Summary

The Department of Family and Protective Services (DFPS) contracted with the Texas Institute for Child & Family Wellbeing (TXICFW) to assist with stakeholder engagement and feedback related to Foster Care Rate Modernization. The goal of Foster Care Rate Modernization is to design a system that improves outcomes for children, youth, and young adults through the establishment of a well-defined service continuum that meets the needs of children in foster care and recognizes and compensates providers and caregivers for delivering high-quality services and care. TXICFW was tasked with designing a robust survey which could be used to validate assumptions inherent in the new service packages. The goal of the survey was to gather information that will be used to validate assumptions and provide specificity needed by HHSC Provider Finance to build out the rate methodology to support the new foster care service continuum.

Given the breadth of potential information that the survey needed to collect, the team at TXCIFW held multiple workshops with providers to understand: 1) what portion of their costs are not paid for through DFPS or STAR Health; and 2) the main costs and cost drivers that are not captured in their annual cost reports to HHSC. Nine workshops were held with providers, foster parents and non-provider stakeholders.

After the workgroups were concluded, the research team developed three surveys. The two broad categories for service package settings were child placing agencies and residential operations. Within residential operations, the specifications for emergency shelters varied enough from the other residential operations to warrant a separate survey. Thus, there were three surveys targeting 1) GROs/RTCs; 2) Emergency shelters; and 3) Child Placing Agencies. Using notes from the workgroups and the DFPS service setting descriptions, the research team developed questions addressing the following topics: capacity; costs related to clinical staff (treatment director, psychiatrists, physicians, therapists and nurses); costs related to case managers; costs related to case direct care staff (if applicable); costs of providing family engagement and aftercare services; ideal lengths of stay; ideal services needed for children with varying needs; costs of caring for children with specialized needs; costs of ensuring children have access to normal activities and age-appropriate items; foster parent recruitment and retention (if applicable); and administrative costs that are not currently captured in cost reports.

Given the breadth of information presented, broad conclusions are difficult to make. However, there were themes that resonated across workshops and surveys. These themes include: 1) payments for the care of children do not cover costs; 2) Medicaid/STAR health does not contribute to sustaining mental health professionals in agencies; 3) external factors strain providers; 4) transportation is a large cost that is not sufficiently reimbursed to foster parents and not sufficiently accounted for in staffing costs for GROs; 5) agencies need access to training for treatment practices; 6) recruiting and retaining foster parents remains an issue; 7) documentation is time-consuming; and 8) Transition to New Service Models will require support, coordination and funding.

It is important to interpret all findings of this report with the understanding that this information is only a piece of the puzzle for understanding how to restructure foster care

rates. The survey did not include foster parents or individuals with lived experience in the system. Additional reports from this survey will provide information about each package and subsequent market research will be conducted.

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Project Background

The Department of Family and Protective Services (DFPS) contracted with the Texas Institute for Child & Family Wellbeing (TXICFW) to assist with stakeholder engagement and feedback related to Foster Care Rate Modernization. The goal of Foster Care Rate Modernization is to design a system that improves outcomes for children, youth, and young adults through the establishment of a well-defined service continuum that meets the needs of children in foster care and recognizes and compensates providers and caregivers for delivering high-quality services and care. A more detailed explanation of the Foster Care Rate Modernization can be found in Foster Care Rate Modernization Report: Final Service Descriptions.

In July and August 2021, DFPS and the Texas Health and Human Services Commission (HHSC) conducted focus groups and presentations with internal and external stakeholders to share information on Foster Care Rate Modernization and gather input to help design service packages that can be found in the Foster Care Rate Modernization Report: Final Service Descriptions. There are two sets of service packages, one for child placing agencies (CPAs) who serve children and caregivers (foster and verified kin) in a family-based setting and one for general residential operations (GROs), which includes residential treatment centers (RTCs) and Emergency Shelters, who serve children in foster care in a facility or group care setting.

With the service descriptions outlined, DFPS and HHSC wanted stakeholder input on the costs of providing services under each service package. HHSC will use findings from this survey, along with multiple other sources, to develop rates for each primary service setting and service add-on.

TXICFW was tasked with designing a robust survey which could be used to validate assumptions inherent in the new service add-ons models. The goal of the survey was to gather information that will be used to validate assumptions and provide specificity needed by HHSC Provider Finance to build out the rate methodology to support the new foster care service continuum.

Methods

Survey Design

The survey was designed in January and February of 2022. Given the breadth of potential information that the survey needed to collect, the team at TXCIFW held multiple workshops with providers to understand: 1) what portion of their costs are not paid for through DFPS or STAR Health; and 2) the main costs and cost drivers that are not captured in their annual cost reports to HHSC. Nine workshops were held with providers, foster parents and non-provider stakeholders. Additionally, three individual interviews were held with the providers who were either very large or who serve highly specialized populations including youth with histories of sexual aggression and youth with human trafficking histories.

Table 1. Survey design workshops and interviews

	Date	Number of participants
Workshop 1: Texas Alliance for Child and Family Services	1.7.22	9
Workshop 2: Child Placing Agencies that also run General Residential Operations	1.18.22	5
Workshop 3: Child Placing Agencies	1.18.22	5
Workshop 4: Residential Treatment Centers	1.19.22	4
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Interview 1: Large provider	1.24.22	1
Interview 2: Provider with multiple licenses, specialized population	1.24.22	1
Interview 3: Provider with specialized populations	1.27.22	1
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Each workgroup was facilitated by Audrey Deckinga from the Deckinga Group with the exception of the non-provider stakeholder workgroup which was facilitated by Dr. Monica Faulkner. Each workgroup was held virtually via zoom and followed a standard guide for questions. Questions addressed: administrative costs; clinical costs; normalcy; documentation/CQI/evaluations; transportation; staff training and retention; family engagement/after care services; recruitment and retention of foster parents (as applicable to license type); and feedback on primary service settings and service add-ons. Workgroups lasted between 1.5 to 2 hours. Notes were taken and reviewed by the research team. Potential survey questions were identified from the notes.

After the workgroups were concluded, the research team developed three surveys. The two broad categories for service package settings were child placing agencies and residential operations. Within residential operations, the specifications for emergency shelters varied enough from the other residential operations to warrant a separate survey. Thus, there were three surveys targeting 1) GROs/RTCs; 2) Emergency shelters; and 3) Child Placing Agencies. Using notes from the workgroups and the DFPS service setting descriptions, the research team developed questions addressing the following topics:

1. Capacity;
2. Costs related to clinical staff (treatment director, psychiatrists, physicians, therapists and nurses);
3. Costs related to case managers;
4. Costs related to case direct care staff (if applicable);
5. Costs of providing family engagement and aftercare services;
6. Ideal lengths of stay;
7. Ideal services needed for children with varying needs;
8. Costs of caring for children with specialized needs;
9. Costs of ensuring children have access to normal activities and age-appropriate items;
10. Foster parent recruitment and retention (if applicable); and
11. Administrative costs that are not currently captured in cost reports.

The length of each survey varied depending on the topics that were relevant to that survey. For example, the GRO/RTC survey had 327 potential questions, but some of these were follow-up questions prompted only by certain responses to previous questions.

Sample

The research team received a list of providers from DFPS. The list was pulled on February 10, 2022. The list contained an email, phone number and name of the Child Care Administrator.

The list contained 410 providers which included 147 child placing agencies; 60 emergency shelters; 49 general residential operations; and 138 residential treatment centers. Sixteen child placing agencies that only provide private adoption services were removed from the sample.

Feedback from the SSCCs is only associated to any licenses they have to provide foster care or residential services. The SSCC network providers who also serve the legacy system were included in the survey distribution

Data Collection

The survey was sent to 394 providers on February 7, 2022. Each provider had a customized survey link that was sent using a mail merge feature in Qualtrics. If a provider had more than one license, they received a survey for each license. The email contained a paper version of the survey for providers to use to gather information. Providers were informed that the survey would take an hour or more to complete and they would need to gather information from multiple individuals. Their survey link could be accessed as many times as needed.

The research team monitored emails that 'bounced back.' If an email did bounce back, the research team contacted DFPS to find an updated email. On February 8, 2022, the research team asked multiple agencies to send an email to their distribution lists advising leaders to be expecting the survey. The Texas Alliance for Child and Family Services (TACFS), Texas Network of Youth Services (TNOYS), Texas Coalition of Children's Homes sent emails to their members. DFPS also sent an email to contractors. As a result, many providers contacted the research team for their survey.

On February 10, 2022 and February 14, 2022, an email reminder was sent to providers who had not yet opened their survey link. On February 15 and 16, 2022, a reminder email was sent by TACFS, TNOYS, Texas Coalition of Children's Homes and DFPS to their distribution lists. On that same day, the research team began making phone calls to agencies who had not opened the survey link. To assist the team in reaching the correct people, TACFS provided contact information to supplement the child care licensing contact information. Phone calls were made to as many providers as possible over the next three days. A final reminder was emailed to providers on February 17, 2022. The research team originally intended to close the survey at 6pm on February 18, 2022, but upon request from several providers, left the survey open until 8am on February 21, 2022.

Data Analysis

After the surveyed closed, the research team began examining the over 1,500 variables available in the dataset. For most variables, an outlier check was conducted using boxplots to identify cases that were outliers. In most cases, the outliers were errors. Most commonly, a provider might add an extra zero to number. For example, someone might report a staff salary of $450,000 rather than $45,000. In these instances, a member of the research team contacted the provider and asked for clarification. If the amount was an error, the data was updated to reflect the correct amount. If the team received no response, we used our judgement to decide whether outliers could be eliminated because they were likely errors. A common example is someone reporting a number greater than 100% for a response that required a percent. In those cases, the research team recoded variables to eliminate numbers that were obviously out of range.

In other cases, outliers were real amounts and simply represented information from some of the largest providers in the state. Variables that asked for dollar amounts almost always had extreme outliers. In examining variables, these outliers seriously impacted the data distributions. To account for these few providers, a 5% trimmed mean is presented in

tables. While the five percent mean is not a perfect strategy for managing outliers, it did provide a better estimate of the mean that in most cases, was very close to the median, which was also reported.

Data was analyzed to produce descriptive statistics only.

Limitations

Prior to reviewing the findings from the survey, it is critical to understand the limitations of the survey. Survey findings should be utilized and interpreted within the context of these limitations.

A primary limitation of the survey is the response rate. As table 2 in the subsequent section details, the response rate for the survey was approximately 50%. An ideal response rate would be 80% to 90%. We attribute the response rate to multiple factors. First, the sample provided by DFPS had the Child Care Administrator's contact information. Oftentimes, the listed Child Care Administrator was not up to date and/or the email listed went to a generic inbox. Given the condensed timeframe for administering the survey, the research team was unable to check contact information prior to administering the survey. To address incorrect and outdated contact information, the research team relied on partner agencies to communicate with their members and these efforts undoubtedly increased the response rate. However, it is also likely that providers simply did not get the email of the survey. A second reason for the low response rate is likely the length and scope of the survey. Completing the survey required substantial effort from providers and as noted from our workgroup participants, many providers are facing unprecedented strain and may not have had time for the survey.

Another limitation of the survey is that despite its scope, there are inevitably items that are not captured. In designing the survey, the research team did not duplicate information that providers currently report in their annual cost reports or information that could be obtained through market research. However, each provider has a unique staffing model and financing structure. Thus, it is difficult to ask providers to fit their models into survey questions that can be analyzed across multiple providers. For example, the survey did not necessarily ask about data entry costs, but provided opportunities to explore the percent of time different staff spend on administrative and paperwork issues. Other examples may be attorney fees and consultations. In some cases, specific types of costs for items such as credentialing, accreditation and training were not asked because that information can be obtained through market research. In some cases, the information was captured in workgroups and it was determined that a question was not necessary.

Despite these limitations, the survey allowed providers an opportunity to share costs that are not normally captured in cost reports. This survey is only a piece of information that will be used to determine rates for foster care.

Structure of Report

This report summarizes findings from the 2022 Foster Care Rate Modernization Survey. DFPS has proposed three primary service settings: 1) Foster Family Care – Home-based/ Community Services setting; 2) General Residential Operations Tier 1-Facility-based treatment services; and 3) General Residential Operations Tier II- Facility-based Sub-acute Stabilization Services. In this report, we are presenting the findings that reflect the current system and thus, we divided the report into two sections that will be familiar to the Texas child welfare community: 1) child placing agencies (CPAs); and 2) residential operations.

This report begins primarily presents quantitative data gathered through surveys. When possible, we have included information from open ended questions and themes from the workshops that were conducted. This qualitative data provides some additional context to the report.

About Participants

This section provides a brief overview about survey participation. Overall, 202 of the 394 providers completed the survey (51.3%), and another 45 had partially completed it. A breakdown of survey participation by provider type is presented in the table below.

Table 2. Completion rates by agency type

	Emailed	Consented	Completed	Response rate
Child Placing Agency (CPA)	147	91	73	49.7%
Emergency Shelter	60	47	41	68.3%
General Residential Operation (GRO)	51	33	28	54.9%
Residential Treatment Center (RTC)	136	76	60	44.1%
TOTAL	394	247	202	51.3%

*An additional 16 providers were not eligible because they either did not have a license or were private adoption providers only. These providers were removed from the sample and are not accounted for in this table.

The majority of the sample consisted of in-state providers (90.6%). However, there were 4 out-of-state CPAs and 35 out-of-state Residential Treatment Centers (RTCs) included in the sample. Only one out-of-state RTC participated in the survey. Overall, in-state providers had a 55% response rate while only one out-of-state provider responded (3%).

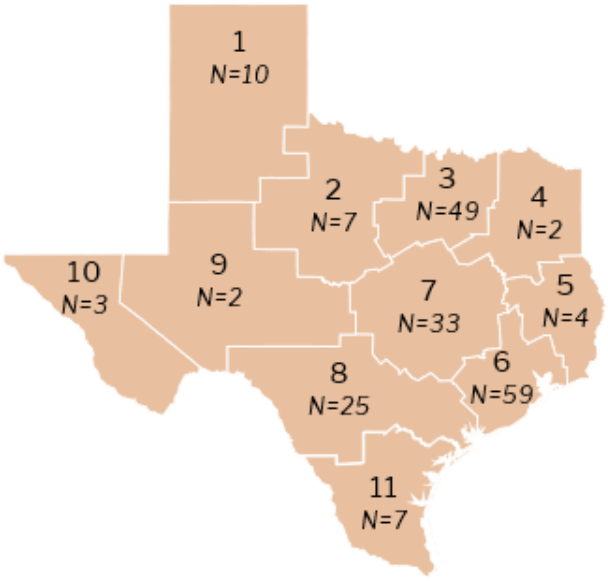
Table 3. Completion rates for in-state vs out of state

	In-state			Out-of-state		
	Emailed	Completed	Response rate	Emailed	Completed	Response rate
CPA	143	73	51.0%	4	0	0.0%
Emergency Shelter	60	41	68.3%	0	0	NA
GRO	49	26	53.1%	0	0	NA
RTC	103	61	59.2%	35	1	2.9%
TOTAL	357	195	54.6%	39	1	2.6%

Participation by Region

All regions had at least one provider participate. The response rate by region varied from 20% to 100%. It should be noted that some providers may have multiple branches across the state, but the main branch was used to represent their region for the purposes of this survey.

Table 4. Response rates by region



Region	Emailed	Completed	Response rate
1	19	10	52.6%
2	11	7	63.6%
3	74	49	66.2%
4	10	2	20.0%
5	9	4	44.4%
6	110	59	53.6%
7	53	33	62.3%
8	46	25	54.3%
9	7	2	28.6%
10	3	3	100.0%
11	13	7	46.2%

Survey Findings: Child Placing Agencies

This section will provide a general overview about Child Placing Agencies that deliver home-based community services to families in Texas based on survey findings and workgroup discussions. Information on CPA capacity, services, staffing structure, administrative costs and budgets will be included in this summary.

CPA Capacity

The following tables present data on the number of families at child placing agencies, the number of families with children placed in their home, and the total number of children currently placed within the agency. The majority of CPAs had less than 50 families at their agency (73%).

When asked to explain some of the reason providers were not operating at capacity, 22 CPA providers referenced the inability to match children's needs with family's desires or abilities. For instance, providers mentioned some families only wanting younger children or those eligible for adoption, families having safety concerns over COVID-19, or families not feeling prepared to accept children with higher needs. Ten CPA providers mentioned heightened monitoring, licensing, or investigation-related issues preventing them from operating at capacity. Nine mentioned having families that were either taking a break from placements or otherwise inactive. Other reasons mentioned included staffing issues, serving more kinship families, being a new agency, and witnessing fewer child removals in the system or more children going to kinship care.

Table 5. Number of children and families at CPAs

	N	Min	Max	Mean	5% trimmed mean*	Median*	Std dev
Number of foster families at agency	89	0	661	60.8	41.7	28.0	109.60
Number of families with children placed	89	0	516	45.2	30.4	22.0	81.92
Number of children currently placed	89	2	625	73.8	54.0	39.0	114.45

*There were six CPAs that had over 300 families. Most CPAs had less than 100 families (85%). In this case, because the data is highly skewed, the average may not be the best way to understand the data. Instead, the 5% trimmed mean or the median may be a more reliable estimate. The 5% trimmed mean is still an average, but it removes 2.5% of the highest and 2.5% of the lowest observations prior to calculating the average. The median represents the middle number in the dataset.

Table 6. Number of children and families at CPAs grouped

	Number of families at agency		Number of families with children placed		Total children currently placed	
	N	%	N	%	N	%
Less than 50	66	72.5%	74	81.3%	55	60.4%
50 - 99	14	15.4%	10	11.0%	24	26.4%
100 – 149	4	4.4%	1	1.1%	4	4.4%
More than 150	7	7.7%	6	6.6%	8	8.8%

CPA Populations Served

The following tables present data on the characteristics of youth served, the percentage of youth served with certain characteristics and age groups served by CPAs. Almost all CPAs (95.62%) served youth with basic needs. Overall, while CPAs reported that they do serve specialized populations such as youth who have experienced human trafficking (45.1%), they also reported that on average, there were only 4.4% of youth in their population who were a part of that population. In terms of age, almost all CPAs (98.6%) served children birth to age four while only 87% served youth 14 and older.

Table 7. Does your CPA offer services for any of the following youth populations? (N=91)

Youth population	Yes, we serve this population	No, but would like to in the future	No, do not serve and don't intend to
Basic child care services	95.62%	2.2%	2.2%
Primary Medical Needs (PMN)	33.0%	12.1%	54.9%
Complex medical needs	36.3%	8.8%	54.9%
IDD/Autism	74.7%	15.4%	9.9%
Experienced human trafficking	45.1%	33.0%	22.0%
Expectant / parenting youth	39.6%	40.7%	19.8%
Substance use disorders	44.0%	24.2%	31.9%
Sexual aggression / sex offender adjudication	41.8%	17.6%	40.7%
Complex mental health needs	73.6%	11.0%	15.4%
14 years old and older	92.3%	5.5%	2.2%
Treatment Foster Family Care*	38.5%	38.5%	23.1%
Short-term assessment/ stabilization	33.0%	39.6%	27.5%

*There are only three providers in the state who currently offer Treatment Foster Family Care (TFFC; services designed to be time-limited and adhere to the model codified in the Texas Family Code); however, 35% of CPAs indicated they currently offer TFFC. Some providers may have answered based on whether or not they served youth receiving treatment services.

Table 8. Estimated percentage of youth at CPAs who currently serve youth

	N	Min	Max	Mean	Std dev
Basic child care services only	78	0%	100%	66.3%	27.42%
Primary Medical Needs	26	0%	100%	13.0%	22.64%
Complex medical needs	28	0%	100%	7.1%	18.87%
IDD/Autism	61	0%	100%	11.9%	20.70%
Experienced human trafficking	36	0%	75%	4.4%	12.81%
Pregnant / parenting	31	0%	4%	0.8%	1.06%
Substance use disorders	36	0%	12%	2.5%	3.42%
Sexual aggression / sex offense adjudication	32	0%	29%	4.0%	5.79%
Complex mental health needs	59	0%	100%	28.7%	31.29%
14 years old and older	75	0%	100%	18.6%	22.15%
Treatment Foster Care	31	0%	100%	27.8%	35.67%
Short-term assessment/stabilization	25	0%	100%	11.2%	27.23%

Table 9. Age groups served by CPAs (N=71)

	N	%
Birth through 4 years old	70	98.6%
5 through 13 years old	69	97.2%
14 years old and older	62	87.3%

CPA After-Hour Admissions

In general, CPAs reported that 39.1% of admissions happened after hours.

Table 10. Percent of admissions that occur after hours

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of admissions that occur after hours	71	0%	100%	39.9%	39.1%	30.0%	28.62%

Table 11. Percent of admissions that occur after hours by grouping

	N	%
Less than 25%	20	28.2%
25% to 49%	23	32.4%
50% to 74%	14	19.7%
75% or higher	14	19.7%

CPA Current Staffing

Staffing across CPAs varies widely. To understand the different staffing structures, a series of questions were asked about treatment directors, psychiatrists, physicians, therapists, nurses and case managers.

Table 12. Clinical staffing at CPAs

	N	%
Treatment Director (N=84)		
Have a Treatment Director	43	51.2%
Have no Treatment Director	41	48.8%
Psychiatrist (N=84)		
Have a contracted psychiatrist	34	40.5%
Have an in-house psychiatrist	0	0.0%
Have both an in-house and contracted psychiatrist	0	0.0%
Do not have a psychiatrist	50	59.5%
Physician (N=82)		
Have a contracted physician	8	9.8%
Have an in-house physician	0	0.0%
Have both an in-house and contracted physician	0	0.0%
Do not have a physician	74	90.2%
Therapist (N=80)		
Have a contracted therapist	36	45.0%
Have an in-house therapist	7	8.8%
Have both an in-house and contracted therapist	7	8.8%
Do not have a therapist	30	37.5%
Nurse (N=77)		
Have a contracted nurse	16	20.8%
Have an in-house nurse	7	9.1%
Have both an in-house and contracted nurse	1	1.3%
Do not have a nurse	53	68.8%

CPA Treatment Directors

A little over half of the CPAs (51%) reported having a treatment director. The majority of those CPAs had one treatment director (85%) and six had two treatment directors (15%). The following tables summarize information on the credentials and salaries of current treatment directors.

Table 13. Treatment Directors' Status as Medicaid/STAR Health Providers at CPAs (N=41)

Status	N	%
Credentialed with Medicaid/STAR Health	17	41.5%
In process of becoming credentialed	5	12.2%
Not interested in becoming credentialed	9	22.0%
Lacks qualifications	5	12.2%

Table 14. Treatment director credentials at CPAs

Credentials	N	%
Licensed Professional Counselor (LPC)	15	32.6%
Licensed Clinical Social Worker (LCSW)	10	21.7%
Licensed Master Social Worker (LMSW)	10	21.7%
Master's degree in a human services field (not licensed)	3	6.3%
Certified education diagnostician with a master's degree in special education or human services field	1	2.2%
Licensed Marriage and Family Therapist (LMFT)	1	2.2%
Psychologist	2	4.3%
Licensed Registered Nurse	4	8.7%
Total	46	100.0%

Table 15. Treatment director salary for CPAs

	N	Min	Max	Mean	Std dev
Typical salary for a treatment director	31	$40,000	$100,000	$67,130.65	$15,507.60

*Note: In some instances, the CPA did not report a salary because the treatment director billed Medicaid directly. One provider indicated their treatment director billed Medicaid and then the CPA paid that them an additional $24,000 on top of what they are reimbursed. This partial salary was removed prior to calculating the average salary of a director.

Table 16. Summary of treatment director salary and benefits for CPAs (N=32)

Salary and benefits	N	%
Typical salary for a treatment director		
Less than $50,000	3	9.4%
$50,000 – $59,999	6	18.8%
$60,000 – $69,999	11	34.4%
$70,000 – $79,999	4	12.5%
$80,000 or higher	8	25.0%
Does treatment director receive benefits?		
Yes	24	75.0%
No	8	25.0%

CPA Psychiatrists

Thirty-four of the 84 providers (40%) reported that their CPA contracted with at least one psychiatrist. Details about contracted psychiatrists are reported in the following tables.

Table 17. About contracted psychiatrists at CPAs (N=34)

	N	%
Number of contracted psychiatrists (for CPAs with at least one contracted psychiatrist)		
1	19	55.9%
2	6	17.6%
3	4	11.8%
4	1	2.9%
5 or more	4	11.8%
Are contracted psychiatrists Medicaid/STAR Health providers?		
Yes	33	97.1%
Some of them	1	2.9%
No	0	0.0%
How are contracted psychiatrists paid?		
Rate per hour	2	5.9%
Rate per session	1	2.9%
They bill Medicaid directly	30	88.2%
Other	1	2.9%

*The hourly rates reported for two CPAs were $180 and $245 per hour. The session rate was not provided; but the CPA did indicate that a typical session was 60 minutes. The CPA who indicated 'other' explained that they pay their contracted psychiatrist $500 per month.

Table 18. Are psychiatrists on-call or available 24/7? (N=32)

	N	%
Available or on-call 24/7	13	40.6%
Not available or on-call 24/7	19	59.4%

CPA Physicians

Eight of the 82 providers (9.75%) reported that their CPA contracted with at least one physician. Details about contracted physicians are reported in the following tables.

Table 19. About contracted physicians at CPAs (N=8)

	N	%
Number of contracted physicians (for CPAs with at least one contracted physician)		
1	3	37.5%
2	2	25.0%
3	0	0.0%
4	0	0.0%
5 or more	3	37.5%
Are contracted physicians Medicaid/STAR Health providers?		
Yes	7	87.5%
Some of them	1	12.5%
No	0	0.0%
How are contracted physicians paid?		
Rate per hour	0	0.0%
Rate per appointment*	1	12.5%
They bill Medicaid/STAR Health directly	6	87.5%
Prefer not to say	1	12.5%

*One CPA paid their physician per appointment and the length of a typical appointment with their contract physician is 90 minutes.

Table 20. Are physicians on-call or available 24/7? (N=8)

	N	%
Available or on-call 24/7	5	62.5%
Not available or on-call 24/7	1	12.5%
Prefer not to say	2	25.0%

CPA Therapists

The majority of CPAs had at least one therapist (63%). Details about therapists' availability, pay, STAR health status, credentialing, billable hours and time are provided in the following tables.

Table 21. Are therapists on-call or available 24/7? (N=50)

	N	%
Available or on-call 24/7	32	64.0%
Not available or on-call 24/7	17	34.0%
Prefer not to say	1	2.0%

CPA Contracted Therapists

A total of 43 of the 80 providers (54%) reported that their CPA contracted with at least one therapist.

Table 22. About contracted therapists At CPAs (N=43)

	N	%
Number of contracted therapists (for CPAs with at least one contracted psychiatrist)		
1	6	14.0%
2	4	9.3%
3	5	11.6%
4	7	16.3%
5 or more	21	48.8%
Are contracted therapists Medicaid/STAR Health providers?		
Yes	42	97.7%
Some of them	1	2.3%
No	0	0.0%
How are contracted therapists paid?		
Rate per hour	2	4.9%
Rate per session	0	92.7%
They bill Medicaid/STAR Health directly	38	2.4%
Other	1	4.9%

*CPAs indicated that contracted therapists were paid an hourly rate of $45 and $125. One contractor described that some of their contracted therapist bill Medicaid/STAR Health directly. In instances where the CPA bills for a therapist, they pay them 90% of the Medicaid/STAR Health payment, which is approximately $67 per session that is directly paid to the contracted therapist.

CPA In-House Therapists

Table 23. About in-house therapists at CPAs (N=14)

	N	%
Number of in-house therapists (for CPAs with at least one in-house therapist)		
1	5	35.7%
2	2	14.3%
3	1	7.1%
4	1	7.1%
5 or more*	5	35.7%
Credentials of in-house therapists		
Licensed Master Social Worker (LMSW)	6	42.9%
Licensed Clinical Social Worker (LCSW)	6	42.9%
Licensed Professional Counselor (LPC)	10	71.4%
Licensed Marriage and Family Therapist (LMFT)	2	14.3%
Licensed Chemical Dependency Counselor (LCDC)	2	14.3%
Licensed Sex Offender Treatment Provider (LSOTP)	1	7.1%
Affiliate Sex Offender Treatment Provider (ASOTP)	0	0.0%
Psychologist	1	7.1%
Other	0	0.0%

CPA Medicaid/STAR Health Credentialing

In all provider workgroups and interviews, there was discussion about the difficulties in getting providers credentialed to be STAR Health Providers. Credentialing was noted to take six months or longer. During that time, agencies are unable to bill for the therapist's time. In some cases, the process is so cumbersome that agencies hire consultants to navigate the system for them.

Table 24. Percent of in-house therapists who are Medicaid/STAR Health providers

	N	Min	Max	Mean	Std dev
% in-house therapists credentialed with Medicaid/STAR Health	14	0%	100%*	43.8%	44.31%
% in-house therapists in process of becoming credentialed	14	0%	75%	15.5%	26.89%
% lack qualifications to become credentialed	14	0%	100%	19.3%	31.44%

*Only four of the 14 CPAs reported that all of their in-house therapists were Medicaid/STAR Health providers (31%).

Table 25. Length of time for Medicaid/STAR Health credentialing for CPAs

	N	Min	Max	Mean	Std dev
Months to become credentialed	8	3	12	6.8	2.66

Table 26. Percent reimbursed by Medicaid/STAR Health for in-house therapists at CPAs

	N	Min	Max	Mean	Std dev
% salary reimbursed by Medicaid	9	0%	100%*	30.1%	36.03%

*Only one provider indicated that Medicaid reimbursed 100% of their therapist's salary.

CPA Non-Billable Services

CPAs were asked to identify which activities therapists engaged in that were not billable by Medicaid/STAR Health. Most commonly, participating in trainings, debriefing or providing staff support, participation in treatment team meetings, and crises response and were listed. In open-ended responses, CPA providers mentioned therapists also spend time getting ready for group consultation, team meetings, and court-related tasks.

Table 27. Non-billable Medicaid/STAR Health services for in-house therapists at CPAs

Non-billable Medicaid/STAR Health services	N	%
Participating in trainings	9	69.2%
Debriefing and providing support for staff	8	61.5%
Participation in treatment team meetings / service planning for child	7	53.8%
Crisis response, de-escalation or processing something that comes up for a child	7	53.8%
Providing staff training	6	46.2%
Family engagement activities	6	46.2%
Supervision	4	30.8%
Sessions that occur on the same day (can only bill for one session)	4	30.8%
Case management activities	4	30.8%
Individual therapy sessions if more than once a week	3	23.1%
Documentation beyond what is allotted by STAR Health / Medicaid	3	23.1%
Family therapy sessions if more than once a week	2	15.4%
Group therapy sessions if more than once a week	1	7.7%

CPA Therapist Salary and Benefits

Table 28. Typical and ideal salary for in-house therapist at CPAs

	N	Min	Max	Mean	Std dev
Typical salary for in-house therapists	13	$30,000*	$63,000	$52,076.92	$10,242.57
Ideal salary for in-house therapists	13	$46,000	$75,000	$63,923.07	$7,750.93

*The CPA who reported their in-house therapist salary as $30,000 indicated that Medicaid/STAR Health reimbursed 100% of pay.

Table 29. Summary of salary and benefits for in-house therapists at CPAs (N=14)

Salary and benefits	N	%
Typical salary for an in-house therapist at a CPA		
Less than $50,000	3	23.1%
$50,000 – $59,999	5	38.5%
$60,000 – $69,999	5	38.5%
$70,000 or more	0	0.0%
Do in-house therapists receive benefits?		
Yes	11	78.6%
No	1	7.1%
Prefer not to say	2	14.3%
How competitive are in-house therapist salaries in your area?		
Not at all competitive	2	15.4%
Not very competitive	6	46.2%
Somewhat competitive	5	38.5%
Very competitive	0	0.0%
Extremely competitive	0	0.0%

CPA Therapist Time

Table 30. Percent of time on tasks for in-house therapists at CPAs

	N	Min	Max	Mean	Std dev
Providing scheduled therapy sessions (individual, group or family)	11	0.0%	48.8%	31.6%	15.48%
Reporting and documentation	11	3.5%	31.9%	15.4%	8.32%
Engaging foster parents or kinship caregivers outside of therapy sessions	11	2.1%	20.0%	9.3%	5.23%
Providing crisis response, de-escalation or additional sessions to help a child process or regulate	11	3.9%	12.5%	8.6%	2.68%
Debriefing and providing support to staff	11	2.5%	23.5%	8.2%	7.03%
Providing staff training and supervision	11	2.4%	15.3%	6.1%	4.17%
Driving to appointments	11	0.0%	23.3%	6.0%	6.82%
Participating in treatment team meetings	11	2.3%	14.9%	5.4%	3.71%
Performing case management	11	0.0%	10.6%	3.3%	4.03%
Receiving training and supervision	11	0.0%	6.4%	3.2%	1.78%
Engaging birth families outside of therapy sessions	11	0.0%	5.0%	1.7%	1.78%
Dealing with Medicaid billing complexities	12	0.0%	5.6%	1.0%	1.72%

When asked about other ways therapists spend time, CPA providers mentioned preparing for group consultation and team meetings (outside of the scheduled meeting time) and doing court-related tasks.

CPA Nurses

Twenty-four CPA providers indicated that they had a nurse (31%), and 13 of those providers (62%) indicating that the nurse was available or on-call 24/7.

Table 31. CPAs that have a nurse available or on-call 24/7 (N=21)

	N	%
Available or on-call 24/7	13	61.9%
Not available or on-call 24/7	8	38.1%

CPA Contracted Nurses

A total of 17 of the 77 providers (22%) reported that their CPA contracted with at least one nurse. Nurses were paid between $30 and $100 an hour. Rates per appointment ranged between $40 and $200. Details about contracted nurses are reported in the following tables.

Table 32. About contracted nurses at CPAs (N=17)

	N	%
Number of contracted nurses (for CPAs with at least one contracted nurse)		
1	11	64.7%
2	5	29.4%
3	1	5.9%
Are contracted nurses Medicaid/STAR Health providers?		
Yes	3	18.8%
Some of them	1	6.3%
No	12	75.0%
How are contracted nurses paid?		
Rate per hour	8	53.3%
Rate per session	5	33.3%
They bill Medicaid directly	2	13.3%

CPA In-House Nurses

Table 33. About in-house nurses at CPAs (N=8)

	N	%
Number of in-house nurses (for CPAs with at least one in-house nurse)		
1	1	100.0%
Is your in-house nurse a Medicaid/STAR Health provider?		
Yes	1	14.3%
Some of them	0	0.0%
No	6	85.7%
Credentials of in-house nurses		
Registered Nurse (RN), Licensed Vocational Nurse (LVN), or Licensed Practical Nurse (LPN)	8	100.0%
Does your in-house nurse receive benefits?		
Yes	4	50.0%
No	3	37.5%
Prefer not to say	1	12.5%

Table 34. Salary of in-house nurses at CPAs

	N	Min	Max	Mean	Std dev
in-house nurse salary	6	$6,200*	$85,000	$37,940.00	$29,764.18

*CPAs indicated that in-house nurse salary ranged from $6,200 to $85,000 (N=6) depending on the number of hours per week worked. CPAs reported that none of their in-house nurses' salaries were reimbursed by Medicaid/STAR Health. Some nurses only worked 2-3 hour per week.

CPA Case Management Staff

Almost all providers (96.1%) noted that case management at their agency was done by a dedicated case manager. In open-ended questions, nine CPA providers said case managers spent time on documentation or other licensing requirements. Six providers said case managers provide additional support for families, five said communicating with CPS, and five said case managers wear multiple hats or take on multiple roles, including intake, placements, and sometimes even social media. Other things mentioned included travel (visits or appointment transport), team communication, communication/coordination with external partners, court-related tasks, training, on call or crisis response. One provider noted:

> *'This job is not a 40-hour week and done. No one takes into consideration the complexities involved with caring for these children and families. If reports are due, if children need to be seen, and other uncompleted activities after you have put in 40 hours - you just do it. There's no overtime per the labor board is you have a college degree and are non-exempt. There are also the tasks of recruiting, home studies, continuous trainings, monitoring for compliance with minimum standards, and making referrals for the children. I'm sure there are many more tasks performed which are unacknowledged."*
> *_CPA Provider*

Tables that follow document tasks and salary information for case managers.

Table 35. Who performs case management within your agency? (N=76)

	N	%
Therapists	0	0.0%
Case managers	73	96.1%
Other	3	3.9%

*One CPA clarified that they have both therapists and case managers who perform case management.
Other responses: Case Managers provide all case management under the supervision of Clinical Coordinator and Area Director; Program director provides case management

CPA Salary and Benefits of Case Managers

Table 36. Case manager salary at CPAs

	N	Min	Max	Mean	Std dev
Typical salary for case managers	72	$30,000	$52,000	$39,310.66	$4,519.50

Table 37. Summary of case manager salary and benefits at CPAs (N=73)

	N	%
Typical salary for case managers at a CPA		
Less than $30,000	1	1.4%
$30,000 - $39,000	37	50.7%
$40,000 - $49,000	33	45.2%
$50,000 - $59,000	2	2.7%
Do case managers receive benefits on top of salary?		
Yes	63	86.3%
No	10	13.7%
How competitive are case manager salaries in your area?		
Not at all competitive	9	12.3%
Not very competitive	10	13.7%
Somewhat competitive	37	49.3%
Very competitive	14	19.2%
Extremely competitive	4	5.5%

CPA Case Manager Time

Table 38. Percent of case managers' time spent on the following tasks at CPAs

	N	Min	Max	Mean	Std dev
Reporting and documentation	68	5.8%	65.0%	23.4%	12.39%
Engaging foster parents or kinship caregivers	68	0.0%	44.0%	17.8%	8.22%
Service planning, case coordination, and cross-system collaboration	68	2.5%	37.5%	13.9%	7.73%
Working directly with child	68	0.0%	33.3%	11.2%	6.29%
Driving to appointments, home visits, courts	68	0.0%	33.3%	11.2%	5.69%
Responding to crises or incidents	68	2.2%	23.3%	7.8%	4.47%
Participating in treatment team meetings	68	0.0%	15.4%	6.8%	3.48%
Receiving training and supervision	68	1.1%	15.0%	5.9%	3.29%
Dealing with Medicaid billing complexities	69	0.0%	10.0%	0.9%	2.03%
Engaging birth families	69	0.0%	12.2%	1.1%	2.38%

When asked about other ways case managers spend time, nine CPA providers said case managers spent time on documentation or other licensing requirements. Six providers said case managers provide additional support for families, five said communicating with CPS, and five said case managers wear multiple hats or take on multiple roles, including intake, placements, and sometimes even social media. Other things mentioned included travel (visits or appointment transport), team communication, communication/coordination with external partners, court-related tasks, training, on call or crisis response.

'This job is not a 40-hour week and done. No one takes into consideration the complexities involved with caring for these children and families. If reports are due, if children need to be seen, and other uncompleted activities after you have put in 40 hours - you just do it. There's no overtime per the labor board is you have a college degree and are non-exempt. There are also the tasks of recruiting, home studies, continuous trainings, monitoring for compliance with minimum standards, and making referrals for the children. I'm sure there are many more tasks performed which are unacknowledged." _CPA Provider

CPA Administrative Staff

In addition to the direct care staff discussed above, providers were asked about administrative staff who are not accounted for in their current cost reports. Subsequent tables provide information about information and technology staff, development and fundraising staff, communications and marketing staff, compliance and licensing staff, and security staff.

CPA Information and Technology Staff

Table 39. Information/technology staff and salaries

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Type of staff							
Full-time staff who only do IT work	37	0	5	1.4	1.3	1.0	1.83
Full-time staff who do IT as one part of their job	37	0	5	0.9	0.7	1.0	1.32
Part-time staff who only do IT	37	0	3	0.2	0.1	0.0	0.64
Part-time staff who do IT as one part of their job	37	0	4	0.4	0.2	0.0	0.89
Salary							
Salary and fringe for IT staff	37	$0	$1,750,000	$129,315	$72,471	$45,000	$306,693

CPA Development and Fundraising Staff

Table 40. Development/fundraising staff and salaries

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Type of staff							
Full-time staff who only do development/fundraising work	39	0	5	1.2	1.0	1.0	1.39
Full-time staff who do development/fundraising as one part of their job	39	0	2	0.7	0.7	1.0	0.79
Part-time staff who only do development/fundraising	39	0	2	0.2	0.1	0.0	0.45
Part-time staff who do development/fundraising as one part of their job	39	0	2	0.1	0.0	0.0	0.35
Salary							
Salary and fringe for development/fundraising staff	39	$0	$2,000,000	$159,649	$89,770	$42,000	$376,335

CPA Communications and Marketing Staff

Table 41. Communication/marketing staff and salaries

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Type of staff							
Full-time staff who only do communication/marketing work	38	0	5	1.0	0.8	0.5	1.48
Full-time staff who do communication/marketing as one part of their job	38	0	2	0.6	0.5	0.5	0.60
Part-time staff who only do communication/marketing	38	0	2	0.2	0.2	0.0	0.54
Part-time staff who do communication/marketing as one part of their job	38	0	2	0.2	0.2	0.0	0.54
Salary							
Salary and fringe for communication/marketing staff	38	$0	$800,000	$71,171	$47,029	$35,150	$143,512

CPA Security Staff

Table 42. Security staff and salaries

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Type of staff							
Full-time staff who only do security work	11	0	1	0.1	0.1	0.0	0.30
Full-time staff who do security as one part of their job	11	0	2	0.6	0.6	0.0	0.81
Part-time staff who only do security	11	0	0	0.0	0.0	0.0	0.00
Part-time staff who do security as one part of their job	11	0	1	0.1	0.1	0.0	0.30
Contracted security staff	11	0	2	0.6	0.6	0.0	0.81
Salary							
Salary and fringe for security staff	11	$0	$140,000	$26,600	$21,778	$15,000	$39,536

CPA Compliance and Licensing Staff

Table 43. Compliance/licensing staff and salaries

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Type of staff							
Full-time staff who only do compliance/licensing work	51	0	5	1.1	1.0	1.0	1.38
Full-time staff who do compliance/licensing as one part of their job	51	0	5	1.3	1.2	1.0	1.38
Part-time staff who only do compliance/licensing	51	0	2	0.1	0.0	0.0	0.41
Part-time staff who do compliance/licensing as part of their job	51	0	5	0.2	0.1	0.0	0.75
Salary							
Salary and fringe for compliance/licensing staff	51	$0	$645,000	$118,920	$99,618	$68,502	$142,337

CPA Recruitment and Retention of Staff

As with foster parents, recruitment and retention of staff was discussed in workgroups and asked about on the survey in relation to therapists and case managers. Top factors noted

on the survey include: competitive pay based on education and experience, health insurance and annual raises built into pay.

When asked if there were other factors important to recruiting and retaining therapists, five CPA providers said that flexibility (such as telehealth or in-home options) and work environment were most important. Three providers mentioned issues related to training or specialization to work with youth in foster care, including timely and accurate documentation. Two mentioned issues with Medicaid/STAR Health credentialing and billing, and two mentioned the agency not being able to afford credentialing. Two said that therapists were contract only or part time. One provider noted:

> *'Star Health is Minimum pay for maximum services. Having Therapist on salary would help for consistency of overall services for kids and support the clinical aspects of the child's care." _CPA Provider*

Table 44. Importance of factors impacting CPA therapist recruitment and retention

	N	Min	Max	Mean	Std dev
*Higher scores indicate a higher level of importance					
Competitive pay based on education and experience	13	2	4	3.46	0.78
Health insurance	13	2	4	3.38	0.77
Annual raises built into pay	13	2	4	3.38	0.65
Retirement program such as an annuity, 401(k) or 403(b) plan	12	2	4	3.33	0.78
Quality supervision	13	3	4	3.31	0.48
Paid time off for vacation, holidays, sick leave, or other	13	2	4	3.23	0.73
Recognition for work	13	2	4	3.23	0.73
Emotional support and/or ability to debrief incidents	13	2	4	3.23	0.73
Being involved in team meetings and planning	13	2	4	3.23	0.83
Professional development opportunities / CEUs	13	2	4	3.15	0.69
Flexibility in scheduling	13	2	4	3.15	0.69
Quality training and coaching	13	2	4	3.15	0.69
Reimbursement for travel / mileage	13	2	4	3.08	0.64
Supervision for interns working towards licensure	13	2	4	2.92	0.64
Lower caseloads	13	1	4	2.92	0.95
Higher pay if working with children needing specialized services	13	2	4	2.85	0.80
Assistance with annual licensing fees	13	2	4	2.77	0.83
Upward mobility within the agency	13	1	4	2.31	0.75

Providers were also asked about factors impacting recruitment and retention of case managers. On the survey, the top three factors included: reimbursement for travel/mileage,

paid time off and emotional support. In open-ended questions, 16 CPA providers mentioned work environment and work-life balance as important factors to case manager recruitment and retention, including involving case managers in mission and values of agency, a positive work environment, and flexible schedule. Nine providers mentioned pay being an important factor. Other factors mentioned included training, manageable caseloads and documentation, and reducing the pattern of increased requirements without improving pay and benefits. Two providers stated:

> *'Agencies should spend time, energy, and money making sure they are incorporating their case management staff into their mission. Helping case managers understand the "WHY" of what an agency does can go a long way towards helping employees feel fulfilled. So, including something about, "Developing a mission-centered focus" would be important." _CPA provider*

> *Attention to overall tasks required by minimum standards. The work increase at each legislative session and extra "Solutions" are added for various issues then the Case manager now gets extra responsibilities to fulfill without extra pay and adding to overall stress and long hours as increased timelines are also added. The biggest disservice ids to the child who does not get the benefit of time. _CPA provider*

Table 45. Importance of factors impacting CPA case manager recruitment and retention

	N	Min	Max	Mean	Std dev
*Higher scores indicate a higher level of importance					
Reimbursement for travel / mileage	74	2	4	3.54	0.58
Paid time off for vacation, holidays, sick leave, or other	73	2	4	3.51	0.63
Emotional support and/or ability to debrief incidents	74	2	4	3.51	0.60
Quality supervision	74	2	4	3.50	0.60
Competitive pay based on education and experience	73	2	4	3.47	0.67
Health insurance	73	2	4	3.44	0.71
Quality training and coaching	73	2	4	3.42	0.60
Recognition for work	73	2	4	3.38	0.62
Flexibility in scheduling	73	2	4	3.38	0.62
Annual raises built into pay	74	2	4	3.32	0.76
Lower caseloads	73	1	4	3.25	0.72
Retirement program such as an annuity, 401(k) or 403(b) plan	74	1	4	3.19	0.84
Higher pay if working with children needing specialized services	74	1	4	3.15	0.84
Professional development opportunities	73	1	4	3.12	0.71
Upward mobility within the agency	74	2	4	3.11	0.69
Tuition assistance (college, CDA)	74	1	4	2.55	0.92

CPA Administration

Several key administrative topics were raised by providers during workgroups that were included in the survey. Providers noted that the following costs are not compensated by DFPS: staff training, recruitment and retention of staff, accreditation, and case management system.

CPA Staff Training

Providers reported spending an average of $27,895 on staff training in the last year. Trainings were accessed in a variety of ways with online, local and in-house trainings being the most common. In open-ended questions, three providers mentioned trainings being completed virtually, two specified this was because of or contingent on the pandemic. One provider mentioned the types of training provided were TBRI, MAB (an EBI), and trauma system's therapy for foster care. One provider mentioned their training was a combination of DFPS required training and training sponsored by their SSCC.

Table 46. Amount spent on staff training last year

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Amount spent	66	$0	$175,662	$48,836	$27,895	$10,000	$124,254

Table 47. Percent of agencies reporting staff engage in training type (N=73)

	N	%
Online training	68	74.7
Trainings developed in-house and provided by dedicated training staff	65	71.4
Staff who have been trained-to-train an external model and provide training on-site	56	76.7
External trainer comes to train staff on-site	47	64.4
Staff attend local trainings in the community	57	78.1
Staff attend regional trainings in the state	43	58.9
Staff attend national trainings out-of-state	13	17.8

CPA Accreditation

In workshops, accreditation was mentioned as an expense that is not covered by DFPS reimbursement. In the survey, most providers responded that they are not accredited or seeking accreditation (56.9%). Both workshop participants and survey respondents noted that accreditation is cost prohibitive.

Table 48. Accreditation statuses and accrediting entities

	N	%
Percent of agencies that are accredited		
Currently accredited	21	32.3%
Working on accreditation	7	10.8%
Not accredited or working on accreditation	37	56.9%
Accrediting entity for those already accredited		
Council on Accreditation (COA)	17	81.0%
Commission on Accreditation of Rehabilitation Facilities (CARF)	3	14.3%
The Joint Commission	0	0.0%
Other	1	4.8%
Accrediting entity for those working towards accreditation		
Council on Accreditation (COA)	1	14.3%
Commission on Accreditation of Rehabilitation Facilities (CARF)	4	57.1%
The Joint Commission	0	0.0%
Other	2	28.6%

Table 49. Reasons not accredited or working on accreditation

	N	%
Cost prohibitive	20	76.9%
Pulls staff away from primary duties	14	53.8%
Not worth the time	3	11.5%
Other reason	5	19.2%

CPA Case Management Systems

Case management systems are also an item that is not considered on provider cost reports. However, 81.4% of providers noted that their agency uses at least one case management system, with Extended Reach being the most commonly used.

Table 50. Case management systems used

	N	%
Percent of agencies that use case management systems		
Do not use any system	8	11.4%
Use one system	57	81.4%
Use two systems	5	7.1%
Case management systems used		
Custom system	4	5.7%
Apricot	2	2.9%
ASI	2	1.3%
Binti	3	4.3%
Casebook	7	4.5%
Charity Tracker	0	0.0%
Client Track	0	0.0%
D365	0	0.0%
EMR Bear	1	1.4%
Evolve	6	8.6%
Excel	1	1.4%
Extended Reach	38	54.3%
FamCare	0	0.0%
HMIS	0	0.0%
KPUI	0	0.0%
Salesforce	1	1.4%
SAM	1	14%

Table 51. Reasons for not using a case management system

	N	%
Cost prohibitive	23	47.7%
Too time consuming to figure out	4	9.1%
Have not done the research	7	1.7%
Too small to need one	24	54.5%
Systems don't do everything we need	5	11.4%
Other reason	5	11.4%

Table 52. Costs for case management systems

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Initial cost for case management system	48	$0	$1,400,000	$108,415	$51,009	$6,000	$295,945
Annual cost for current case management systems	48	$0	$390,000	$40,912	$29,931	$15,000	$71,736
Costs for updates in last year that were outside of annual costs	48	$0	$130,000	$16,367	$11,704	$2,000	$32,697

CPA Service Provision

CPAs were asked a variety of questions related to services. Topics included treatment models, foster parent recruitment and retention, and normalcy.

CPA Treatment Models

Most CPAs (69.4%) reported using at least one evidence-informed practice. Of those who use an evidence-informed practice, TBRI was the most often used practice. In open-ended responses, seven CPA providers talked about the high costs of training, treatment models, and evidence-informed practices, with two stating that they would like to utilize certain models and practices but lack the funds. Five mentioned the content of the training, with a major theme being trauma-informed/focused. Five talked about the support they have or need for training, such as having an organizational impact department or relying on community partners for training. Related to EBI, one provider said:

> *'Our EBI training is trauma-focused and based on TBRI principals. <Our agency> does not permit restraints in our foster homes and uses an EBI curriculum that specifically focuses on relationship building, recognition of escalating stressors in the child/parents/home, redirection, self-care, and working to help children learn positive behaviors." _CPA Provider*

CPA Current Treatment Models

Table 53. Number of evidence-informed practices used by CPAs

	N	%
Does not use an evidence-informed practice	15	30.6%
Uses 1 evidence-informed practice	15	30.6%
Uses 2 evidence-informed practices	11	22.4%
Uses 3 evidence-informed practices	3	6.1%
Uses 4 evidence-informed practices	3	6.1%
Uses 5 evidence-informed practices	2	4.1%

Table 54. Current treatment models used by CPAs (N=49)

Treatment model	Number of providers
TBRI	25
TF-CBT	8
Together Facing the Challenge	4
Nurturing Parenting	3
Trauma Informed Care	3
CPI	2
Pressley Ridge - Treatment Foster Care	2
Sanctuary Trauma Informed Care	2
BCMT	1
Behavior Crisis Intervention	1
Circle of Security	1
Clinical Expertise	1
Defiant Child/Defiant Teen	1
EMDR	1
Evidence from Research	1
Family Centered Treatment	1
Motivational Interviewing	1
PCIT	1
SAMA	1
Standards of Quality for Family Strength and Support - NFSN	1
Strengths Model	1
Structure Analysis Family Evaluation (SAFE)	1
Systematic Training for Effective Therapy	1
Targeted Case Management	1
Team Building Activities	1
Trauma Systems Therapy for Foster Care	1
Triple P	1

Table 55. Emergency Behavior Intervention (EBI) used by CPAs

	N	%
Prevention of Aggressive and Physical Holds (PAPH)	22	31.40%
Satori Alternatives to Managing Aggression (SAMA)	19	27.10%
Developed in-house	12	17.10%
Behavior Crisis Management Technique Model	6	8.60%
Crisis Prevention Institute - Nonviolent Crisis Intervention (CPI)	4	5.70%
Managing Aggressive Behavior (MAB)	4	5.70%
Trust Based Relational Intervention (TBRI)	2	2.90%
Trauma Informed Care	1	1.40%

CPA Ideal Treatment Models

Table 56. CPA ideal treatment models (N=22)

Treatment Model	Number of providers
TBRI	25
TF-CBT	8
Together Facing the Challenge	4
Nurturing Parenting	3
Trauma Informed Care	3
CPI	2
Pressley Ridge - Treatment Foster Care	2
Sanctuary Trauma Informed Care	2
BCMT	1
Behavior Crisis Intervention	1
Circle of Security	1
Clinical Expertise	1
Defiant Child/Defiant Teen	1
EMDR	1
Evidence from Research	1
Family Centered Treatment	1
Motivational Interviewing	1
PCIT	1
SAMA	1
Standards of Quality for Family Strength and Support - NFSN	1
Strengths Model	1
Structure Analysis Family Evaluation (SAFE)	1
Systematic Training for Effective Therapy	1
Targeted Case Management	1
Team Building Activities	1
Trauma Systems Therapy for Foster Care	1
Triple P	1

CPA Cost of Treatment Model

Table 57. Costs associated with treatment models within last year

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Last year's costs associated with treatment models used by your CPA	39	$0	$175,662	$20,961	$14,181	$5,000	$39,585

CPA Normalcy

In workshops, providers and foster parents discussed at length the costs associated with normal activities. Using their information, the research team designed a series of questions to understand various costs including staff who coordinate activities, basic needs items, activities and summer camps. All workshops discussed the higher costs for older youth related to clothes, hygiene and activities. All workshops also discussed challenges to youth driving and working. Thus, a series of questions focused on the costs for older youth.

CPA Staff Who Coordinate Normalcy Activities

Table 58. Numbers of staff who coordinate normalcy activities

	N	Min	Max	Mean	Std dev
Full-time staff whose job is only coordination of activities	67	0	5	0.2	0.89
Full-time staff who coordinate activities as one part of their job	67	0	5	1.0	1.75
Part-time staff whose job is only coordination of activities	67	0	5	0.1	0.62
Part-time staff who coordinate activities as one part of their job	67	0	5	0.1	1.62

Table 59. Percent of staff CPAs who have to coordinate normalcy activities (N=67)

	0	1	2	3	4	5
Full-time staff whose job is only coordination of activities	59%	6%	0%	0%	0%	2%
Full-time staff who coordinate activities as one part of their job	43%	12%	0%	1%	3%	8%
Part-time staff whose job is only coordination of activities	65%	1%	0%	0%	0%	1%
Part-time staff who coordinate activities as one part of their job	65%	1%	0%	0%	0%	1%

CPA Annual Normalcy Costs

Providers were asked how much their agency spends per child in a year on activities, camps, holidays, birthday, clothing, hygiene, and hair care. Some outliers were removed from this analysis because they represented a total cost spent per agency rather than a per child. The costs per child are broken down by age group in the next three tables.

Table 60. Annual costs per child for items for children less than 5 years old

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Clothing	31	$0	$600	$152	$137	$100	$176
Hygiene products	31	$0	$500	$43	$26	$0	$101
Hair care	31	$0	$500	$41	$21	$0	$105
Birthdays	31	$0	$500	$68	$47	$25	$131
Holidays	31	$0	$5,000	$389	$213	$100	$958
Milestones (i.e. graduations)	31	$0	$500	$50	$32	$10	$103
Normalcy activities	31	$0	$1,200	$107	$66	$0	$251
Summer camp	31	$0	$1,000	$40	$7	$0	$180

Table 61. Annual costs per child for items for children 5 to 13 years old

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Clothing	31	$0	$1,500	$220	$171	$100	$321
Hygiene products	31	$0	$500	$55	$35	$0	$119
Hair care	31	$0	$500	$42	$23	$0	$108
Birthdays	31	$0	$500	$80	$62	$50	$130
Holidays	31	$0	$5,000	$465	$298	$125	$979
Milestones (i.e. graduations)	31	$0	$500	$73	$54	$25	$130
Normalcy activities	31	$0	$1,200	$120	$81	$20	$249
Summer camp	31	$0	$1,000	$66	$34	$0	$185

Table 62. Annual costs per child for items for children 14 years old and older

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Clothing	28	$0	$1,500	$270	$220	$100	$394
Hygiene products	28	$0	$500	$67	$48	$0	$126
Hair care	28	$0	$500	$47	$28	$0	$112
Birthdays	28	$0	$500	$91	$74	$50	$137
Holidays	28	$0	$2,500	$292	$202	$113	$524
Milestones (i.e. graduations)	28	$0	$500	$108	$92	$50	$154
Normalcy activities	28	$0	$1,400	$177	$122	$40	$346
Summer camp	28	$0	$500	$67	$49	$0	$118

Table 63. How agencies cover costs for normalcy

	N	Use in-kind donations	Find sponsors	Find other entities*	Our agency pays for this	Foster parents pay for this
Costs of activities	66	56.1%	59.1%	33.3%	62.1%	62.1%
Costs of clothing, hygiene and haircare	69	49.3%	36.2%	30.4%	59.4%	78.3%
Costs of celebration and milestones	69	47.8%	43.5%	30.4%	62.3%	71.0%

*Includes child welfare boards, support agencies

CPA Activities

Table 64. Percent of youth who attend summer camp and ideal percent of attendance

	N	Min	Max	Mean	Std dev
Youth who attend summer camp	65	0	85%	15.1%	20.17%
Youth who would ideally attend summer camp	65	0	100%	56.5%	34.21%

CPA Specialized Cost Considerations for Older Youth

Allowance

Table 65. Do foster families typically provide an allowance for youth? (N=62)

	N	%
Yes	13	21.0%
No	49	79.0%

Employment

Table 66. Percent of youth who have jobs when age-appropriate (N=58)

	N	%
Yes	50	86.2%
No	8	13.8%

Table 67. Number of days a week youth typically work

	N	Min	Max	Mean	Std dev
Days a week that youth work	48	2	5	2.9	0.79

Table 68. How agencies manage transporting youth to work (N=50)

	N	%
Foster parents	45	90.0%
Other	5	10.0%

Driving

Table 69. Percent of youth who complete driver's education (N=59)

	N	%
Always	8	0.0%
Most of the time	24	40.7%
About half of the time	6	10.2%
Some of the time	20	33.9%
Never	1	1.7%

Table 70. Percent of adults who transport youth to driver's education (N=60)

	N	%
Foster parents	59	98.3%
CPA staff	1	1.7%

Table 71. Means that youth have to obtain a car (N=51)

	N	%
Use in-kind donations to cover costs	8	15.7%
Find sponsors to help cover costs	12	23.5%
Find other entities to help (Child welfare boards, support agencies)	8	15.7%
Our agency pays for this	4	7.8%
The youth/youth's family pays for this	24	47.1%
Foster family pays for this	20	39.2%
Youth cannot have a car	3	5.9%
Other	12	23.5%

Table 72. Percent of agencies who help with vehicle costs (N=52)

	N	%
Vehicle maintenance costs	2	3.8%
Care insurance costs	2	3.8%

Preparation for Adulting Living (PAL)

Table 73. Percent of agencies who offer PAL classes (N=58)

	N	%
Yes	7	12.1%
No	51	87.9%

Table 74. Frequency of youth attendance at PAL classes (N=48)

	N	%
Never	2	4.2%
Once a week	12	25.0%
Every other week	1	2.1%
Once a month	14	29.2%
Other	19	39.6%

Table 75. Percent of Adults Who Typically Transport Youth to PAL Classes (N=51)

	N	%
Foster parents	46	90.2%
Other	2	3.9%
Does not apply	3	5.9%

CPA Foster Parent Recruitment and Retention

Providers were asked questions related to foster parent recruitment and retention including costs, barriers, strategies and needs for kin families.

CPA Costs of Recruitment and Retention

In workshops with CPAs, costs of foster parent recruitment and retention were raised in each group. Providers noted that these costs are not reimbursable, but they are necessary to ensure capacity and quality. They also noted that there are many families who never finish the process of becoming a foster parent and costs associated with training are a loss to the agency. One provider in a workshop stated, "<costs for recruitment> has to come out of capital initially- 6 months or more before we are able to catch up on costs."

On the survey, there was a broad range in terms of costs related to recruitment and retention. Based on information from the workshops, this may be due to the various ways agencies recruit. Some agencies pay for marketing campaigns while others rely on word of mouth referrals. Likewise, some agencies have dedicated staff for recruitment and others have case managers do recruitment. One CPA provider noted:

> *'Recruiting and retaining foster parents has become increasingly difficult over the course of the past five years and especially in context of communities that are mitigating the impact of COVID. We have seen an increase in the severity of needs from children who are coming into foster care which has challenged organizations like ours to increase the time and attention we allocate to recruitment, verification, and retention activities. In many instances, we find that the public at large has erroneous and all too often negatively skewed information regarding the circumstances that bring children into foster care and the needs to care for them. We spend significant resources on advertisements, marketing and speaking engagements correct misinformation and open doors to reach potential candidates." _CPA Provider*

Table 76. Amount spent on foster parent recruitment and retention last year

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Amount spent	59	$0	$1,100,000	$136,377	$35,447	$9,269	$222,701

Table 77. Amount spent on foster parent recruitment and retention last year (N=59)

	N	%
Less than $1,000	11	18.6%
$1,000 - $9,999	20	33.9%
$10,000 - $24,999	9	15.3%
$25,000 - $49,999	7	11.9%
$50,000 - $99,999	4	6.8%
$100,000 or higher	8	13.6%

CPA Budget for Recruitment and Retention

When asked how CPAs pay for foster parent recruitment and retention, 24 providers said that recruitment and retention costs fall on their agency (either fundraised or otherwise included in their operating budget). Two providers said DFPS reimbursement covers these costs, one said both their agency and DFPS cover these costs, and two said they have no costs related to recruitment and retention (relying only on word-of-mouth recruitment).

CPA Pass Through Rate

The "pass through rate" for CPAs was raised in workshops as a factor that may promote foster parent retention. Some agencies noted that they paid families higher than the minimum pass through rate. Foster parents who participated in workgroups noted that the minimum pass through rate was not sufficient in covering all costs related to caring for a child. In the survey, providers averaged a 58.8% pass through rate to their families.

Table 78. Percent of funds 'passed through" to foster parents

	N	Min	Max	Mean	Std dev
Percent of funds	55	25%	100%	58.8%	14.89%

CPA Barriers to Recruitment and Retention

Providers in workshops commented on the challenges to recruitment and retention that relate to stress, difficulty accessing services, documentation requirements and burnout. Foster parents spoke at length about missing work to manage appointments and transportation for children in their homes. In particular, there is a substantial amount of work for foster parents (and CPAs) for first 30 days in a new placement as youth need medical and dental visits, enrollment in school and various assessments.

These sentiments were echoed in the survey where 14 comments centered around barriers to accessing health care services, including mental health services - having providers available, timeliness, appropriate care, especially in rural areas. Three providers mentioned problems finding childcare, including respite or care for children with higher needs. Other things mentioned were lack of help with transport, difficulty accessing educational support, and lack of information about the child's case. In the survey, providers noted that foster parents were likely to have difficulty accessing most services.

Finally, open-ended survey responses and workgroup participants noted that the current climate in the child welfare system is negatively impacting families. Three providers said that there were too many burdensome requirements by the state. Two said they had dedicated staff or efforts toward requirement, two said that risks and investigations are problematic for recruitment and retention, and two said that COVID has make recruitment and retention more difficult. Two providers noted:

> *'The current environment where foster parents are being held accountable for everything that might go wrong, for any normal bumps or bruises, and the potential for receiving RTBs for any serious incident is having an impact on*

recruitment and retention. The current media around foster care is also not helpful in this endeavor." _CPA Provider

'About 77% of our families are foster to adopt. This requires us to ensure that we continuously verify homes as many of those families will adopt and relinquish their license as their goal is now complete. DFPS data reflects that about 60% of children are reunified with their parents and/or family thus working with new families on this also impacts the ability to recruit and retain families. Additionally, additional training or factors like Heightened Monitoring impact the ability to retain foster parents." _CPA Provider

Table 79. Difficulty recruiting/retaining foster parents with similar demographic makeup to youth (N=67)

	N	%
Very difficult	29	28.4%
Somewhat difficult	29	43.3%
Neither easy nor difficult	9	13.4%
Somewhat easy	7	10.4%
Very easy	3	4.5%

Table 80. Likelihood of difficulty obtaining services for foster parents

	N	% Not at all likely	%Somewhat likely	% Very likely	% Extremely likely
Psychiatric care	69	27.5%	26.1%	27.5%	18.8%
Psychological evaluations	68	42.6%	30.9%	22.1%	4.4%
Specialty physician care	68	32.4%	39.7%	16.2%	11.8%
Pediatric care	68	67.6%	23.5%	8.8%	0.0%
Dental care	68	70.6%	25.0%	4.4%	0.0%
Orthodontic care	68	45.6%	32.4%	16.2%	5.9%
Individual therapy	68	48.5%	25.0%	19.1%	7.4%
Group therapy	66	28.8%	31.8%	28.8%	10.6%
Physical therapy	66	45.5%	36.4%	12.1%	6.1%
Occupational therapy	66	45.5%	34.8%	13.6%	6.1%
Speech therapy	67	43.3%	35.8%	14.9%	6.0%
Childcare accepting subsidies	64	23.4%	40.6%	15.6%	20.3%
Childcare	67	25.4%	37.3%	20.9%	16.4%
Tutoring	66	31.8%	42.4%	18.2%	7.6%

CPA Recruitment and Retention Strategies

Agencies noted multiple strategies for retaining foster parents. In terms of retention, respite care was noted by providers in workshops and the survey. Foster parents also focused heavily on the need for respite care. Foster parents need breaks between placements when taking care of high needs children. To meet this need, some agencies pay foster parents even though they do not have a current placement. They essentially "double pay" for a child to go to a respite provider and they are not compensated for the double payment.

Other retention strategies mentioned in workshops were foster parent appreciation events, paying for family outings to a theme park and peer support. A key retention strategy noted in the survey's open-ended questions relates to support for basic needs and normalcy activities. Four CPA providers mentioned helping families with normalcy or basic needs, especially kinship families who may not have the resources that foster families do (i.e. often kinship families need more support with home development).

Table 81. Factors that increase the likelihood of recruitment and retention

	N	Min	Max	Mean	Std dev
*Higher scores indicate a higher level of importance					
Dedicated agency staff (recruiter, home developer, trainer, case manager, etc.)	70	2	4	3.71	0.54
Community engagement (i.e. with churches and community groups)	70	2	4	3.37	0.59
Respite / childcare	69	2	4	3.36	0.66
Support with documentation	69	1	4	3.25	0.78
Software/databases (to manage training, licensing, paperwork, case management, etc.)	69	1	4	3.16	0.85
Marketing (social media, billboards, commercials, google ads, etc.)	69	2	4	3.14	0.73
Peer support	69	2	4	3.13	0.66
Recruitment events	70	1	4	3	0.82
Support for coordinating child's appointments	69	1	4	2.86	0.85
Support for normalcy activities (extracurricular activities, leisure activities, technology, camps, family outings, etc.)	69	1	4	2.8	0.87
Support with child transportation	69	1	4	2.77	0.81
Support for basic necessities (clothing, diapers, car seats, strollers, etc.)	69	1	4	2.75	0.79
Assistance with home development and repairs	69	1	4	2.55	1.01

CPA Work with Kinship Families

Non-provider advocates who participated in a workgroup noted a need to overhaul recruitment strategies to focus on recruiting foster parents who would engage with the

children's family and support reunification. However, workshop participants noted that CPAs get a lower return on their investment with kinship families compared to foster families because after all the training and support, kinship parents likely will not take in other children after permanency outcome of their related child. Additionally, providers noted that kinship caregivers need two to three times more support than foster families because they need extra assistance getting licensed. One provider noted that kinship models are costly,

> *'<We> have to fundraise if you want to bring in, for example, a great kinship model $50-150k. $45-50k is low end for training costs for subset of 20 people. '_CPA provider*

Table 82. Extent to which CPA providers agree with the statement, 'kinship families require more assistance in getting licensed compared to foster families." (N=68)

	N	%
Disagree	3	4.4%
Somewhat disagree	5	7.4%
Neither agree nor disagree	7	10.3%
Somewhat agree	16	23.5%
Agree	37	54.4%

Table 83. Extent to which CPA providers agree with the statement, 'kinship families do not stay long enough for us to invest in recruitment."(N=68)

	N	%
Disagree	16	23.5%
Somewhat disagree	10	14.7%
Neither agree nor disagree	17	25.0%
Somewhat agree	12	17.6%
Agree	13	19.1%

Table 84. Extent to which CPA providers agree with the statement, 'kinship families require more case management than foster families." (N=68)

	N	%
Disagree	5	7.4%
Somewhat disagree	5	7.4%
Neither agree nor disagree	8	11.8%
Somewhat agree	20	29.4%
Agree	30	44.1%

CPA Budget

Providers were asked a series of questions about their budgets including their overall budget, percent of budget that is administrative costs and sources of income.

CPA Annual Budget

There was a wide range in budgets. In order to provide context for budget numbers, several calculations were made. The first calculation shows the annual budget data. Because the range of budgets was so wide, interpreting the trimmed mean of $2.1 million is likely the most accurate way to understand the average annual budget. Another way to look at this data was to divide the annual budget by the number of children currently placed with the agency. In doing so, the budget numbers per child have a smaller range and a more normal curve.

Table 85. Annual budget

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Annual budget	61	$100,000	$25,000,000	$2,919,459	$2,130,529	$1,000,500	$4,677,480
Annual budget by number of children currently placed in agency	61	$2,174	$324,000	$41,633	$35,647	$32,895	$43,895

Table 86. Percent of agency budgets within ranges

	N	%
$100,000 - $199,999	3	4.8%
$200,000 - $299,999	3	4.8%
$300,000 - $399,999	4	6.3%
$400,000 - $499,999	4	6.3%
$500,000 or higher	49	77.8%

CPA Administrative Costs

Agencies were asked to note the percent of their annual budget that covered administrative costs. The mean was 23.1%.

Table 87. Percent of budget that is administrative costs

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of budget that are administrative costs	61	0%	75%	23.1%	22.1%	21.1%	16.60%

Table 88. Percent of budget that is administrative costs within ranges

	N	%
Less than 25%	33	54.1%
25% to 49%	22	36.1%
50% to 74%	5	8.2%
75% or higher	1	1.6%

CPA Income Sources

Providers were asked about different sources of funding that support their organization. On average, they reported that 69.6% of their budget comes from DFPS funding while almost none comes from Medicaid/STAR Health. For those that do fundraise, an average of 19.2% of their budget comes from fundraising and donations.

Table 89. Percent of Income that is paid by DFPS

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
% of income paid by DFPS	73	0%	100%	69.6%	71.8%	85.0%	36.61%

Table 90. Percent of budget that is paid by DFPS within ranges

	N	%
Less than 25%	14	19.2%
25% to 49%	4	5.5%
50% to 74%	8	11.0%
75% or higher	47	64.4%

Table 91. Percent of income that is paid by Medicaid/STAR Health

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
% of income paid by Medicaid/ STAR Health	73	0%	30%	1.2%	0.2%	0.0%	4.90%
% of income paid by Medicaid/ STAR Health IF any income is paid	6	2%	30%	14.5%	14.3%	15.0%	10.65%

Table 92. Percent of budget that is paid by Medicaid/STAR Health within ranges

	N	%
None	67	91.8%
1 to 25%	5	6.8%
25% to 49%	1	1.4%
50% to 74%	0	0.0%
75% or higher	0	0.0%

Table 93. Percent of income that is paid by private fundraising/donations

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of income that is paid by private fundraising/ donations	73	0%	100%	9.5%	7.2%	0.0%	17.0%
Percent of income that is paid by private fundraising/ donations IF any income is paid	36	1%	100%	19.2%	17.0%	15.0%	20.0%

Table 94. Percent of budget that is paid by private fundraising/donations within ranges

	N	%
None	37	50.7%
1 to 25%	24	32.9%
25% to 49%	11	15.1%
50% to 74%	1	1.4%
75% or higher	0	0.0%

Table 95. Percent of income that is paid by other income sources

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of income that is paid by other income sources	72	0%	90%	5.5%	2.7%	0.0%	15.2%
Percent of income that is paid by other income sources IF any income is paid	19	1%	90%	21%	18.2%	10.0%	23.8%

Table 96. Percent of budget that is paid by other funding sources within ranges

	N	%
None	53	34.0%
1 to 25%	13	8.3%
25% to 49%	4	2.6%
50% to 74%	1	0.6%
75% or higher	1	0.6%

Survey Findings: Foster Family Care (FFC) Service Packages

Home-based/Community Services

In addition to questions about the current costs, providers were asked to think about each service package in relation to what they would need to provide services. Providers answered questions about ideal staffing, caseloads, salaries and services. In this section, we present findings for each foster family care package.

Primary Setting – Basic Foster Family Care (BFFC) – FFC Service Package

Brief Description: A foster home that provides a child's basic living needs, including food, clothing, shelter, education, vocational, and extracurricular needs which may vary based on age and developmental level. Each home has no more than 6 children in a home and must adhere to HHSC CPA Minimum Standards Section 749.2551. Children in these living situations attend visitation with siblings and other members of their family at least once a week. This section examines needs and costs specific to the provision of this service package.

Basic Foster Family Care – CPA Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the basic foster family care package. Most providers indicated that specialized staff were not needed. As for treatment directors, 73% do not think a treatment director is needed. In terms of other staff, providers did not think it was important to have a psychiatrist (55%), physician (65%) or nurse (76%) for children needing basic foster family care. However, even though providers said it was not important, the providers indicated they would like a psychiatrist (55%), physician (65%) and/or nurse (41%). For all these positions, contracted staff was the preference.

Unlike the other clinical and medical staff, 86% providers reported that therapists were important and 83% reported wanting a therapist. Almost all providers (73%) reported that therapists would ideally be contracted and only 48% felt a therapist needed to be on call after hours.

For case managers, the ideal and preferred level of education was a bachelor's degree in human services. Providers (93%) noted that no additional certifications were needed for case managers.

BFFC – CPA Treatment Director

Table 97. BFFC (CPA) - Should a treatment director be required? (N=83)

	N	%
Yes	10	12.0%
No	73	88.0%

BFFC – CPA Psychiatrists

Table 98. BFFC (CPA) - How important is to have a psychiatrist? (N=83)

	N	%
Not important	46	55.4%
Somewhat important	21	25.3%
Very important	12	14.5%
Extremely important	4	4.8%

Table 99. BFFC (CPA) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=81)		
Yes	49	60.5%
No	32	39.5%
If yes, would you prefer to contract with them or have them in-house? (N=49)		
Contract	47	95.9%
In-house	2	4.1%

Table 100. BFFC (CPA) - Should a psychiatrist on-call or available 24/7? (N=49)

	N	%
Yes	20	40.8%
No	29	59.2%

BFFC – CPA Physicians

Table 101. BFFC (CPA) - How important is it to have a physician? (N=79)

	N	%
Not important	51	64.6%
Somewhat important	17	21.5%
Very important	7	8.9%
Extremely important	4	5.1%

Table 102. BFFC (CPA) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=79)		
Yes	47	59.5%
No	32	40.5%
If yes, would you prefer to contract with them or have them in-house? (N=47)		
Contract	46	97.9%
In-house	1	2.1%

Table 103. BFFC (CPA) - Should a physician on-call or available 24/7? (N=47)

	N	%
Yes	17	36.2%
No	30	63.8%

BFFC – CPA Therapists

Table 104. BFFC (CPA) - How important is having a therapist? (N=78)

	N	%
Not important	11	14.1%
Somewhat important	32	41.0%
Very important	22	28.2%
Extremely important	13	16.7%

Table 105. BFFC (CPA) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=77)		
Yes	64	83.1%
No	13	16.9%
If yes, would you prefer to contract with them or have them in-house? (N=64)		
Contract	47	73.4%
In-house	17	26.6%

Table 106. BFFC (CPA) - Should a therapist be on-call or available 24/7? (N=64)

	N	%
Yes	31	48.4%
No	33	51.6%

BFFC – CPA Nurses

Table 107. BFFC (CPA) - How important is having a nurse? (N=75)

	N	%
Not important	57	76.0%
Somewhat important	12	16.0%
Very important	3	4.0%
Extremely important	3	4.0%

Table 108. BFFC (CPA) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=74)		
Yes	30	40.5%
No	44	59.5%
If yes, would you prefer to contract with them or have them in-house? (N=30)		
Contract	27	90.0%
In-house	3	10.0%

Table 109. BFFC (CPA) - Should a nurse be on-call or available 24/7? (N=30)

	N	%
Yes	14	46.7%
No	16	53.3%

BFFC – CPA Case Management Staff

Table 110. BFFC (CPA) - Recommended level of education

	Minimum (N=72)		Preferred (N=68)	
	N	%	N	%
High School Diploma or GED	2	2.2%	0	0.0%
Associate's Degree	1	1.1%	2	2.9%
Bachelor's Degree	29	32.6%	17	25.0%
Bachelor's Degree (human service field)	40	44.9%	31	45.6%
Master's Degree	0	0.0%	2	2.9%
Master's Degree (human service field)	0	0.0%	16	23.5%

Table 111. BFFC (CPA) - Do case managers need any certifications? (N=74)

	N	%
No certifications needed	69	93.2%
Certifications needed	5	6.8%

Basic Foster Family Care – CPA Ideal Caseloads and Competitive Salaries

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal (3%), the mean response for the typical caseload 17 youth. However, the ideal caseload was 14 and the maximum caseload was 18 children. For case managers, the typical caseload was 18 youth. The ideal caseload was 15 youth and the maximum caseload was 20 youth.

For salaries, providers noted that a competitive therapist salary without benefits was $63,417. For case managers, the mean competitive salary without benefits was $42,958.

BFFC – CPA Therapist Caseloads

Table 112. BFFC (CPA) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	5	10	30	17	15	10	8.37
Ideal caseload	6	10	23	14	13	10	5.12
Max caseload	6	12	30	18	15	12*	7.52

*Multiple modes exist. The smallest value is shown

BFFC – CPA Competitive Salary

Table 113. BFFC (CPA) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	12	$46,000	$75,000	$63,417	$65,000	$60,000	$7,868

BFFC – CPA Case Manager Caseloads

Table 114. BFFC (CPA) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	57	7	30	18.7	18	15	6.28
Ideal caseload	68	5	35	16.6	15	15	5.59
Max caseload	67	7	40	21.3	20	20	6.49

BFFC – CPA Competitive Salary

Table 115. BFFC (CPA) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	59	$30,000	$60,000	$42,958	$43,500	$45,000	$6,812

Basic Foster Family Care – Services

Providers were asked about the recommended frequency of therapy for children needing basic foster family care. For individual therapy 33% of providers suggested therapy should be once a month. Providers (42%) also felt family therapy should be once a month. Most providers (52%) felt group therapy was not needed. Providers were also asked about services they would recommend for children in basic foster family care. The following services were noted by 75% or more of the providers: education and tutoring services (96%); assistance with high school diploma or GED (89%); play therapy (88%); psychological testing and evaluation (87%); assistance with obtaining a driver's license (86%); recreational therapy (84%); healthy relationship programs/classes (80%); dietician/nutrition services (78%); youth support groups (76%); and peer mentoring (76%).

In open ended questions, CPA providers additionally mentioned youth in basic foster family care may need family support specialists to help with the burden of transportation, tutoring, etc., care coordination, and insurance navigation. One provider mentioned services need to be child specific and able to combine with other services.

BFFC – Therapy

Table 116. BFFC - Recommended frequency of therapy sessions

	Total N	None %	1x every other month %	1x per month %	2x per month %	1x per week %	2x per week %	3x per week %	4x per week %	5x per week %	6x per week %	Daily %	Prefer not to say %
BFFC	Individual Therapy												
	69	12%	6%	33%	29%	17%	0%	1%	1%	0%	0%	0%	0%
	Family Therapy												
	65	11%	15%	42%	25%	8%	0%	0%	0%	0%	0%	0%	0%
	Group Therapy												
	62	52%	10%	27%	2%	6%	2%	0%	0%	0%	0%	0%	2%

BFFC – Needed Services

Table 117. BFFC - Additional recommended services

	Total N	Service needed N	%
Education and tutoring services	71	68	95.8%
Assistance with HS diploma or GED	71	63	88.7%
Play therapy	67	59	88.1%
Psychological testing and evaluation	69	60	87.0%
Assistance with obtaining a driver's license	71	61	85.9%
Recreational therapy	67	56	83.6%
Healthy Relationship Programs / Classes	71	57	80.3%
Dietician / Nutrition services	55	43	78.2%
Youth support groups	71	54	76.1%
Peer mentoring	71	54	76.1%
Parenting programs/classes	71	52	73.2%
Parent support groups	71	50	70.4%
Art therapy	67	46	68.7%
Speech Therapy	69	44	63.8%
Occupational Therapy	69	44	63.8%
Behavior Support Specialist	69	42	60.9%
Prenatal and Postnatal Care	55	33	60.0%
Dance / Movement therapy	67	39	58.2%
Legal services	71	39	54.9%
Personal Care Services (PCS)	55	30	54.5%
Animal therapy	67	36	53.7%
Risk assessments	69	37	53.6%
Crisis Services / Stabilization	69	35	50.7%
Physical / Rehabilitation Therapy	69	33	47.8%
Equine therapy	67	31	46.3%
Medical specialists	55	25	45.5%
Nursing - Other	55	21	38.2%
Applied Behavior Analysis (ABA)	69	23	33.3%
Forensic assessments	69	21	30.4%
Neurofeedback	69	20	29.0%
Private Duty Nursing (PDN)	55	13	23.6%

Note: Services highlighted in orange were identified by at least 75% of CPAs as needed services

BFFC – Maximum Length of Services

Providers were also asked about the recommended maximum length of services for youth in basic foster family care. The most common response (41%) was that there should be no maximum service length.

Table 118. BFFC - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
BFFC	70	3%	0%	4%	1%	10%	3%	24%	7%	6%	41%

Primary Setting – Complex Medical Needs/Primary Medical Needs Support Services (CMN/PMN) – FFC Service Package

Brief description: Foster homes that provide additional services for children, youth, and young adults with a medical diagnosis that requires constant monitoring, access to skilled nursing and other care up to 24 hours per day/7 days a week, and/or for whom the child cannot live without the support, direction, or service of others. CPA and caregiver specialize in coordination of health care services through STAR Health and the child has an increased number of appointments and potential for hospitalizations. Additionally, child is engaged in specialty services such as occupational, physical, and speech therapy, as well as enhanced nutritional services. Caregiver serves as the medical consenter and must be proficient in meeting child's daily living needs.

Note: Primary Medical Needs (PMN) and Complex Medical Needs (CMN) are currently combined in this package; however, to validate if this structure makes the most sense, PMN and CMN were asked about separately on this survey. Information on the costs and services for both PMN and CMN will be provided in this section.

Primary Medical Needs (PMN) – Foster Family Care

PMN – CPA Ideal Staffing

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 8 children.

Providers were asked about ideal staffing for clinical and medical staff for the primary medical needs package. Most providers (68%) a treatment director is needed for youth with primary medical needs. In terms of other staff, providers reported it was important to have clinical and medical staff: Roughly 60% felt a psychiatrist was important, 62% felt a physician was important and 97% felt having a nurse was important when working with youth with primary medical needs. However, even though providers said it was not important, the providers indicated they would like a psychiatrist (70%), physician (80%) and/or nurse (97%). For all these positions, contracted staff was the preference.

In terms of therapists, 79% providers reported that therapists were important and 82% reported wanting a therapist. Almost all providers (82%) reported that therapists would ideally be contracted and only 54% felt a therapist needed to be on call after hours.

For case managers, the ideal and preferred level of education was a bachelor's degree in human services. Providers (82%) noted that no additional certifications were needed for case managers working with youth with primary medical needs. In open-ended questions, CPA providers mentioned case managers working with youth with primary medical needs need the following trainings and certifications or qualifications: trauma informed care,

training on children's medical needs, only trainings (not certifications), and a bachelor's degree.

PMN – CPA Treatment Director

Table 119. PMN (CPA) - Should a treatment director be required? (N=38)

	N	%
Yes	26	68.4%
No	12	31.6%

PMN – CPA Psychiatrists

Table 120. PMN (CPA) - How important is to have a psychiatrist? (N=38)

	N	%
Not important	15	39.5%
Somewhat important	16	42.1%
Very important	5	13.2%
Extremely important	2	5.3%

Table 121. PMN (CPA) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=37)		
Yes	26	70.3%
No	11	29.7%
If yes, would you prefer to contract with them or have them in-house? (N=26)		
Contract	21	80.8%
In-house	5	19.2%

Table 122. PMN (CPA) - Should a psychiatrist be on-call or available 24/7? (N=26)

	N	%
Yes	15	57.7%
No	11	42.3%

PMN – CPA Physicians

Table 123. PMN (CPA) - How important is it to have a physician? (N=34)

	N	%
Not important	13	38.2%
Somewhat important	7	20.6%
Very important	7	20.6%
Extremely important	7	20.6%

Table 124. PMN (CPA) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=35)		
Yes	28	80.0%
No	7	20.0%
If yes, would you prefer to contract with them or have them in-house? (N=28)		
Contract	24	85.7%
In-house	4	14.3%

Table 125. PMN (CPA) - Should a physician be on-call or available 24/7? (N=28)

	N	%
Yes	22	78.6%
No	6	21.4%

PMN – CPA Therapists

Table 126. PMN (CPA) - How important is having a therapist? (N=33)

	N	%
Not important	7	21.2%
Somewhat important	12	36.4%
Very important	8	24.2%
Extremely important	6	18.2%

Table 127. PMN (CPA) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=34)		
Yes	28	82.4%
No	6	17.6%
If yes, would you prefer to contract with them or have them in-house? (N=28)		
Contract	23	82.1%
In-house	5	17.9%

Table 128. PMN (CPA) - Should a therapist be on-call or available 24/7? (N=28)

	N	%
Yes	15	53.6%
No	13	46.4%

PMN – CPA Nurses

Table 129. PMN (CPA) - How important is having a nurse? (N=32)

	N	%
Not important	1	3.1%
Somewhat important	4	12.5%
Very important	10	31.3%
Extremely important	17	53.1%

Table 130. PMN (CPA) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=33)		
Yes	32	97.0%
No	1	3.0%
If yes, would you prefer to contract with them or have them in-house? (N=32)		
Contract	20	62.5%
In-house	12	37.5%

Table 131. PMN (CPA) - Should a nurse be on-call or available 24/7? (N=32)

	N	%
Yes	27	84.4%
No	5	15.6%

PMN – CPA Case Management Staff

Table 132. PMN (CPA) - Recommended level of education for case managers

	Minimum (N=32)		Preferred (N=29)	
	N	%	N	%
High School Diploma or GED	0	0.0%	0	0%
Associate's Degree	0	0.0%	0	0.0%
Bachelor's Degree	14	34.1%	5	17.2%
Bachelor's Degree (human service field)	17	41.5%	11	37.9%
Master's Degree	0	0.0%	3	10.3%
Master's Degree (human service field)	1	2.4%	10	34.5%

Table 133. PMN (CPA) - Do case managers need any certifications? (N=33)

	N	%
No certifications needed	27	81.8%
Certifications needed	6	18.2%

PMN – CPA Ideal Caseloads and Competitive Salaries

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated they had in-house therapists, the mean response for the typical caseload 8 children. However, the ideal caseload was 5 and the maximum caseload was 7 children. For case managers, the typical caseload was 12 children. The ideal caseload was 10 children and the maximum caseload was 14 children. Providers were also asked how many case managers should be supervised by one supervisor. The mean response was 5.15 case managers for each case supervisor.

For salaries, providers noted that a competitive therapist salary without benefits was $64,500. For case managers, the mean competitive salary without benefits was $44,788.

PMN – CPA Therapist Caseloads

Table 134. PMN (CPA) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	3	2	20	8	3	2*	10.12
Ideal caseload	4	0	15	5	2	0*	6.95
Max caseload	4	0	20	7	3	3	9.11

*Multiple modes exist. The smallest mode is shown.

PMN – CPA Therapist Competitive Salary

Table 135. PMN (CPA) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	8	$46,000	$75,000	$64,500	$65,000	$65,000	$8,734

PMN – CPA Case Manager Caseloads

Table 136. PMN (CPA) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	24	1	30	12	14	15	8.12
Ideal caseload	27	1	25	10	10	5*	6.46
Max caseload	26	1	30	14	14	20	8.28

*Multiple modes exist. The smallest mode is shown.

PMN – CPA Case Manager Competitive Salary

Table 137. PMN (CPA) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	26	$32,000	$60,000	$44,788	$45,000	$45,000	$7,370

PMN – Foster Family Care (FFC) Services

PMN – FFC Therapy

Providers were asked about the recommended frequency of therapy for children with primary medical needs. For individual therapy 31% of providers suggested individual therapy was not needed. Providers (50%) felt family therapy should be once a month. Most providers (60%) felt group therapy was not needed.

Table 138. PMN (FFC) - Recommended frequency of therapy sessions for youth

		N Total	None %	1x every other month %	1x per month %	2x per month %	1x per week %	2x per week %	3x per week %	4x per week %	5x per week %	6x per week %	Daily %	Prefer not to say %
PMN (FFC)	Individual Therapy													
		29	31%	3%	28%	17%	17%	0%	0%	0%	0%	0%	0%	3%
	Family Therapy													
		26	19%	8%	50%	15%	4%	0%	0%	0%	0%	0%	0%	4%
	Group Therapy													
		25	60%	4%	24%	0%	4%	0%	0%	0%	0%	0%	0%	8%

PMN – FFC Maximum Length of Services

Providers were also asked about the recommended maximum length of services for youth with primary medical needs. The most common response (60%) was that there should be no maximum service length.

Table 139. PMN (FFC) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
PMN (FFC)	30	0%	0%	0%	3%	7%	7%	10%	7%	7%	60%

PMN – CPA Aftercare

Providers were also asked about the recommended length of services for youth with primary medical needs. The most common response (41%) was that there should be six months of aftercare services. Additionally, the average caseload for an aftercare case manager would be 11 youth with primary medical needs.

Table 140. PMN (CPA) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months %	No max %
PMN (CPA)	32	13%	0%	0%	19%	0%	0%	41%	0%	0%	0%	0%	0%	6%	22%

Table 141. PMN (CPA) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std Dev
PMN (CPA) estimated aftercare caseload	27	1	25	11	7

Complex Medical Needs (CMN) – Foster Family Care

CMN – CPA Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the complex medical needs package add on. Most providers (61%) reported a treatment director is needed for youth with complex medical needs. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 65% felt a psychiatrist was important, 67% felt a physician was important and 100% felt having a nurse was important when working with youth with complex medical needs. Providers indicated they would like a (71%), physician (88%) and/or nurse (100%). For all these positions, contracted staff was the preference.

In terms of therapists, 79% providers reported that therapists were important and 82% reported wanting a therapist. Almost all providers (82%) reported that therapists would ideally be contracted and only 41% felt a therapist needed to be on call after hours.

For case managers, the ideal and preferred level of education was a bachelor's degree in human services. Providers (77%) noted that additional certifications were not needed for case managers working with youth with complex medical needs. In open-ended questions, CPA providers mentioned case managers working with youth with complex medical needs need the following trainings and certifications or qualifications: trauma informed care, training on children's medical needs, only trainings (not certifications), and a bachelor's degree.

CMN – CPA Treatment Director

Table 142. CMN (CPA) - Should a treatment director be required? (N=38)

	N	%
Yes	23	60.5%
No	15	39.5%

CMN – CPA Psychiatrists

Table 143. CMN (CPA) - How important is it to have a psychiatrist? (N=37)

	N	%
Not important	13	35.1%
Somewhat important	9	24.3%
Very important	12	32.4%
Extremely important	3	8.1%

Table 144. CMN (CPA) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=35)		
Yes	25	71.4%
No	10	28.6%
If yes, would you prefer to contract with them or have them in-house? (N=25)		
Contract	19	76.0%
In-house	6	24.0%

Table 145. CMN (CPA) - Should psychiatrist be on-call or available 24/7? (N=25)

	N	%
Yes	13	52.0%
No	12	48.0%

CMN – CPA Physicians

Table 146. CMN (CPA) - How important is it to have a physician? (N=33)

	N	%
Not important	11	33.3%
Somewhat important	8	24.2%
Very important	8	24.2%
Extremely important	6	18.2%

Table 147. CMN (CPA) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=33)		
Yes	29	87.9%
No	4	12.1%
If yes, would you prefer to contract with them or have them in-house? (N=29)		
Contract	25	86.2%
In-house	4	13.8%

Table 148. CMN (CPA) - Should a physician be on-call or available 24/7? (N=29)

	N	%
Yes	21	72.4%
No	8	27.6%

CMN – CPA Therapists

Table 149. CMN (CPA) - How important is having a therapist? (N=33)

	N	%
Not important	7	21.2%
Somewhat important	12	36.4%
Very important	8	24.2%
Extremely important	6	18.2%

Table 150. CMN (CPA) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=34)		
Yes	28	82.4%
No	6	17.6%
If yes, would you prefer to contract with them or have them in-house? (N=28)		
Contract	23	82.1%
In-house	5	17.9%

Table 151. CMN (CPA) - Should a therapist be on-call or available 24/7? (N=28)

	N	%
Yes	15	40.8%
No	13	59.2%

CMN – CPA Nurses

Table 152. CMN (CPA) - How important is having a nurse? (N=32)

	N	%
Not important	0	0.0%
Somewhat important	6	18.8%
Very important	12	37.5%
Extremely important	14	43.8%

Table 153. CMN (CPA) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=32)		
Yes	32	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=32)		
Contract	18	56.3%
In-house	14	43.8%

Table 154. CMN (CPA) - Should a nurse be on-call or available 24/7? (N=32)

	N	%
Yes	25	78.1%
No	7	21.9%

CMN – CPA Case Management Staff

Table 155. CMN (CPA) - Recommended level of education for case managers

	Minimum (N=30)		Preferred (N=27)	
	N	%	N	%
High School Diploma or GED	0	0.0%	0	0.0%
Associate's Degree	0	0.0%	1	3.7%
Bachelor's Degree	8	19.5%	1	3.7%
Bachelor's Degree (human service field)	21	51.2%	12	44.4%
Master's Degree	1	2.4%	2	7.4%
Master's Degree (human service field)	0	0.0%	11	40.7%

Table 156. CMN (CPA) - Do case managers need any certifications? (N=31)

	N	%
No certifications needed	24	77.4%
Certifications needed	7	22.6%

CMN – CPA Ideal Caseloads and Competitive Salaries

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 10 children. However, the ideal caseload was 7 and the maximum caseload was 10 children. For case managers, the typical caseload was 14 children. The ideal caseload was 12 children and the maximum caseload was 15 children.

Providers were also asked how many case managers should be supervised by one supervisor. The mean response was 5.15 case managers for each case supervisor.

For salaries, providers noted that a competitive therapist salary without benefits was $67,500. For case managers, the mean competitive salary without benefits was $47,100.

CMN – CPA Therapist Caseloads

Table 157. CMN (CPA) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	4	1	20	10	9	1*	9.47
Ideal caseload	4	1	15	7	6	1	6.95
Max caseload	4	2	20	10	9	2	9.18

*Multiple modes exist. The smallest value is shown.

CMN – CPA Therapist Competitive Salary

Table 158. CMN (CPA) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	8	$60,000	$75,000	$67,500	$67,500	$65,000*	$4,629

*Multiple modes exist. The smallest value is shown.

CMN – CPA Case Manager Caseloads

Table 159. CMN (CPA) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	18	1	30	14	15	15	9.84
Ideal caseload	23	1	25	12	12	20	7.14
Max caseload	22	1	30	15	17	20	9.03

CMN – CPA Case Manager Competitive Salary

Table 160. CMN (CPA) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	20	$35,000	$65,000	$47,100	$45,000	$45,000	$7,867

CMN – Foster Family Care (FFC) Services

CMN – FFC Therapy

Providers were asked about the recommended frequency of therapy for children with complex medical needs. For individual therapy 30% of providers suggested individual therapy should be once a month. Providers (61%) felt family therapy should be once a month. Most providers (64%) felt group therapy was not needed.

Table 161. CMN (FFC) - Recommended frequency of therapy sessions

		Total N	None %	1x every other month %	1x per month %	2x per month %	1x per week %	2x per week %	3x per week %	4x per week %	5x per week %	6x per week %	Daily %	Prefer not to say %
CMN (FFC)	Individual Therapy													
		27	22%	0%	30%	26%	15%	0%	0%	0%	0%	0%	7%	0%
	Family Therapy													
		23	17%	0%	61%	13%	9%	0%	0%	0%	0%	0%	0%	0%
	Group Therapy													
		22	64%	0%	23%	5%	5%	0%	0%	0%	0%	0%	0%	5%

CMN – FFC Maximum Length of Services

Providers were also asked about the recommended maximum length of services for youth with complex medical needs. The most common response (55%) was that there should be no maximum service length.

Table 162. CMN (FFC) - Recommended maximum length of services

	Total N	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
CMN (CPA)	29	0%	0%	0%	7%	7%	3%	14%	7%	7%	55%

CMN – CPA Aftercare

Providers were also asked about the recommended length of aftercare for youth with complex medical needs. The most common response (37%) was that there should be six months of aftercare services. Additionally, the average caseload for an aftercare case manager would be 12 youth with complex medical needs.

Table 163. CMN (CPA) - Recommended length of aftercare

	Total N	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months	No max
CMN (CPA)	30	10%	0%	0%	20%	0%	0%	37%	0%	0%	3%	0%	0%	10%	20%

Table 164. CMN (CPA) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std Dev
CMN (CPA) estimated aftercare case managers	52	1	30	12	7

CMN/PMN – Foster Family Care (FFC) Needed Services

Providers were also asked about services they would recommend for children with primary and complex medical needs. The following services were noted by 75% or more of the providers: dietician/nutrition services (92%); nursing (92%); medical specialists (92%); speech therapy (92%); occupational therapy (92%); recreational therapy (87%); physical/rehabilitation therapy (87%); education and tutoring services (82%); personal care services (82%); private duty nursing (80%); play therapy (77%) and parent support groups (76%).

In open-ended responses, CPA providers additionally mentioned youth with primary medical needs / complex medical needs may need family support specialists to help with the burden of transportation, tutoring, etc., care coordination, and insurance navigation. One provider mentioned services need to be child specific and able to combine with other services.

Table 165. CMN/PMN (FFC) - Additional recommended services

	Total N	Service needed N	%
Dietician / Nutrition services	38	35	92.1%
Nursing - Other	38	35	92.1%
Medical specialists	38	35	92.1%
Speech Therapy	37	34	91.9%
Occupational Therapy	37	34	91.9%
Recreational therapy	31	27	87.1%
Physical / Rehabilitation Therapy	37	32	86.5%
Education and tutoring services	33	27	81.8%
Personal Care Services (PCS)	38	31	81.6%
Private Duty Nursing (PDN)	38	30	78.9%
Play therapy	31	24	77.4%
Parent support groups	33	25	75.8%
Animal therapy	31	22	71.0%
Psychological testing and evaluation	37	26	70.3%
Healthy Relationship Programs / Classes	33	22	66.7%
Art therapy	31	20	64.5%
Assistance with HS diploma or GED	33	21	63.6%
Parenting programs/classes	33	21	63.6%
Dance / Movement therapy	31	19	61.3%
Youth support groups	33	20	60.6%
Behavior Support Specialist	37	22	59.5%
Crisis Services / Stabilization	37	21	56.8%
Peer mentoring	33	18	54.5%
Equine therapy	31	16	51.6%
Risk assessments	37	19	51.4%
Assistance with obtaining a driver's license	33	15	45.5%
Legal services	33	15	45.5%
Prenatal and Postnatal Care	38	17	44.7%
Neurofeedback	37	15	40.5%
Applied Behavior Analysis (ABA)	37	11	29.7%
Forensic assessments	37	8	21.6%

Note: Services highlighted in orange were identified by at least 75% of CPAs as needed services

Primary Setting – Intellectual and Developmental Disabilities/Autism Support Services (IDD/A) – FFC Service Package

Brief Description: Services to support children, youth, and young adults with a diagnosis of an intellectual or developmental disability (IDD) and/or Autism in a foster family care setting. Both the CPA and caregiver will have additional skills and training to meet the needs of this population. They will coordinate to ensure participation in community-based services. Children and youth may require home and transportation to be accessible. This population often participates in occupational and physical therapy, as well as Applied Behavior Analysis on a regular basis. This section examines needs and costs specific to the provision of this service package.

IDD/Autism – CPA Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the IDD/Autism package add on. Most providers (58%) reported a treatment director is needed for youth with IDD/Autism. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 78% felt a psychiatrist was important, 60% felt a physician was important and 62% felt having a nurse was important when working with youth with IDD/Autism. Providers indicated they would like a psychiatrist (91%), physician (75%) and/or nurse (62%). For all these positions, contracted staff was the preference.

In terms of therapists, 91% providers reported that therapists were important and 100% reported wanting a therapist. The majority of providers (73%) reported that therapists would ideally be contracted and only 55% felt a therapist needed to be on call after hours.

For case managers, the ideal level of education was a bachelor's degree in human services and the preferred level of education is a Master's degree in a human services field. Providers (84%) noted that additional certifications were not needed for case managers working with youth with IDD/Autism. In open-ended questions, CPA providers mentioned case managers working with youth with intellectual and developmental disabilities and/or Autism may need the following training, certifications, or qualifications: trauma informed care, training/certifications related to IDD/Autism, EBI, CPR, child development, psychotropic medication training, child abuse training, bachelor's degree, master's degree, and case management certification.

IDD/A – CPA Treatment Director

Table 166. IDD/A (CPA) - Should a treatment director be required? (N=75)

	N	%
Yes	44	58.7%
No	31	41.3%

IDD/A – CPA Psychiatrists

Table 167. IDD/A (CPA) - How important is to have a psychiatrist? (N=78)

	N	%
Not important	17	21.8%
Somewhat important	15	19.2%
Very important	31	39.7%
Extremely important	15	19.2%

Table 168. IDD/A (CPA) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=75)		
Yes	68	90.7%
No	7	9.3%
If yes, would you prefer to contract with them or have them in-house? (N=68)		
Contract	57	83.8%
In-house	11	16.2%

Table 169. IDD/A (CPA) - Should a psychiatrist be on-call or available 24/7? (N=68)

	N	%
Yes	34	50.0%
No	34	50.0%

IDD/A – CPA Physicians

Table 170. IDD/A (CPA) - How important is it to have a physician? (N=72)

	N	%
Not important	29	40.3%
Somewhat important	21	29.2%
Very important	15	20.8%
Extremely important	7	9.7%

Table 171. IDD/A (CPA) - Ideal Physician

	N	%
Would you ideally have a physician when working with this population? (N=73)		
Yes	55	75.3%
No	18	24.7%
If yes, would you prefer to contract with them or have them in-house? (N=55)		
Contract	51	92.7%
In-house	4	7.3%

Table 172. IDD/A (CPA) - Should a physician be on-call or available 24/7? (N=55)

	N	%
Yes	27	49.1%
No	28	50.9%

IDD/A – CPA Therapists

Table 173. IDD/A (CPA) - How important is having a therapist? (N=70)

	N	%
Not important	6	8.6%
Somewhat important	7	10.0%
Very important	30	42.9%
Extremely important	27	38.6%

Table 174. IDD/A (CPA) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=71)		
Yes	71	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=71)		
Contract	52	73.2%
In-house	19	26.8%

Table 175. IDD/A (CPA) - Should a therapist be on-call or available 24/7? (N=71)

	N	%
Yes	39	54.9%
No	32	45.1%

IDD/A – CPA Nurses

Table 176. IDD/A (CPA) - How important is having a nurse? (N=68)

	N	%
Not important	26	38.2%
Somewhat important	24	35.3%
Very important	11	16.2%
Extremely important	7	10.3%

Table 177. IDD/A (CPA) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=68)		
Yes	43	63.2%
No	25	36.8%
If yes, would you prefer to contract with them or have them in-house? (N=43)		
Contract	36	83.7%
In-house	7	16.3%

Table 178. IDD/A (CPA) - Should a nurse be on-call or available 24/7? (N=43)

	N	%
Yes	22	51.2%
No	21	48.8%

IDD/A – CPA Case Management Staff

Table 179. IDD/A (CPA) - Recommended level of education for case managers

	Minimum level (N=66)		Preferred level (N=63)	
	N	%	N	%
High School Diploma or GED	0	0.0%	0	0.0%
Associate's Degree	0	0.0%	1	1.6%
Bachelor's Degree	29	35.4%	12	19.0%
Bachelor's Degree (human service field)	35	42.7%	21	33.3%
Master's Degree	1	1.2%	4	6.3%
Master's Degree (human service field)	1	1.2%	25	39.7%

Table 180. IDD/A (CPA) - Do case managers need any certifications? (N=68)

	N	%
No certifications needed	57	83.8%
Certifications needed	11	16.2%

IDD/Autism – CPA Ideal Caseloads and Competitive Salaries

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 11 children. However, the ideal caseload was 9 and the maximum caseload was 12 children. For case managers, the typical caseload was 13 children. The ideal caseload was 12 children and the maximum caseload was 15 children. Providers were also asked how many case managers should be supervised by one supervisor. The mean response was 5.15 case managers for each case supervisor.

For salaries, providers noted that a competitive therapist salary without benefits was $65,000. For case managers, the mean competitive salary without benefits was $45,894.

IDD/A – CPA Therapist Caseloads

Table 181. IDD/A (CPA) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	7	1	30	11	10	10	9.69
Ideal caseload	9	1	20	9	10	10	5.28
Max caseload	9	3	30	12	12	12	7.80

IDD/A – CPA Therapist Competitive Salary

Table 182. IDD/A (CPA) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	11	$55,000	$75,000	$65,000	$65,000	$60,000.00*	$5,916

*Multiple modes exist. The smallest value is shown

IDD/A – CPA Case Manager Caseloads

Table 183. IDD/A (CPA) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	40	1	30	13	15	15	7.93
Ideal caseload	49	1	25	12	12	10*	6.62
Max caseload	48	1	30	15	15	20	7.95

*Multiple modes exist. The smallest value is shown

IDD/A – CPA Case Manager Competitive Salary

Table 184. IDD/A (CPA) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	52	$32,000	$65,000	$45,894	$45,000	$45,000	$7,922

IDD/Autism – Foster Family Care Services

Providers were asked about the recommended frequency of therapy for children with IDD/Autism. For individual therapy 47% of providers suggested individual therapy should be once per week. Providers (33%) felt family therapy should be once a month. Providers (33%) felt group therapy should be once a month. Providers were also asked about services they would recommend for children with IDD/Autism. The following services were noted by 75% or more of the providers: education and tutoring services (99%); psychological testing and evaluation (96%); behavior support specialist (91%); art therapy (91%); recreational therapy (88%); play therapy (88%); speech therapy (86%); occupational therapy (85%); animal therapy (85%); assistance with high school diploma or GED (85%); healthy relationship programs/classes (82%); dietician/nutrition services (81%); crisis services/stabilization (80%); physical/ rehabilitation therapy (79%); equine therapy (77%); and dance/movement therapy (75%)

In open-ended responses, CPA providers additionally mentioned youth with intellectual and developmental disability and/or Autism may need transportation, education services (such as tutoring), support for their families of origin and for foster or adoptive caregivers, specialized therapies not covered by Medicaid, support with basic needs (i.e. soiling clothing). One provider mentioned services need to be child specific and able to combine with other services. Another provider said:

> *'Recognition that this diverse group of children require very specialized and in most cases life time care. It would be wonderful to return them to their family of origin and train the family and support the family in their care. Again, this would be a lifetime commitment to this child and their family- not just until they age out and no longer the state's responsibility." _CPA Provider*

IDD/A – FFC Therapy

Table 185. IDD/A (FFC) - Recommended frequency of therapy sessions

		Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
		N	%	%	%	%	%	%	%	%	%	%	%	%
IDD/A (FFC)	Individual Therapy													
		62	0%	3%	13%	18%	47%	10%	3%	2%	0%	0%	3%	2%
	Family Therapy													
		55	2%	7%	33%	29%	22%	5%	0%	0%	0%	0%	2%	0%
	Group Therapy													
		54	28%	9%	33%	7%	15%	4%	0%	0%	0%	0%	0%	4%

IDD/A – FFC Needed Services

Table 186. IDD/A (FFC) - Additional recommended services

	Total N	Service needed N	%
Education and tutoring services	65	64	98.5%
Psychological testing and evaluation	66	63	95.5%
Behavior Support Specialist	66	60	90.9%
Art therapy	65	59	90.8%
Recreational therapy	65	57	87.7%
Play therapy	65	57	87.7%
Speech Therapy	66	57	86.4%
Occupational Therapy	66	56	84.8%
Animal therapy	65	55	84.6%
Assistance with HS diploma or GED	65	55	84.6%
Healthy Relationship Programs / Classes	65	53	81.5%
Dietician / Nutrition services	57	46	80.7%
Crisis Services / Stabilization	66	53	80.3%
Physical / Rehabilitation Therapy	66	52	78.8%
Equine therapy	65	50	76.9%
Dance / Movement therapy	65	49	75.4%
Applied Behavior Analysis (ABA)	66	48	72.7%
Youth support groups	65	47	72.3%
Peer mentoring	65	47	72.3%
Parent support groups	65	46	70.8%
Personal Care Services (PCS)	57	39	68.4%
Assistance with obtaining a driver's license	65	43	66.2%
Risk assessments	66	42	63.6%
Neurofeedback	66	42	63.6%
Medical specialists	57	36	63.2%
Parenting programs/classes	65	41	63.1%
Legal services	65	31	47.7%
Nursing - Other	57	26	45.6%
Prenatal and Postnatal Care	57	22	38.6%
Forensic assessments	66	23	34.8%
Private Duty Nursing (PDN)	57	18	31.6%

Note: Services highlighted in orange were identified by at least 75% of CPAs as needed services

IDD/A – FFC Maximum Length of Services

Providers were also asked about the recommended maximum length of services for youth with IDD/Autism. The most common response (48%) was that there should be no maximum service length.

Table 187. IDD/A (FFC) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
IDD/A (CPA)	64	2%	2%	0%	2%	11%	2%	19%	9%	6%	48 %

IDD/Autism – CPA Aftercare

Providers were also asked about the recommended length of aftercare for youth with IDD/Autism. The most common response (32%) was that there should be six months of aftercare services. Additionally, the average caseload for an aftercare case manager would be 12 youth with IDD/Autism.

Table 188. IDD/A (CPA) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months	No max
IDD/A (CPA)	65	11%	2%	3%	9%	0%	2%	32%	2%	0%	0%	0%	0%	14%	26%

Table 189. IDD/A (CPA) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std Dev
IDD/A (CPA) estimated aftercare caseload	55	2	30	12	7

Service Add-On – Human Trafficking Services (HT) – FFC

Brief Description: Services to support children, youth, and young adults who have experienced sex and/or labor trafficking. The CPA and caregiver will have specialized skill and training in delivering services to survivors of human trafficking (HT), as well as interventions for protecting this population in the community. Examples of services included specialize treatment modalities and mentor programs. After care and transition services are critical for discharge success in the HT population. This service add-on can be combined with other service add-ons inherent in the foster care continuum. This section examines needs and costs specific to the provision of this service add-on.

Human Trafficking – CPA Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the human trafficking package. Most providers (62%) reported a treatment director is needed for youth who have experienced human trafficking. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 82% felt a psychiatrist was important, 64% felt a physician was important and 55% felt having a nurse was important when working with youth who have experienced human trafficking. Providers indicated they would like a psychiatrist (92%), physician (76%) and/or nurse (54%). For all these positions, contracted staff was the preference and most reported that psychiatrists (60%), physician (55%), and nurse (61%) should be on call 24/7.

In terms of therapists, 97% providers reported that therapists were important and 100% reported wanting a therapist. The majority of providers (70%) reported that therapists would ideally be contracted and only 68% felt a therapist needed to be on call after hours.

For case managers, providers (45%) noted the minimum level of education was a bachelor's degree in human services, but the ideal level of education is a Master's Degree in a human service field (42%). Providers (79%) noted that additional certifications were not needed for case managers working with youth who have experienced human trafficking. In open-ended questions, CPA providers mentioned case managers working with youth who have experienced human trafficking may need the following training, certifications, or qualifications: trauma informed care, mental health, human trafficking specific training, bachelor's degree, master's degree, and case management certification.

HT – CPA Treatment Director

Table 190. HT (CPA) - Should a treatment director be required? (N=63)

	N	%
Yes	39	61.9%
No	24	38.1%

HT – CPA Psychiatrists

Table 191. HT (CPA) - How important is to have a psychiatrist? (N=66)

	N	%
Not important	12	18.2%
Somewhat important	11	16.7%
Very important	24	36.4%
Extremely important	19	28.8%

Table 192. HT (CPA) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=63)		
Yes	58	92.1%
No	5	7.9%
If yes, would you prefer to contract with them or have them in-house? (N=58)		
Contract	51	87.9%
In-house	7	12.1%

Table 193. HT (CPA) - Should a psychiatrist be on-call or available 24/7? (N=58)

	N	%
Yes	35	60.3%
No	23	39.7%

HT – CPA Physicians

Table 194. HT (CPA) - How important is to have a physician? (N=42)

	N	%
Not important	15	35.7%
Somewhat important	2	4.8%
Very important	1	2.4%
Extremely important	24	57.1%

Table 195. HT (CPA) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=62)		
Yes	47	75.8%
No	15	24.2%
If yes, would you prefer to contract with them or have them in-house? (N=47)		
Contract	44	93.6%
In-house	3	6.4%

Table 196. HT (CPA) - Should a physician be on-call or available 24/7? (N=47)

	N	%
Yes	26	55.3%
No	21	44.7%

HT – CPA Therapists

Table 197. HT (CPA) - How important is having a therapist? (N=60)

	N	%
Not important	2	3.3%
Somewhat important	4	6.7%
Very important	22	36.7%
Extremely important	32	53.3%

Table 198. HT (CPA) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=59)		
Yes	59	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=59)		
Contract	41	69.5%
In-house	18	30.5%

Table 199. HT (CPA) - Should a therapist be on-call or available 24/7?(N=59)

	N	%
Yes	40	67.8%
No	19	32.2%

HT – CPA Nurses

Table 200. HT (CPA) - How important is having a nurse? (N=58)

	N	%
Not important	26	44.8%
Somewhat important	17	29.3%
Very important	8	13.8%
Extremely important	7	12.1%

Table 201. HT (CPA) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=57)		
Yes	31	54.4%
No	26	45.6%
If yes, would you prefer to contract with them or have them in-house? (N=31)		
Contract	25	80.6%
In-house	6	19.4%

Table 202. HT (CPA) - Should a nurse be on-call or available 24/7? (N=31)

	N	%
Yes	19	61.3%
No	12	38.7%

HT – CPA Case Management Staff

Table 203. HT (CPA) - Recommended level of education for case managers

	Minimum (N=55)		Preferred (N=52)	
	N	%	N	%
High School Diploma or GED	0	0.0%	0	0.0%
Associate's Degree	0	0.0%	1	1.9%
Bachelor's Degree	20	28.2%	8	15.4%
Bachelor's Degree (human service field)	32	45.1%	18	34.6%
Master's Degree	1	1.4%	3	5.8%
Master's Degree (human service field)	2	2.8%	22	42.3%

Table 204. HT (CPA) - Do case managers need any certifications? (N=57)

	N	%
No certifications needed	45	78.9%
Certifications needed	12	21.1%

Human Trafficking – CPA Ideal Caseloads and Competitive Salaries

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 9 children. However, the ideal caseload was 8 and the maximum caseload was 11 children. For case managers, the typical caseload was 14 children. The ideal caseload was 11 children and the maximum caseload was 14 children. Providers were also asked how many case managers should be supervised by one supervisor. The mean response was 5.15 case managers for each case supervisor.

For salaries, providers noted that a competitive therapist salary without benefits was $65,000. For case managers, the mean competitive salary without benefits was $46,812.

HT – CPA Therapist Caseloads

Table 205. HT (CPA) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	7	1	20	9	10	10	6.84
Ideal caseload	8	1	15	8	8	8*	4.88
Max caseload	8	1	20	11	11	20	7.03

*Multiple modes exist. The smallest mode is shown.

HT – CPA Therapist Competitive Salary

Table 206. HT (CPA) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	10	$55,000	$75,000	$65,000	$65,000	$60,000*	$6,236

*Multiple modes exist. The smallest value is shown.

HT – CPA Case Manager Caseloads

Table 207. HT (CPA) - Typical, ideal and maximum caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	30	1	30	14	15	15	8.43
Ideal caseload	42	1	25	11	10	10	6.31
Max caseload	42	1	30	14	15	20	7.93

HT – CPA Case Manager Competitive Salary

Table 208. HT (CPA) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	43	$30,000	$62,400	$46,812	$45,000	$45,000	$7,859

Human Trafficking – Foster Family Care Services

Providers were asked about the recommended frequency of therapy for children who have experienced human trafficking. For individual therapy 54% of providers suggested individual therapy should be once per week. Providers (33%) felt family therapy should be once a month or twice a month. Providers (20%) felt group therapy should be once or twice a month. Providers were also asked about services they would recommend for children who have experienced human trafficking. The following services were noted by 75% or more of the providers: Crisis Services / Stabilization (98%); education and tutoring services (98%); psychological testing and evaluation (96%); healthy relationship programs / classes (96%); recreational therapy (94%); assistance with HS diploma or GED (93%); art therapy (89%); forensic assessments (89%); risk assessments (89%); peer mentoring (89%); assistance with obtaining a driver's license (87%); legal services (87%); Behavior support specialist (85%); youth support groups (85%); dance/movement therapy (78%); and play therapy (78%).

In open-ended responses, CPA providers additionally mentioned youth who have experienced human trafficking may need transition services (i.e., vocational, education, job), health services (especially mental health and OB/GYN), normalcy activities, peer support, drop-in centers. One provider mentioned services need to be child specific and able to combine with other services.

HT – FFC Therapy

Table 209. HT (FFC) - Recommended frequency of therapy sessions

		Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
		N	%	%	%	%	%	%	%	%	%	%	%	%
HT (FFC)	Individual Therapy													
		50	0%	0%	4%	12%	54%	18%	4%	2%	2%	0%	4%	0%
	Family Therapy													
		46	2%	2%	33%	33%	22%	4%	2%	0%	0%	0%	0%	2%
	Group Therapy													
		45	11%	9%	20%	20%	22%	9%	2%	0%	0%	0%	4%	2%

HT – FFC Needed Services

Table 210. HT (FFC) - Additional recommended services

	Total N	Service needed N	%
Crisis Services / Stabilization	53	52	98.1%
Education and tutoring services	53	52	98.1%
Psychological testing and evaluation	53	51	96.2%
Healthy Relationship Programs / Classes	53	51	96.2%
Recreational therapy	54	51	94.4%
Assistance with HS diploma or GED	53	49	92.5%
Art therapy	54	48	88.9%
Forensic assessments	53	47	88.7%
Risk assessments	53	47	88.7%
Peer mentoring	53	47	88.7%
Assistance with obtaining a driver's license	53	46	86.8%
Legal services	53	46	86.8%
Behavior Support Specialist	53	45	84.9%
Youth support groups	53	45	84.9%
Dance / Movement therapy	54	42	77.8%
Play therapy	54	42	77.8%
Dietician / Nutrition services	45	33	73.3%
Animal therapy	54	39	72.2%
Personal Care Services (PCS)	45	31	68.9%
Parent support groups	53	36	67.9%
Equine therapy	54	36	66.7%
Medical specialists	45	30	66.7%
Parenting programs/classes	53	35	66.0%
Applied Behavior Analysis (ABA)	53	29	54.7%
Prenatal and Postnatal Care	45	23	51.1%
Nursing - Other	45	23	51.1%
Neurofeedback	53	26	49.1%
Physical / Rehabilitation Therapy	53	24	45.3%
Occupational Therapy	53	23	43.4%
Speech Therapy	53	20	37.7%
Private Duty Nursing (PDN)	45	10	22.2%

Note: Services highlighted in orange were identified by at least 75% of CPAs as needed services

HT – FFC Maximum Length of Services

Providers were also asked about the recommended maximum length of services for youth who have experienced human trafficking. The most common response (47%) was that there should be no maximum service length.

Table 211. HT (FFC) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
HT (FFC)	53	2%	2%	2%	0%	8%	2%	21%	8%	9%	47%

Human Trafficking – CPA Aftercare

Providers were also asked about the recommended length of after care services for youth who have experienced human trafficking. The most common response (30%) was that there should be six months of aftercare services or there should be no maximum length of aftercare services. Additionally, the average caseload for an aftercare case manager would be 11 youth who have experienced human trafficking.

Table 212. HT (CPA) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months	No max
HT (CPA)	54	6%	2%	4%	11%	0%	2%	30%	0%	0%	0%	0%	0%	17%	30%

Table 213. HT (CPA) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std Dev
HT (CPA) estimated aftercare caseload	49	1	25	11	6

Service Add-On – Expectant and Parenting Youth (EPY) Support Services – FFC

Brief Description: Services to support youth who are pregnant or parenting in the State's conservatorship or extended foster care. CPA and caregiver will have specialized programming to assist and support the youth parent, to include coordination between community resources and STAR Health/Medicaid. Due to the increased number of pre-natal and post pregnancy appointments for both the parent and the child, there are increased transportation costs inherent for the youth's foster parent. This section examines needs and costs specific to the provision of this service add-on.

Expectant/Parenting Youth – CPA Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the expectant and parenting youth package. Most providers (79%) reported a treatment director is not needed for expectant and parenting youth. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 62% felt a psychiatrist was important, 58% felt a physician was important and 70% felt having a nurse was important when working with expectant and parenting youth. Providers indicated they would like a psychiatrist (74%), physician (86%) and/or nurse (70%). For all these positions, contracted staff was the preference and most reported that psychiatrists (43%), physician (66%), and nurse (81%) should be on call 24/7.

In terms of therapists, 95% providers reported that therapists were important and 95% reported wanting a therapist. The majority of providers (73%) reported that therapists would ideally be contracted and only 58% felt a therapist needed to be on call after hours.

For case managers, the both the minimum and ideal level of education was a bachelor's degree in human services. Providers (92%) noted that additional certifications were not needed for case managers working with expectant and parenting youth. In open-ended questions, CPA providers mentioned case managers working with youth who are pregnant or parenting need the following training, certifications, or qualifications: trauma informed care, parenting skills, CPR, child development, human trafficking, suicide prevention, child abuse, bachelor's degree, and master's degree.

EPY – CPA Treatment Director

Table 214. EPY (CPA) - Should a treatment director be required? (N=67)

	N	%
Yes	14	20.9%
No	53	79.1%

EPY – CPA Psychiatrists

Table 215. EPY (CPA) - How important is it to have a psychiatrist? (N=69)

	N	%
Not important	26	37.7%
Somewhat important	20	29.0%
Very important	22	31.9%
Extremely important	1	1.4%

Table 216. EPY (CPA) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=66)		
Yes	49	74.2%
No	17	25.8%
If yes, would you prefer to contract with them or have them in-house? (N=49)		
Contract	45	91.8%
In-house	4	8.2%

Table 217. EPY (CPA) - Should a psychiatrist be on-call or available 24/7? (N=49)

	N	%
Yes	21	42.9%
No	28	57.1%

EPY – CPA Physicians

Table 218. EPY (CPA) - How important is it to have a physician? (N=64)

	N	%
Not important	27	42.2%
Somewhat important	14	21.9%
Very important	14	21.9%
Extremely important	9	14.1%

Table 219. EPY (CPA) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=64)		
Yes	55	85.9%
No	9	14.1%
If yes, would you prefer to contract with them or have them in-house? (N=55)		
Contract	51	92.7%
In-house	4	7.3%

Table 220. EPY (CPA) - Should a physician on-call or available 24/7? (N=55)

	N	%
Yes	36	65.5%
No	19	34.5%

EPY – CPA Nurses

Table 221. EPY (CPA) - How important is having a nurse? (N=60)

	N	%
Not important	18	30.0%
Somewhat important	14	23.3%
Very important	16	26.7%
Extremely important	12	20.0%

Table 222. EPY (CPA) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=60)		
Yes	42	70.0%
No	18	30.0%
If yes, would you prefer to contract with them or have them in-house? (N=42)		
Contract	35	83.3%
In-house	7	16.7%

Table 223. EPY (CPA) - Should a nurse be on-call or available 24/7? (N=42)

	N	%
Yes	34	81.0%
No	8	19.0%

EPY – CPA Case Management Staff

Table 224. EPY (CPA) - Recommended level of education for case managers

	Minimum level (N=56)		Preferred level (N=55)	
	N	%	N	%
High School Diploma or GED	0	0%	0	0%
Associate's Degree	1	1.4%	2	3.6%
Bachelor's Degree	22	30.1%	12	21.8%
Bachelor's Degree (human service field)	33	45.2%	19	34.5%
Master's Degree	0	0%	5	9.1%
Master's Degree (human service field)	0	0%	17	30.9%

Table 225. EPY (CPA) - Do case managers need any certifications? (N=60)

	N	%
No certifications needed	55	91.7%
Certifications needed	5	8.3%

Expectant/Parenting Youth – CPA Ideal Caseloads and Competitive Salaries

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 12 children. However, the ideal caseload was 8 and the maximum caseload was 12 children. For case managers, the typical caseload was 13 children. The ideal caseload was 12 children and the maximum caseload was 14 children. Providers were also asked how many case managers should be supervised by one supervisor. The mean response was 5.15 case managers for each case supervisor.

For salaries, providers noted that a competitive therapist salary without benefits was $62,818. For case managers, the mean competitive salary without benefits was $44,467.

EPY – CPA Therapist Caseloads

Table 226. EPY (CPA) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	6	1	30	12	10	10	10.93
Ideal caseload	8	0	20	8	8	0*	7.05
Max caseload	8	0	30	12	11	0*	10.79

*Multiple modes exist. The smallest value is shown.

EPY – CPA Therapist Competitive Salary

Table 227. EPY (CPA) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	11	$46,000	$75,000	$62,818	$65,000	$60,000*	$7,960

*Multiple modes exist. The smallest value is shown.

EPY – CPA Case Manager Caseloads

Table 228. EPY (CPA) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	32	1	30	13	14	15	8.75
Ideal caseload	46	1	25	12	12	15	6.75
Max caseload	44	1	30	14	15	20	8.52

EPY – CPA Case Manager Competitive Salary

Table 229. EPY (CPA) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	48	$30,000	$62,400	$44,467	$45,000	$45,000	$7,111

EPY – CPA Therapists

Table 230. EPY (CPA) - How important is having a therapist? (N=62)

	N	%
Not important	3	4.8%
Somewhat important	16	25.8%
Very important	30	48.4%
Extremely important	13	21.0%

Table 231. EPY (CPA) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=62)		
Yes	59	95.2%
No	3	4.8%
If yes, would you prefer to contract with them or have them in-house? (N=59)		
Contract	43	72.9%
In-house	16	27.1%

Table 232. EPY (CPA) - Should a therapist be on-call or available 24/7? (N=59)

	N	%
Yes	34	57.6%
No	25	42.4%

Expectant/Parenting Youth – Foster Family Care Services

Providers were asked about the recommended frequency of therapy for children who have experienced human trafficking. For individual therapy 43% of providers suggested individual therapy should be once per week. Providers (52%) felt family therapy should be once a month. Providers (43%) felt group therapy should be once a month. Providers were also asked about services they would recommend for children who have experienced human trafficking. The following services were noted by 75% or more of the providers: Parenting programs/classes (98%); prenatal and postnatal care (96%); assistance with HS diploma or GED (96%); education and tutoring services (94%); dietician/ nutrition services (93%); healthy relationship programs/classes (93%; parent support groups (93%); psychological testing and evaluation (91%); recreational therapy (89%); assistance with obtaining a driver's license (89%); peer mentoring (82%); and youth support groups (78%).

In open-ended responses, CPA providers additionally mentioned youth who are pregnant or parenting may need transition services (i.e., vocational, job), peer support and postpartum support (including support for postpartum depression). One provider mentioned services need to be child specific and able to combine with other services.

EPY – FFC Therapy

Table 233. EPY (FFC) - Recommended frequency of therapy sessions

		Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
		N	%	%	%	%	%	%	%	%	%	%	%	%
EPY (FFC)	Individual Therapy													
		53	0%	2%	25%	25%	43%	0%	4%	0%	0%	0%	0%	2%
	Family Therapy													
		48	2%	6%	52%	23%	13%	0%	2%	0%	0%	0%	0%	2%
	Group Therapy													
		46	13%	11%	43%	9%	11%	4%	2%	0%	0%	0%	2%	4%

EPY – FFC Needed Services

Table 234. EPY (FFC) - Additional recommended services

	Total N	Service needed N	%
Parenting programs/classes	54	53	98.1%
Prenatal and Postnatal Care	55	53	96.4%
Assistance with HS diploma or GED	54	52	96.3%
Education and tutoring services	54	51	94.4%
Dietician / Nutrition services	55	51	92.7%
Healthy Relationship Programs / Classes	54	50	92.6%
Parent support groups	54	50	92.6%
Psychological testing and evaluation	53	48	90.6%
Recreational therapy	47	42	89.4%
Assistance with obtaining a driver's license	54	48	88.9%
Peer mentoring	54	44	81.5%
Youth support groups	54	42	77.8%
Risk assessments	53	39	73.6%
Crisis Services / Stabilization	53	39	73.6%
Behavior Support Specialist	53	39	73.6%
Art therapy	47	34	72.3%
Legal services	54	39	72.2%
Medical specialists	55	36	65.5%
Animal therapy	47	30	63.8%
Dance / Movement therapy	47	30	63.8%
Nursing - Other	55	30	54.5%
Personal Care Services (PCS)	55	27	49.1%
Equine therapy	47	22	46.8%
Play therapy	47	19	40.4%
Forensic assessments	53	21	39.6%
Physical / Rehabilitation Therapy	53	20	37.7%
Applied Behavior Analysis (ABA)	53	19	35.8%
Occupational Therapy	53	18	34.0%
Speech Therapy	53	17	32.1%
Neurofeedback	53	16	30.2%
Private Duty Nursing (PDN)	55	9	16.4%

Note: Services highlighted in orange were identified by at least 75% of CPAs as needed services

EPY – FFC Maximum Length of Services

Providers were also asked about the recommended maximum length of services for children who have experienced human trafficking. The most common response (47%) was that there should be no maximum services length.

Table 235. EPY (FFC) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
EPY (FFC)	55	2%	0%	0%	2%	9%	2%	22%	11%	5%	47%

Expectant/Parenting Youth – CPA Aftercare

Providers were also asked about the recommended length of services for children who have experienced human trafficking. The most common response (30%) was that there should be six months of aftercare services. Additionally, the average caseload for an aftercare case manager would be 11 children who have experienced human trafficking.

Table 236. EPY (CPA) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months %	No max %
EPY (CPA)	56	7%	2%	4%	13%	0%	2%	30%	0%	0%	4%	0%	0%	25%	14%

Table 237. EPY (CPA) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std Dev
EPY (CPA) Estimated aftercare caseload	50	0	25	11	7

Service Add-On – Substance Use Disorders (SUD) Support Services – FFC

Brief Description: Services to support children, youth, and young adults with substance use disorders. CPA and caregiver will have enhanced programming and training to support youth battling addiction. This section examines needs and costs specific to the provision of this service add-on.

Substance Use Disorders – CPA Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the youth with substance use disorders package. Most providers (71%) reported a treatment director is needed for youth with substance use disorders. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 85% felt a psychiatrist was important, 70% felt a physician was important and 69% felt having a nurse was important when working with youth with substance use disorders. Providers indicated they would like a psychiatrist (96%), physician (86%) and/or nurse (71%). For all these positions, contracted staff was the preference and most reported that psychiatrists (61%), physician (61%), and nurse (64%) should be on call 24/7.

In terms of therapists, 96% providers reported that therapists were important and 100% reported wanting a therapist. The majority of providers (64%) reported that therapists would ideally be contracted and only 67% felt a therapist needed to be on call after hours.

For case managers, the minimum and ideal level of education was a bachelor's degree in human services (50%), but the preferred level of education was a master's degree in human services (45%). Providers (77%) noted that additional certifications were not needed for case managers working with youth with substance use disorders. In open-ended questions, CPA providers mentioned case managers working with youth with substance use disorders may need the following training, certifications, or qualifications: trauma informed care, mental health, SUD specific, CPR, child development, psychotropic med, human trafficking, suicide prevention, child abuse, bachelor's degree, master's degree, and case management certification.

SUD – CPA Treatment Director

Table 238. SUD (CPA) - Should a treatment director be required? (N=56)

	N	%
Yes	40	71.4%
No	16	28.6%

SUD – CPA Psychiatrists

Table 239. SUD (CPA) - How important is it to have a psychiatrist? (N=59)

	N	%
Not important	9	15.3%
Somewhat important	8	13.6%
Very important	26	44.1%
Extremely important	16	27.1%

Table 240. SUD (CPA) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=56)		
Yes	54	96.4%
No	2	3.6%
If yes, would you prefer to contract with them or have them in-house? (N=54)		
Contract	45	83.3%
In-house	9	16.7%

Table 241. SUD (CPA) - Should a psychiatrist be on-call or available 24/7? (N=54)

	N	%
Yes	33	61.1%
No	21	38.9%

SUD – CPA Physicians

Table 242. SUD (CPA) - How important is it to have a physician? (N=54)

	N	%
Not important	16	29.6%
Somewhat important	16	29.6%
Very important	13	24.1%
Extremely important	9	16.7%

Table 243. SUD (CPA) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=55)		
Yes	47	85.5%
No	8	14.5%
If yes, would you prefer to contract with them or have them in-house? (N=47)		
Contract	44	93.6%
In-house	3	6.4%

Table 244. SUD (CPA) - Should a physician be on-call or available 24/7? (N=47)

	N	%
Yes	29	61.7%
No	18	38.3%

SUD – CPA Therapists

Table 245. SUD (CPA) - How important is having a therapist? (N=53)

	N	%
Not important	2	3.8%
Somewhat important	1	1.9%
Very important	23	43.4%
Extremely important	27	50.9%

Table 246. SUD (CPA) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=52)		
Yes	52	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=52)		
Contract	33	63.5%
In-house	19	36.5%

Table 247. SUD (CPA) - Should a therapist be on-call or available 24/7? (N=52)

	N	%
Yes	35	67.3%
No	17	32.7%

SUD – CPA Nurses

Table 248. SUD (CPA) - How important is having a nurse? (N=52)

	N	%
Not important	16	30.8%
Somewhat important	13	25.0%
Very important	14	26.9%
Extremely important	9	17.3%

Table 249. SUD (CPA) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=51)		
Yes	36	70.6%
No	15	29.4%
If yes, would you prefer to contract with them or have them in-house? (N=36)		
Contract	30	83.3%
In-house	6	16.7%

Table 250. SUD (CPA) - Should a nurse be on-call or available 24/7? (N=36)

	N	%
Yes	23	63.9%
No	13	36.1%

SUD – CPA Case Management Staff

Table 251. SUD (CPA) - Recommended level of education for case managers

	Minimum level (N=49)		Preferred level (N=47)	
	N	%	N	%
High School Diploma or GED	0	0.0%	0	0.0%
Associate's Degree	0	0.0%	1	2.1%
Bachelor's Degree	17	27.4%	6	12.8%
Bachelor's Degree (human service field)	31	50.0%	17	36.2%
Master's Degree	0	0.0%	2	4.3%
Master's Degree (human service field)	1	1.6%	21	44.7%

Table 252. SUD (CPA) - Do case managers need any certifications? (N=51)

	N	%
No certifications needed	39	76.5%
Certifications needed	12	23.5%

Substance Use Disorders – CPA Ideal Caseloads and Competitive Salaries

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 12 children. However, the ideal caseload was 8 and the maximum caseload was 12 children. For case managers, the typical caseload was 14 children. The ideal caseload was 12 children and the maximum caseload was 15 children. Providers were also asked how many case managers should be supervised by one supervisor. The mean response was 5.15 case managers for each case supervisor.

For salaries, providers noted that a competitive therapist salary without benefits was $64,444. For case managers, the mean competitive salary without benefits was $46,536.

SUD – CPA Therapist Caseloads

Table 253. SUD (CPA) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	6	2	20	12	13	20	7.62
Ideal caseload	8	0	15	8	9	15	5.85
Max caseload	8	0	25	12	13	0*	8.93

*Multiple modes exist. The smallest value is shown

SUD – CPA Therapist Competitive Salary

Table 254. SUD (CPA) - Competitive salary without benefits for an in-house therapist

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	9	$55,000	$75,000	$64,444	$65,000	$60,000	$6,346

SUD – CPA Case Manager Caseloads

Table 255. SUD (CPA) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	27	1	30	14	15	15	8.44
Ideal caseload	39	1	25	12	12	10	6.70
Max caseload	38	1	30	15	15	15*	8.25

*Multiple modes exist. The smallest value is shown

SUD – CPA Case Manager Competitive Salary

Table 256. SUD (CPA) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	39	$35,000	$62,400	$46,536	$45,000	$50,000	$7,077

Substance Use Disorders – Foster Family Care Services

Providers were asked about the recommended frequency of therapy for children who have experienced human trafficking. For individual therapy 60% of providers suggested individual therapy should be once per week. Providers (39%) felt family therapy should be once a month. Providers (30%) felt group therapy should be once a month or once a week. Providers were also asked about services they would recommend for youth with substance use disorders. The following services were noted by 75% or more of the providers: psychological testing and evaluation (96%); recreational therapy (96%); education and tutoring services (92%); peer mentoring (92%); crisis services/stabilization (88%); behavior support specialist (88%); assistance with HS diploma or GED (88%); healthy relationship programs/classes (85%); youth support groups (85%); risk assessments (78%); assistance with obtaining a driver's license (77%); art therapy (76%); and legal services (75%).

In open-ended responses, CPA providers additionally mentioned youth with substance use disorders may need support for their parents, support for normalcy to divert from substance use. One provider said services need to be child specific and able to combine with other services. Another said:

> *'... provide money for these children to join NORMAL activities which are costly that NORMAL children experience. Support the foster parents and agencies to provide wholesome recreational experiences for these children. (Average cost of baseball, soccer, dance lessons, etc. in the community is high.) ..." _CPA Provider*

SUD – FFC Therapy

Table 257. SUD (FFC) - Recommended frequency of therapy sessions

		Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
		N	%	%	%	%	%	%	%	%	%	%	%	%
SUD (FFC)	Individual Therapy													
		45	0%	0%	4%	11%	60%	16%	2%	2%	0%	0%	2%	2%
	Family Therapy													
		41	2%	0%	39%	20%	34%	0%	0%	2%	0%	0%	0%	2%
	Group Therapy													
		40	8%	0%	30%	15%	30%	13%	0%	0%	3%	0%	0%	3%

SUD – FCC Needed Services

Table 258. SUD (FFC) - Additional recommended services

	Total N	Service needed N	%
Psychological testing and evaluation	49	47	95.9%
Recreational therapy	46	44	95.7%
Education and tutoring services	48	44	91.7%
Peer mentoring	48	44	91.7%
Crisis Services / Stabilization	49	43	87.8%
Behavior Support Specialist	49	43	87.8%
Assistance with HS diploma or GED	48	42	87.5%
Healthy Relationship Programs / Classes	48	41	85.4%
Youth support groups	48	41	85.4%
Risk assessments	49	38	77.6%
Assistance with obtaining a driver's license	48	37	77.1%
Art therapy	46	35	76.1%
Legal services	48	36	75.0%
Dietician / Nutrition services	42	29	69.0%
Medical specialists	42	29	69.0%
Equine therapy	46	28	60.9%
Dance / Movement therapy	46	27	58.7%
Animal therapy	46	26	56.5%
Parent support groups	48	27	56.3%
Personal Care Services (PCS)	42	23	54.8%
Parenting programs/classes	48	26	54.2%
Applied Behavior Analysis (ABA)	49	21	42.9%
Forensic assessments	49	19	38.8%
Play therapy	46	17	37.0%
Physical / Rehabilitation Therapy	49	18	36.7%
Neurofeedback	49	17	34.7%
Nursing - Other	42	14	33.3%
Occupational Therapy	49	14	28.6%
Speech Therapy	49	13	26.5%
Prenatal and Postnatal Care	42	11	26.2%
Private Duty Nursing (PDN)	42	7	16.7%

Note: Services highlighted in orange were identified by at least 75% of CPAs as needed services

SUD – FFC Maximum Length of Services

Providers were also asked about the recommended maximum length of services for youth with substance use disorders. The most common response (49%) was that there should be no maximum service length.

Table 259. SUD (FFC) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
SUD (FFC)	47	2%	2%	0%	2%	11%	2%	19%	0%	13%	49%

Substance Use Disorders – CPA Aftercare

Providers were also asked about the recommended length of services for youth with substance use disorders. The most common response (27%) was that there should be 12 months or more of aftercare services. Additionally, the average caseload for an aftercare case manager would be 11 youth with substance use disorders.

Table 260. SUD (CPA) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months	No max
SUD (CPA)	49	6%	4%	2%	14%	2%	2%	20%	0%	0%	0%	0%	0%	27%	22%

Table 261. SUD (CPA) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std Dev
SUD (CPA) estimated aftercare caseload	44	0	25	11	7

Primary Setting – Sexual Aggression/Sex Offender Adjudication (SA/SO) Support Services – FFC Service Package

Brief Description: Services to support children, youth, and young adults who have been identified as sexually aggressive and/ who have been adjudicated a sex offender. The CPA will have a robust treatment model and specific programming designed to meet the unique needs of this population, and caregivers will have training specific to support the rehabilitation needs of the child or youth. This section examines needs and costs specific to the provision of this service package.

Sexual Aggression/Sex Offender Adjudication – CPA Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the youth with histories of sexual aggression package. Most providers (67%) reported a treatment director is needed for youth with histories of sexual aggression. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 78% felt a psychiatrist was important, 55% felt a physician was important and 55% felt having a nurse was important when working with youth with histories of sexual aggression. Providers indicated they would like a psychiatrist (90%), physician (66%) and/or nurse (57%). For all these positions, contracted staff was the preference and most reported that psychiatrists (77%), physician (48%), and nurse (58%) should be on call 24/7.

In terms of therapists, 96% providers reported that therapists were important and 100% reported wanting a therapist. The majority of providers (73%) reported that therapists would ideally be contracted and only 73% felt a therapist needed to be on call after hours.

For case managers, the minimum level of education was a bachelor's degree in human services (43%), but the preferred level of education was a master's degree in human services (47%). Providers (81%) noted that additional certifications were needed for case managers working with youth with histories of sexual aggression. In open-ended questions, CPA providers mentioned case managers working with youth with sexual aggression or who have been adjudicated as sex offenders may need the following training, certifications, or qualifications: sexual aggression/disorders specific training, trauma informed care, certified case manager, bachelor's degree, master's degree, and mental health.

SA/SO – CPA Treatment Director

Table 262. SA/SO (CPA) - Should a treatment director be required? (N=48)

	N	%
Yes	32	66.7%
No	16	33.3%

SA/SO – CPA Psychiatrists

Table 263. SA/SO (CPA) - How important is to have a psychiatrist? (N=51)

	N	%
Not important	11	21.6%
Somewhat important	7	13.7%
Very important	15	29.4%
Extremely important	18	35.3%

Table 264. SA/SO (CPA) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=48)		
Yes	43	89.6%
No	5	10.4%
If yes, would you prefer to contract with them or have them in-house? (N=43)		
Contract	35	81.4%
In-house	8	18.6%

Table 265. SA/SO (CPA) - Should a psychiatrist be on-call or available 24/7? (N=43)

	N	%
Yes	33	76.7%
No	10	23.3%

SA/SO – CPA Physicians

Table 266. SA/SO (CPA) - How important is it to have a physician? (N=47)

	N	%
Not important	21	44.7%
Somewhat important	13	27.7%
Very important	4	8.5%
Extremely important	9	19.1%

Table 267. SA/SO (CPA) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=47)		
Yes	31	66.0%
No	16	34.0%
If yes, would you prefer to contract with them or have them in-house? (N=31)		
Contract	30	96.8%
In-house	1	3.2%

Table 268. SA/SO (CPA) - Should a physician be on-call or available 24/7? (N=47)

	N	%
Yes	15	48.4%
No	16	51.6%

SA/SO – CPA Therapists

Table 269. SA/SO (CPA) - How important is having a therapist? (N=45)

	N	%
Not important	2	4.4%
Somewhat important	1	2.2%
Very important	13	28.9%
Extremely important	29	64.4%

Table 270. SA/SO (CPA) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=45)		
Yes	45	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=45)		
Contract	33	73.3%
In-house	12	26.7%

Table 271. SA/SO (CPA) - Should a therapist be on-call or available 24/7? (N=45)

	N	%
Yes	33	73.3%
No	12	26.7%

SA/SO – CPA Nurses

Table 272. SA/SO (CPA) - How important is having a nurse? (N=42)

	N	%
Not important	19	45.2%
Somewhat important	9	21.4%
Very important	6	14.3%
Extremely important	8	19.0%

Table 273. SA/SO (CPA) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=42)		
Yes	24	57.1%
No	18	42.9%
If yes, would you prefer to contract with them or have them in-house? (N=24)		
Contract	19	79.2%
In-house	5	20.8%

Table 274. SA/SO (CPA) - Should a nurse be on-call or available 24/7? (N=24)

	N	%
Yes	14	58.3%
No	10	41.7%

SA/SO – CPA Case Management Staff

Table 275. SA/SO (CPA) - Recommended level of education

	Minimum (N=40)		Preferred (N=38)	
	N	%	N	%
High School Diploma or GED	0	0.0%	0	0.0%
Associate's Degree	0	0.0%	1	2.6%
Bachelor's Degree	16	29.6%	6	15.8%
Bachelor's Degree (human service field)	23	42.6%	9	23.7%
Master's Degree	0	0.0%	4	10.5%
Master's Degree (human service field)	1	1.9%	18	47.4%

Table 276. SA/SO (CPA) - Do case managers need any certifications? (N=42)

	N	%
No certifications needed	34	81.0%
Certifications needed	8	19.0%

Sexual Aggression/Sex Offender Adjudication – CPA Ideal Caseloads and Competitive Salaries

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 7 children. The ideal caseload was 7 and the maximum caseload was 10 children. For case managers, the typical caseload was 12 children. The ideal caseload was 11 children and the maximum caseload was 13 children. Providers were also asked how many case managers should be supervised by one supervisor. The mean response was 5.15 case managers for each case supervisor.

For salaries, providers noted that a competitive therapist salary without benefits was $67,500. For case managers, the mean competitive salary without benefits was $47,981.

SA/SO – CPA Therapist Caseloads

Table 277. SA/SO (CPA) -Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	4	3	10	7	7	3*	4.04
Ideal caseload	6	1	15	7	8	1*	5.10
Max caseload	6	1	20	10	11	12	6.89

*Multiple modes exist. The smallest mode is shown.

SA/SO – CPA Therapist Competitive Salary

Table 278. SA/SO (CPA) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	6	$60,000	$75,000	$67,500	$67,500	$65,000*	$5,244

*Multiple modes exist. The smallest mode is shown.

SA/SO – CPA Case Manager Caseloads

Table 279. SA/SO (CPA) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	17	1	25	12	12	15	7.66
Ideal caseload	23	1	25	11	12	15	5.97
Max caseload	21	1	30	13	12	12	7.96

SA/SO – CPA Competitive Salary

Table 280. SA/SO (CPA) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	32	$35,000	$62,400	$47,981	$50,000	$50,000	$7,279

Sexual Aggression/Sex Offender Adjudication – Foster Family Care Services

Providers were asked about the recommended frequency of therapy for children who have histories of sexual aggression. For individual therapy 61% of providers suggested individual therapy should be once per week. Providers (32%) felt family therapy should be twice a month. Providers (43%) felt group therapy should be twice a month. Providers were also asked about services they would recommend for youth with histories of sexual aggression. The following services were noted by 75% or more of the providers: psychological testing and evaluation (95%); healthy relationship programs / classes (95%); risk assessments (90%); education and tutoring services (90%); recreational therapy (87%); crisis Services/stabilization (85%); behavior support specialist (85%); assistance with HS diploma or GED (85%); youth support groups (85%); forensic assessments (83%); peer mentoring (78%); and personal care services (75%).

In open-ended responses, CPA providers additionally mentioned youth with sexual aggression or who have been adjudicated as sex offenders may need support for their parents such as a family support specialist (to help with transportation, tutoring, other

family services), therapy specific to sexual behavior issues (even for younger kids, one provider mentioned some services only start at age 10). One provider said services should be child specific and able to combine with other services.

SA/SO – FFC Therapy

Table 281. SA/SO (FFC) - Recommended frequency of therapy sessions

	N Total	None %	1x every other month %	1x per month %	2x per month %	1x per week %	2x per week %	3x per week %	4x per week %	5x per week %	6x per week %	Daily %	Prefer not to say %
SA/SO (FFC)	Individual Therapy												
	38	0%	0%	8%	5%	61%	16%	5%	3%	0%	0%	3%	0%
	Family Therapy												
	34	3%	3%	29%	32%	26%	6%	0%	0%	0%	0%	0%	0%
	Group Therapy												
	34	15%	3%	18%	26%	24%	9%	3%	0%	0%	0%	3%	0%

SA/SO – FFC Needed Services

Table 282. SA/SO (FFC) - Additional recommended services

	Total N	Services needed N	%
Psychological testing and evaluation	41	39	95.1%
Healthy Relationship Programs / Classes	41	39	95.1%
Risk assessments	41	37	90.2%
Education and tutoring services	41	37	90.2%
Recreational therapy	38	33	86.8%
Crisis Services / Stabilization	41	35	85.4%
Behavior Support Specialist	41	35	85.4%
Assistance with HS diploma or GED	41	35	85.4%
Youth support groups	41	35	85.4%
Forensic assessments	41	34	82.9%
Peer mentoring	41	32	78.0%
Personal Care Services (PCS)	28	21	75.0%
Play therapy	38	28	73.7%
Legal services	41	30	73.2%
Art therapy	38	27	71.1%
Assistance with obtaining a driver's license	41	29	70.7%
Dance / Movement therapy	38	24	63.2%
Medical specialists	28	16	57.1%
Animal therapy	38	21	55.3%
Equine therapy	38	21	55.3%
Dietician / Nutrition services	28	15	53.6%
Applied Behavior Analysis (ABA)	41	21	51.2%
Parent support groups	41	20	48.8%
Parenting programs/classes	41	19	46.3%
Neurofeedback	41	16	39.0%
Physical / Rehabilitation Therapy	41	15	36.6%
Prenatal and Postnatal Care	28	10	35.7%
Nursing - Other	28	9	32.1%
Speech Therapy	41	13	31.7%
Occupational Therapy	41	13	31.7%
Private Duty Nursing (PDN)	28	6	21.4%

Note: Services highlighted in orange were identified by at least 75% of CPAs as needed services

SA/SO – FFC Maximum Length of Services

Providers were also asked about the recommended maximum length of services for youth with histories of sexual aggression. The most common response (54%) was that there should be no maximum service length.

Table 283. SA/SO (FFC) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
SA/SO (FFC)	39	5%	0%	0%	0%	13%	3%	10%	5%	10%	54%

Sexual Aggression/Sex Offender Adjudication – CPA Aftercare

Providers were also asked about the recommended length of aftercare for youth with histories of sexual aggression. The most common response (22%) was that aftercare service should six months. Additionally, the average caseload for an aftercare case manager would be 11 youth with histories of sexual aggression.

Table 284. SA/SO (CPA) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months %	No max %
SA/SO (CPA)	41	10%	2%	5%	15%	0%	0%	22%	0%	0%	0%	0%	0%	20%	27%

Table 285. SA/SO (CPA) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std Dev
SA/SO (CPA) estimated aftercare caseload	34	0	30	11	7

Primary Setting – Mental and Behavioral Health (MBH) Support Services – FFC Service Package

Brief Description: Services to children, youth, and young adults who have a DSM-5 diagnosis and for whom routine clinical intervention is needed to support day-to-day activities. CPA and caregiver must be trained in and incorporate an evidence-informed treatment model into the intervention used with the child. This section examines needs and costs specific to the provision of this service package.

Mental and Behavioral Health – CPA Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the youth with complex mental health needs package. Most providers (70%) reported a treatment director is needed for youth with complex mental health needs. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 84% felt a psychiatrist was important, 58% felt a physician was important and 61% felt having a nurse was important when working with youth with complex mental health needs. Providers indicated they would like a psychiatrist (96%), physician (75%) and/or nurse (59%). For all these positions, contracted staff was the preference and most reported that psychiatrists (75%), physician (56%), and nurse (54%) should be on call 24/7.

In terms of therapists, 96% providers reported that therapists were important and 100% reported wanting a therapist. The majority of providers (69%) reported that therapists would ideally be contracted and only 72% felt a therapist needed to be on call after hours.

For case managers, the minimum level of education was a bachelor's degree in human services (47%), but the preferred level of education was a master's degree in human services (53%). Providers (81%) noted that no additional certifications were needed for case managers working with youth with complex mental health needs. In open-ended questions, CPA providers mentioned case managers working with youth with a DSM – 5 diagnosis or complex mental health needs may need the following training, certifications, or qualifications: trauma informed care, mental health (including Mental Health First Aid), case management certification, bachelor's degree, and master's degree.

MBH – CPA Treatment Director

Table 286. MBH (CPA) - Should a treatment director be required? (N=70)

	N	%
Yes	49	70.0%
No	21	30.0%

MBH – CPA Psychiatrists

Table 287. MBH (CPA) - How important is to have a psychiatrist? (N=73)

	N	%
Not important	12	16.4%
Somewhat important	6	8.2%
Very important	24	32.9%
Extremely important	31	42.5%

Table 288. MBH (CPA) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=70)		
Yes	67	95.7%
No	3	4.3%
If yes, would you prefer to contract with them or have them in-house? (N=67)		
Contract	52	77.6%
In-house	15	22.4%

Table 289. MBH (CPA) - Should a psychiatrist be on-call or available 24/7? (N=67)

	N	%
Yes	50	74.6%
No	17	25.4%

MBH – CPA Physicians

Table 290. MBH (CPA) - How important is it to have a physician? (N=69)

	N	%
Not important	29	42.0%
Somewhat important	16	23.2%
Very important	16	23.2%
Extremely important	8	11.6%

Table 291. MBH (CPA) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=69)		
Yes	52	75.4%
No	17	24.6%
If yes, would you prefer to contract with them or have them in-house? (N=52)		
Contract	51	98.1%
In-house	1	1.9%

Table 292. MBH (CPA) - Should a physician be on-call or available 24/7? (N=52)

	N	%
Yes	29	55.8%
No	23	44.2%

MBH – CPA Therapists

Table 293. MBH (CPA) - How important is having a therapist? (N=68)

	N	%
Not important	3	4.4%
Somewhat important	3	4.4%
Very important	24	35.3%
Extremely important	38	55.9%

Table 294. MBH (CPA) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=67)		
Yes	67	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=67)		
Contract	46	68.7%
In-house	21	31.3%

Table 295. MBH (CPA) - Should a therapist be on-call or available 24/7? (N=67)

	N	%
Yes	48	71.6%
No	19	28.4%

MBH – CPA Nurses

Table 296. MBH (CPA) - How important is having a nurse? (N=65)

	N	%
Not important	25	38.5%
Somewhat important	20	30.8%
Very important	11	16.9%
Extremely important	9	13.8%

Table 297. MBH (CPA) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=63)		
Yes	37	58.7%
No	26	41.3%
If yes, would you prefer to contract with them or have them in-house? (N=37)		
Contract	29	78.4%
In-house	8	21.6%

Table 298. MBH (CPA) - Should a nurse be on-call or available 24/7? (N=37)

	N	%
Yes	20	54.1%
No	17	45.9%

MBH – CPA Case Management Staff

Table 299. MBH (CPA) - Recommended level of education for case managers

	Minimum (N=62)		Preferred (N=59)	
	N	%	N	%
High School Diploma or GED	0	0.0%	0	0.0%
Associate's Degree	0	0.0%	1	1.7%
Bachelor's Degree	23	29.9%	7	11.9%
Bachelor's Degree (human services field)	36	46.8%	16	27.1%
Master's Degree	0	0.0%	4	6.8%
Master's Degree (human services field)	3	3.9%	31	52.5%

Table 300. MBH (CPA) - Do case managers need any certifications? (N=64)

	N	%
No certifications needed	52	81.3%
Certifications needed	12	18.8%

Mental and Behavioral Health – CPA Ideal Caseloads and Competitive Salaries

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 13 children. The ideal caseload was 11 and the maximum caseload was 14 children. For case managers, the typical caseload was 14 children. The ideal caseload was 12 children and the maximum caseload was 15 children. Providers were also asked how many case managers should be supervised by one supervisor. The mean response was 5.15 case managers for each case supervisor.

For salaries, providers noted that a competitive therapist salary without benefits was $63,727. For case managers, the mean competitive salary without benefits was $46,835.

MBH – CPA Therapist Caseloads

Table 301. MBH (CPA) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	7	5	35	13	10	10	10.35
Ideal caseload	9	1	23	11	12	12	6.44
Max caseload	9	3	28	14	14	14*	7.83

*Multiple modes exist. The smallest mode is shown.

MBH – CPA Therapist Competitive Salary

Table 302. MBH (CPA) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	11	$46,000	$75,000	$63,727	$65,000	$65,000*	$8,174

*Multiple modes exist. The smallest mode is shown.

MBH – CPA Case Manager Caseloads

Table 303. MBH (CPA) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	39	3	30	14	15	15	6.86
Ideal caseload	54	1	25	12	12	15	5.82
Max caseload	53	2	30	15	15	20	7.70

MBH – CPA Case Manager Competitive Salary

Table 304. MBH (CPA) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	49	$30,000	$70,000	$46,835	$45,000	$50,000	$8,269

Mental and Behavioral Health – Foster Family Care Services

Providers were asked about the recommended frequency of therapy for children who have complex mental health needs. For individual therapy 62% of providers suggested individual therapy should be once per week. Providers (40%) felt family therapy should be twice a month. Providers (33%) felt group therapy should be twice a month or once a week. Providers were also asked about services they would recommend for children who have complex mental health needs. The following services were noted by 75% or more of the providers: Psychological testing and evaluation (100%); education and tutoring services (100%); recreational therapy (93%); crisis services/stabilization (92%); risk assessments (89%); behavior support specialist (89%); assistance with HS diploma or GED (86%); art therapy (84%); play therapy (84%); healthy relationship programs/classes (83%); youth support groups (81%); peer mentoring (81%); animal therapy (80%); equine therapy (80%); dietician/nutrition services (77%); dance/movement therapy (77%); and medical specialists (75%).

In open-ended responses, CPA providers additionally mentioned youth with a DSM – 5 diagnosis or complex mental health needs may need family support specialists (to help with some of the burden of transportation, tutoring, etc.), vocational or job support, realistic service plans, frequent mental health assessments, foster parents experienced with complex mental health needs, low child-to-caregiver ratio in home, and crisis support (including rural). One provider said services need to be child specific and able to combine with other services.

MBH – FFC Therapy

Table 305. MBH (FFC) - Recommended frequency of therapy sessions

		Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
		N	%	%	%	%	%	%	%	%	%	%	%	%
MBH (FFC)	Individual Therapy													
		58	0%	0%	2%	7%	62%	17%	2%	2%	0%	0%	9%	0%
	Family Therapy													
		53	0%	4%	26%	40%	21%	8%	0%	2%	0%	0%	0%	0%
	Group Therapy													
		52	12%	6%	33%	17%	21%	8%	0%	2%	0%	0%	0%	2%

MBH – FFC Needed Services

Table 306.MBH (FFC) - Additional recommended services

	Total N	Services needed N	%
Psychological testing and evaluation	62	62	100.0%
Education and tutoring services	59	59	100.0%
Recreational therapy	61	57	93.4%
Crisis Services / Stabilization	62	57	91.9%
Risk assessments	62	55	88.7%
Behavior Support Specialist	62	55	88.7%
Assistance with HS diploma or GED	59	51	86.4%
Art therapy	61	51	83.6%
Play therapy	61	51	83.6%
Healthy Relationship Programs / Classes	59	49	83.1%
Youth support groups	59	48	81.4%
Peer mentoring	59	48	81.4%
Animal therapy	61	49	80.3%
Equine therapy	61	49	80.3%
Dietician / Nutrition services	44	34	77.3%
Dance / Movement therapy	61	47	77.0%
Medical specialists	44	33	75.0%
Assistance with obtaining a driver's license	59	44	74.6%
Speech Therapy	62	40	64.5%
Occupational Therapy	62	40	64.5%
Personal Care Services (PCS)	44	28	63.6%
Physical / Rehabilitation Therapy	62	38	61.3%
Applied Behavior Analysis (ABA)	62	37	59.7%
Parent support groups	59	35	59.3%
Legal services	59	35	59.3%
Neurofeedback	62	36	58.1%
Parenting programs/classes	59	33	55.9%
Forensic assessments	62	27	43.5%
Nursing - Other	44	18	40.9%
Prenatal and Postnatal Care	44	13	29.5%
Private Duty Nursing (PDN)	44	10	22.7%

Note: Services highlighted in orange were identified by at least 75% of CPAs as needed services

MBH – FFC Maximum Length of Services

Providers were also asked about the recommended maximum length of services for youth with complex mental health needs. The most common response (52%) was that there should be no maximum service length.

Table 307. MBH (FFC) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
MBH (FFC)	60	2%	2%	0%	2%	10%	2%	13%	2%	17%	52%

Mental and Behavioral Health – CPA Aftercare

Providers were also asked about the recommended length of services for youth with complex mental health needs. The most common response (31%) was that aftercare service should be for six months. Additionally, the average caseload for an aftercare case manager would be 12 youth with complex mental health needs.

Table 308. MBH (CPA) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months	No max
MBH (CPA)	61	10%	3%	2%	12%	2%	0%	31%	0%	0%	0%	0%	0%	21%	20%

Table 309. MBH (CPA) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std Dev
MBH (CPA) estimated aftercare caseload	52	1	30	12	7

Service Add-On – Transition Support Services for Youth and Young Adults (14+ Years) – FFC

Brief Description:

Services to support youth and young adults between the ages of 14-22 as they begin to transition into adulthood. CPA and caregiver specialize in providing additional training and support to assist with experiential learning which may include basic daily living skills, cooking, shopping, obtaining a state ID card, obtaining a driver's license, managing finances, obtaining employment, and supporting youth's goals. Findings from this survey relevant to the needs and costs associated with the provision of services to youth in this age group are examined below.

Transition Support (14+ Years) – CPA Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the youth ages 14 and older package ad-on. Most providers (76%) reported a treatment director is not needed for youth ages 14 and older. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 71% felt a psychiatrist was important, 51% felt a physician was important and 39% felt having a nurse was important when working with youth ages 14 and older. Providers indicated they would like a psychiatrist (80%), physician (68%) and/or nurse (45%). For all these positions, contracted staff was the preference and most reported that psychiatrists (52%), physician (37%), and nurse (49%) should be on call 24/7.

In terms of therapists, 93% providers reported that therapists were important and 97% reported wanting a therapist. The majority of providers (72%) reported that therapists would ideally be contracted and only 49% felt a therapist needed to be on call after hours.

For case managers, providers (91%) noted that no additional certifications were needed for case managers working with youth ages 14 and older. In open-ended questions, CPA providers mentioned case managers working with youth 14 and older may need the following training, certifications, or qualifications: trauma informed care, mental health, child development, psychotropic med, human trafficking, suicide prevention, child abuse, certified case manager, adolescent training, bachelor's degree, and master's degree.

14+ Years – CPA Treatment Director

Table 310. 14+ years (CPA) - Should a treatment director be required? (N=80)

	N	%
Yes	18	22.5%
No	62	77.5%

14+ Years – CPA Psychiatrists

Table 311. 14+ years (CPA) - How important is to have a psychiatrist? (N=84)

	N	%
Not important	24	28.6%
Somewhat important	30	35.7%
Very important	24	28.6%
Extremely important	6	7.1%

Table 312. 14+ years (CPA) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=81)		
Yes	65	80.2%
No	16	19.8%
If yes, would you prefer to contract with them or have them in-house? (N=65)		
Contract	58	89.2%
In-house	7	10.8%

Table 313. 14+ years (CPA) - Should a psychiatrist be on-call or available 24/7? (N=65)

	N	%
Yes	34	52.3%
No	31	47.7%

14+ Years – CPA Physicians

Table 314. 14+ years (CPA) - How important is it to have a physician? (N=78)

	N	%
Not important	38	48.7%
Somewhat important	23	29.5%
Very important	13	16.7%
Extremely important	4	5.1%

Table 315. 14+ years (CPA) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=79)		
Yes	54	68.4%
No	25	31.6%
If yes, would you prefer to contract with them or have them in-house? (N=54)		
Contract	53	98.1%
In-house	1	1.9%

Table 316. 14+ years (CPA) - Should a physician be on-call or available 24/7? (N=54)

	N	%
Yes	20	37.0%
No	34	63.0%

14+ Years – CPA Therapists

Table 317. 14+ years (CPA) - How important is having a therapist? (N=77)

	N	%
Not important	5	6.5%
Somewhat important	23	29.9%
Very important	29	37.7%
Extremely important	20	26.0%

Table 318. 14+ years (CPA) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=77)		
Yes	75	97.4%
No	2	2.6%
If yes, would you prefer to contract with them or have them in-house? (N=75)		
Contract	54	72.0%
In-house	21	28.0%

Table 319. 14+ years (CPA) - Should a therapist be on-call or available 24/7? (N=75)

	N	%
Yes	37	49.3%
No	38	50.7%

14+ Years – CPA Nurses

Table 320. 14+ years (CPA) - How important is having a nurse?

	N	%
Not important	45	60.8%
Somewhat important	17	23.0%
Very important	5	6.8%
Extremely important	7	9.5%

Table 321. 14+ years (CPA) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=74)		
Yes	33	44.6%
No	41	55.4%
If yes, would you prefer to contract with them or have them in-house? (N=33)		
Contract	29	87.9%
In-house	4	12.1%

Table 322. 14+ years (CPA) - Should a nurse be on-call or available 24/7? (N=33)

	N	%
Yes	16	48.5%
No	17	51.5%

14+ Years – CPA Case Management Staff

Table 323. 14+ years (CPA) - Do case managers need any certifications (N=74)

	N	%
No certifications needed	67	90.5%
Certifications needed	7	9.5%

Transition Support (14+ Years) – CPA Ideal Caseloads and Competitive Salaries

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 12 children. The ideal caseload was 11 and the maximum caseload was 14 children. For case managers, the typical caseload was 15 children. The ideal caseload was 14 children and the maximum caseload was 17 children. Providers were

also asked how many case managers should be supervised by one supervisor. The mean response was 5.15 case managers for each case supervisor.

For salaries, providers noted that a competitive therapist salary without benefits was $63,417. For case managers, the mean competitive salary without benefits was $44,449.

14+ Years – CPA Therapist Caseloads

Table 324. 14+ years (CPA) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	7	3	30	12	10	10	9.67
Ideal caseload	8	2	25	11	10	2*	7.48
Max caseload	8	3	30	14	13	3*	9.55

*Multiple modes exist. The smallest mode is shown.

14+ Years – CPA Therapist Competitive Salary

Table 325. 14+ years (CPA) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	12	$46,000	$75,000	$63,417	$65,000	$60,000*	$7,868

*Multiple modes exist. The smallest mode is shown.

14+ Years – CPA Case Manager Caseloads

Table 326. 14+ years (CPA) - Typical, ideal and maximum caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	52	1	30	15	15	15	7.16
Ideal caseload	64	1	30	14	15	15	6.29
Max caseload	63	3	35	17	17	15*	7.46

*Multiple modes exist. The smallest mode is shown.

14+ Years – CPA Case Manager Competitive Salary

Table 327. 14+ years (CPA) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	57	$30,000	$60,000	$44,449	$45,000	$45,000	$7,203

Transition Support (14+ Years) – Foster Family Care Services

Providers were asked about the recommended frequency of therapy for children ages 14 and older. For individual therapy 40% of providers suggested individual therapy should be once per week. Providers (35%) felt family therapy should be once a week. Providers (28%) felt group therapy should be once a month. Providers were also asked about services they would recommend for children ages 14 and older. The following services were noted by 75% or more of the providers: education and tutoring services (97%); assistance with obtaining a driver's license (94%); youth support groups (94%); psychological testing and evaluation (93%); assistance with HS diploma or GED (93%); healthy relationship programs/classes (93%); recreational therapy (88%); peer mentoring (82%); crisis services/stabilization (81%); behavior support specialist (81%); art therapy (75%); animal therapy (73%); risk assessments (73%); and dance/movement therapy (72%).

In open-ended responses, CPA providers additionally mentioned youth ages 14 and older may need family support specialists (to help with transportation, tutoring, etc.) and job support. One provider said services need to be child specific and able to combine with other services.

14+ Years – FFC Therapy

Table 328. 14+ years (FFC) - Recommended frequency of therapy sessions

	N Total	None %	1x every other month %	1x per month %	2x per month %	1x per week %	2x per week %	3x per week %	4x per week %	5x per week %	6x per week %	Daily %	Prefer not to say %
14+ years (FFC)	Individual Therapy												
	52	0%	0%	6%	12%	40%	25%	10%	2%	0%	0%	6%	0%
	Family Therapy												
	48	0%	2%	27%	27%	35%	4%	4%	0%	0%	0%	0%	0%
	Group Therapy												
	47	11%	4%	28%	15%	23%	15%	0%	0%	0%	0%	2%	2%

14+ Years – FFC Needed Services

Table 329. 14+ years (FFC) - Additional recommended services

	Total N	Service needed N	%
Education and tutoring services	67	65	97.0%
Assistance with obtaining a driver's license	67	63	94.0%
Youth support groups	67	63	94.0%
Psychological testing and evaluation	63	62	92.5%
Assistance with HS diploma or GED	67	62	92.5%
Healthy Relationship Programs / Classes	67	62	92.5%
Recreational therapy	61	59	88.1%
Peer mentoring	67	55	82.1%
Crisis Services / Stabilization	63	54	80.6%
Behavior Support Specialist	63	54	80.6%
Art therapy	61	50	74.6%
Animal therapy	61	49	73.1%
Risk assessments	63	49	73.1%
Dance / Movement therapy	61	48	71.6%
Equine therapy	61	42	62.7%
Legal services	67	40	59.7%
Parent support groups	67	38	56.7%
Parenting programs/classes	67	37	55.2%
Dietician / Nutrition services	47	34	50.7%
Play therapy	61	30	44.8%
Forensic assessments	63	30	44.8%
Applied Behavior Analysis (ABA)	63	30	44.8%
Personal Care Services (PCS)	47	29	43.3%
Medical specialists	47	27	40.3%
Speech Therapy	63	24	35.8%
Occupational Therapy	63	24	35.8%
Physical / Rehabilitation Therapy	63	23	34.3%
Neurofeedback	63	21	31.3%
Prenatal and Postnatal Care	47	15	22.4%
Nursing - Other	47	10	14.9%
Private Duty Nursing (PDN)	47	8	11.9%
Personal Care Services (PCS)	47	29	43.3%

Note: Services highlighted in orange were identified by at least 75% of CPAs as needed services

14+ Years – FFC Maximum Length of Services

Providers were also asked about the recommended maximum length of services for youth ages 14 and older. The most common response (46%) was that there should be no maximum services.

Table 330. 14+ years (FFC) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
14+ years (FFC)	55	4%	0%	0%	2%	9%	2%	15%	13%	11%	46%

Primary Setting – Treatment Foster Family Care (TFFC) – FFC Service Package[1]

Brief Description: Treatment Foster Family Care Services are designed to be time-limited and adhere to the model codified in the Texas Family Code. Examples include services to children with severe emotional disturbance who require frequent one-to-one support and intervention. Services include evidence-informed treatment models, wrap-around and aftercare services. This section examines needs and costs specific to the provision of this service package.

Treatment Foster Family Care – CPA Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the youth treatment foster family care package. Most providers (79%) reported a treatment director is needed for youth treatment foster family care. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 91% felt a psychiatrist was important, 69% felt a physician was important and 63% felt having a nurse was important when working with youth treatment foster family care. Providers indicated they would like a psychiatrist (97%), physician (77%) and/or nurse (68%). For all these positions, contracted staff was the preference and most reported that psychiatrists (77%), physician (56%), and nurse (53%) should be on call 24/7.

In terms of therapists, 97% providers reported that therapists were important and 100% reported wanting a therapist. The majority of providers (67%) reported that therapists would ideally be contracted and only 80% felt a therapist needed to be on call after hours.

For case managers, the minimum level of education was a bachelor's degree in human services (39%), but the preferred level of education was a master's degree in human services (44%). Providers (72%) noted that no additional certifications were needed for case managers working with youth treatment foster family care. In open-ended questions, CPA providers mentioned case managers working with youth in Treatment Foster Family Care may need the following training, certifications, or qualifications: trauma informed care, TBRI, mental health, TFC certification/training, Screening, Assessment, Risk, Transitional Care Evaluations, masters, bachelors, certified case management, child development, psychotropic med, suicide prevention, child abuse, Child Placement Management Staff certification, and primary med needs training.

[1] There are only three providers in the state who currently offer Treatment Foster Family Care (TFFC; services designed to be time-limited and adhere to the model codified in the Texas Family Code); however, 35% of CPAs indicated they currently offer TFFC. Some providers may have answered based on whether or not they served youth receiving treatment services. Providers who indicated they served or would like to serve TFFC in the future were included in the data for this section.

TFFC – CPA Treatment Director

Table 331. TFFC (CPA) - Should a treatment director be required? (N=62)

	N	%
Yes	55	78.6%
No	7	10.0%

TFFC – CPA Psychiatrists

Table 332. TFFC (CPA) - How important is it to have a psychiatrist? (N=66)

	N	%
Not important	6	9.1%
Somewhat important	9	13.6%
Very important	28	42.4%
Extremely important	23	34.8%

Table 333. TFFC (CPA) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=63)		
Yes	61	96.8%
No	2	3.2%
If yes, would you prefer to contract with them or have them in-house? (N=61)		
Contract	40	65.6%
In-house	21	34.4%

Table 334. TFFC (CPA) - Should a psychiatrist be on-call or available 24/7? (N=61)

	N	%
Yes	47	77.0%
No	14	23.0%

TFFC – CPA Physicians

Table 335. TFFC (CPA) - How important is it to have a physician? (N=62)

	N	%
Not important	19	30.6%
Somewhat important	19	30.6%
Very important	15	24.2%
Extremely important	9	14.5%

Table 336. TFFC (CPA) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=62)		
Yes	48	77.4%
No	14	22.6%
If yes, would you prefer to contract with them or have them in-house? (N=48)		
Contract	44	91.7%
In-house	4	8.3%

Table 337. TFFC (CPA) - Should a physician be on-call or available 24/7? (N=48)

	N	%
Yes	27	56.3%
No	21	43.8%

TFFC – CPA Therapists

Table 338. TFFC (CPA) - How important is having a therapist? (N=61)

	N	%
Not important	2	3.3%
Somewhat important	2	3.3%
Very important	20	32.8%
Extremely important	37	60.7%

Table 339. TFFC (CPA) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=61)		
Yes	61	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=61)		
Contract	41	67.2%
In-house	20	32.8%

Table 340. TFFC (CPA) - Should a therapist be on-call or available 24/7? (N=61)

	N	%
Yes	49	80.3%
No	12	19.7%

TFFC – CPA Nurses

Table 341. TFFC (CPA) - How important is having a nurse? (N=60)

	N	%
Not important	22	36.7%
Somewhat important	20	33.3%
Very important	10	16.7%
Extremely important	8	13.3%

Table 342. TFFC (CPA) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=59)		
Yes	40	67.8%
No	19	32.2%
If yes, would you prefer to contract with them or have them in-house? (N=40)		
Contract	34	85.0%
In-house	6	15.0%

Table 343. TFFC (CPA) - Should a nurse be on-call or available 24/7? (N=40)

	N	%
Yes	21	52.5%
No	19	47.5%

TFFC – CPA Case Management Staff

Table 344. TFFC (CPA) - Recommended level of education case managers

	Minimum level (N=56)		Preferred level (N=52)	
	N	%	N	%
High School Diploma or GED	0	0%	0	0%
Associate's Degree	1	1.4%	1	1.9%
Bachelor's Degree	22	31.4%	7	13.5%
Bachelor's Degree (human services field)	27	38.6%	17	32.7%
Master's Degree	0	0.0%	3	5.8%
Master's Degree (human services field)	6	8.6%	23	44.2%
Other	0	0.0%	1	1.9%

Table 345. TFFC (CPA) - Do case managers need any certifications? (N=58)

	N	%
No certifications needed	42	72.4
Certifications needed	16	27.6

Treatment Foster Family Care – CPA Ideal Caseloads and Competitive Salaries

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 11 children. The ideal caseload was 9 and the maximum caseload was 12 children. For case managers, the typical caseload was 13 children. The ideal caseload was 12 children and the maximum caseload was 14 children. Providers were also asked how many case managers should be supervised by one supervisor. The mean response was 5.15 case managers for each case supervisor.

For salaries, providers noted that a competitive therapist salary without benefits was $63,600. For case managers, the mean competitive salary without benefits was $47,200.

TFFC – CPA Therapist Caseloads

Table 346. TFFC (CPA) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	7	3	20	11	10	8*	5.47
Ideal caseload	8	3	14	9	8	6*	3.78
Max caseload	8	3	20	12	11	10	4.92

*Multiple modes exist. The smallest value is shown

TFFC – CPA Therapist Competitive Salary

Table 347. TFFC (CPA) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	10	$46,000	$75,000	$63,600	$65,000	$70,000	$8,605

TFFC – CPA Case Manager Caseloads

Table 348. TFFC (CPA) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	33	1	30	13	12	10*	7.56
Ideal caseload	44	2	25	12	10	10	5.65
Max caseload	42	3	30	14	13	10	7.56

*Multiple modes exist. The smallest value is shown

Table 349. TFFC (CPA) - Case management supervision recommendation

	N	Min	Max	Mean	Std Dev
Number of case managers that should be supervised by one case supervisor	75	2	10	5.15	1.83

TFFC – CPA Case Mangers Competitive Salary

Table 350. TFFC (CPA) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	45	$30,000	$60,000	$47,200	$47,000	$50,000	$7,809

Treatment Foster Family Care – Services

Providers were asked about the recommended frequency of therapy for children who are in treatment foster care. For individual therapy 36% of providers suggested individual therapy should be once per week. Providers (38%) felt family therapy should be once a month. Providers (44%) felt group therapy should be once a month. Providers were also asked about services they would recommend for children who are in treatment foster care. The following services were noted by 75% or more of the providers: psychological testing and evaluation (100%); education and tutoring services (100%); recreational therapy (98%); art therapy (94%); crisis services/stabilization (94%); healthy relationship programs/classes (94%); behavior support specialist (93%); play therapy (90%); assistance with HS diploma or GED (89%); peer mentoring (89%); risk assessments (87%); youth support groups (85%); animal therapy (82%); equine therapy (82%); dance/movement therapy (82%); assistance with obtaining a driver's license (77%); and dietician/nutrition services (75%).

TFFC – Therapy

Table 351. TFFC - Recommended frequency of therapy sessions

		Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
		N	%	%	%	%	%	%	%	%	%	%	%	%
TFFC	Individual Therapy													
		66	5%	6%	17%	29%	36%	0%	2%	2%	0%	0%	2%	3%
	Family Therapy													
		60	3%	10%	38%	27%	17%	2%	0%	0%	0%	0%	0%	3%
	Group Therapy													
		59	17%	5%	44%	14%	12%	2%	0%	0%	0%	0%	2%	5%

TFFC – Needed Services

Table 352. TFFC - Additional recommended services

	Total N	Service needed N	%
Psychological testing and evaluation	54	54	100.0%
Education and tutoring services	53	53	100.0%
Recreational therapy	54	53	98.1%
Art therapy	54	51	94.4%
Crisis Services / Stabilization	54	51	94.4%
Healthy Relationship Programs / Classes	53	50	94.3%
Behavior Support Specialist	54	50	92.6%
Play therapy	54	48	88.9%
Assistance with HS diploma or GED	53	47	88.7%
Peer mentoring	53	47	88.7%
Risk assessments	54	47	87.0%
Youth support groups	53	45	84.9%
Animal therapy	54	44	81.5%
Equine therapy	54	44	81.5%
Dance / Movement therapy	54	44	81.5%
Assistance with obtaining a driver's license	53	41	77.4%
Dietician / Nutrition services	40	30	75.0%
Medical specialists	40	29	72.5%
Personal Care Services (PCS)	40	27	67.5%
Parenting programs/classes	53	34	64.2%
Parent support groups	53	34	64.2%
Applied Behavior Analysis (ABA)	54	33	61.1%
Speech Therapy	54	33	61.1%
Occupational Therapy	54	33	61.1%
Physical / Rehabilitation Therapy	54	30	55.6%
Legal services	53	29	54.7%
Forensic assessments	54	28	51.9%
Neurofeedback	54	28	51.9%
Nursing - Other	40	16	40.0%
Prenatal and Postnatal Care	40	13	32.5%
Private Duty Nursing (PDN)	40	10	25.0%

Note: Services highlighted in orange were identified by at least 75% of CPAs as needed services

TFFC – Maximum Length of Services

Providers were also asked about the recommended maximum length of services for youth treatment foster family care. The most common response (48%) was that there should be no maximum service length.

Table 353. TFFC - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
TFFC (FFC)	69	1%	1%	3%	3%	6%	3%	23%	4%	7%	48%

Treatment Foster Family Care – CPA Aftercare

Providers were also asked about the recommended length of services for youth in treatment foster care. The most common response (30%) was that aftercare should be 12 or more months. Additionally, the average caseload for an aftercare case manager would be 11 youth in treatment foster care.

Table 354. TFFC (CPA) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months %	No max %
TFFC (CPA)	56	9%	4%	2%	5%	4%	0%	29%	0%	2%	2%	0%	0%	30%	14%

Table 355. TFFC (CPA) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std Dev
TFFC (CPA) estimated aftercare caseload	48	2	30	11	7

Primary Setting – Short-Term Assessment/ Stabilization (STAS) Services – FFC Service Package

Brief Description: A foster home that in addition to the base package foster home includes time-limited services for children, youth, and young adults who are new to care or transitioning from unpaid or unauthorized placements. Care requires additional flexibility on behalf of child-placing agency (CPA) and foster parent to admit children 24/7 and enhanced skill in assessment and coordination to support transition of child to most appropriate placement. Examples include children and youth who may be returning from a runaway episode or a disruption in kinship placement. This section examines needs and costs specific to the provision of this service package.

Short-Term Assessment/Stabilization – CPA Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the short-term assessment/stabilization. Most providers (58%) reported a treatment director is needed for short-term assessment/stabilization. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 81% felt a psychiatrist was important, 64% felt a physician was important and 61% felt having a nurse was important for short-term assessment/stabilization. Providers indicated they would like a psychiatrist (98%), physician (83%) and/or nurse (61%). For all these positions, contracted staff was the preference and most reported that psychiatrists (70%), physician (63%), and nurse (65%) should be on call 24/7.

In terms of therapists, 96% providers reported that therapists were important and 98% reported wanting a therapist. The majority of providers (66%) reported that therapists would ideally be contracted and only 71% felt a therapist needed to be on call after hours.

For case managers, the minimum level of education was a bachelor's degree in human services (41%), but the preferred level of education was a master's degree in human services (49%). Providers (80%) noted that no additional certifications were needed for case managers working in short-term assessment/stabilization. In open-ended questions, CPA providers mentioned case managers working with youth needing assessment and stabilization services may need the following training, certifications, or qualifications: trauma informed care, mental health, Screening, Assessment, Risk, Transitional Care Evaluations, and short-term assessment and stabilization training, CPR, child development, psychotropic med, suicide prevention, child abuse, certified case management, bachelor's degree, and master's degree.

STAS – CPA Treatment Director

Table 356. STAS (CPA) - Should a treatment director be required? (N=57)

	N	%
Yes	33	57.9%
No	24	42.1%

STAS – CPA Psychiatrists

Table 357. STAS (CPA) - How important is it to have a psychiatrist? (N=63)

	N	%
Not important	12	19.0%
Somewhat important	11	17.5%
Very important	24	38.1%
Extremely important	16	25.4%

Table 358. STAS (CPA) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=60)		
Yes	59	98.3%
No	1	1.7%
If yes, would you prefer to contract with them or have them in-house? (N=59)		
Contract	42	71.2%
In-house	17	28.8%

Table 359. STAS (CPA) - Should a psychiatrist be on-call or available 24/7? (n=59)

	N	%
Yes	41	69.5%
No	18	30.5%

STAS – CPA Physicians

Table 360. STAS (CPA) - How important is it to have a physician? (N=59)

	N	%
Not important	21	35.6%
Somewhat important	17	28.8%
Very important	13	22.0%
Extremely important	8	13.6%

Table 361. STAS (CPA) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=59)		
Yes	49	83.1%
No	10	16.9%
If yes, would you prefer to contract with them or have them in-house? (N=49)		
Contract	43	87.8%
In-house	6	12.2%

Table 362. STAS (CPA) - Should a physician be on-call or available 24/7? (N=49)

	N	%
Yes	31	63.3%
No	18	36.7%

STAS – CPA Therapists

Table 363. STAS (CPA) - How important is it to have a therapist? (N=57)

	N	%
Not important	2	3.5%
Somewhat important	6	10.5%
Very important	18	31.6%
Extremely important	31	54.4%

Table 364. STAS (CPA) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=57)		
Yes	56	98.2%
No	1	1.8%
If yes, would you prefer to contract with them or have them in-house? (N=56)		
Contract	37	66.1%
In-house	19	33.9%

Table 365. STAS (CPA) - Should a therapist be on-call or available 24/7? (N=56)

	N	%
Yes	40	71.4%
No	16	28.6%

STAS – CPA Nurses

Table 366. STAS (CPA) - How important is having a nurse? (N=57)

	N	%
Not important	22	38.6%
Somewhat important	17	29.8%
Very important	10	17.5%
Extremely important	8	14.0%

Table 367. STAS (CPA) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=56)		
Yes	34	60.7%
No	22	39.3%
If yes, would you prefer to contract with them or have them in-house? (N=34)		
Contract	27	79.4%
In-house	7	20.6%

Table 368. STAS (CPA) - Should a nurse on-call or available 24/7? (N=34)

	N	%
Yes	22	64.7%
No	12	35.3%

STAS – CPA Case Management Staff

Table 369. STAS (CPA) - Recommended level of education for case managers

	Minimum level (N=53)		Preferred level (N=49)	
	N	%	N	%
High School Diploma or GED	1	1.5%	0	0.0%
Associate's Degree	0	0.0%	1	2.0%
Bachelor's Degree	20	30.3%	7	14.3%
Bachelor's Degree (human service field)	27	40.9%	15	30.6%
Master's Degree	0	0.0%	2	4.1%
Master's Degree (human service field)	5	7.6%	24	49.0%

Table 370. STAS (CPA) - Do case managers need any certifications? (N=55)

	N	%
No certifications needed	44	80.0%
Certifications needed	11	20.0%

Short-Term Assessment/Stabilization – CPA Ideal Caseloads and Competitive Salaries

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 13 children. The ideal caseload was 7 and the maximum caseload was 10 children. For case managers, the typical caseload was 13 children. The ideal caseload was 11 children and the maximum caseload was 13 children. Providers were also asked how many case managers should be supervised by one supervisor. The mean response was 5.15 case managers for each case supervisor.

For salaries, providers noted that a competitive therapist salary without benefits was $65,000. For case managers, the mean competitive salary without benefits was $46,871.

STAS – CPA Therapist Caseloads

Table 371. STAS (CPA) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	4	5	20	13	13	5*	6.45
Ideal caseload	5	0	12	7	8	0*	4.69
Max caseload	5	0	15	10	12	15	6.38

*Multiple modes exist. The smallest value is shown.

STAS (CPA) – CPA Therapist Competitive Salary

Table 372. STAS (CPA) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	8	$55,000	$75,000	$65,000	$65,000	$60,000.00*	$6,547

*Multiple modes exist. The smallest value is shown

STAS (CPA) – CPA Case Manager Caseloads

Table 373. STAS (CPA) – Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	30	1	30	13	14	15	8.44
Ideal caseload	40	1	25	11	10	10*	6.27
Max caseload	38	2	30	13	12	10	7.86

*Multiple modes exist. The smallest value is shown

STAS (CPA) – CPA Case Manager Competitive Salary

Table 374. STAS (CPA) – Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	42	$30,000	$75,000	$46,871	$45,000	$45,000	$8,824

Short-Term Assessment/Stabilization – Foster Family Care Services

Providers were asked about the recommended frequency of therapy for short-term assessment/stabilization. For individual therapy 40% of providers suggested individual therapy should be once per week. Providers (35%) felt family therapy should be once a week. Providers (26%) felt group therapy should be once a week. Providers were also asked about services they would recommend for children who have complex mental health needs. The following services were noted by 75% or more of the providers: Psychological testing and evaluation (100%); education and tutoring services (93%); crisis services/stabilization (90%); healthy relationship programs/classes (89%); recreational therapy (86%); risk assessments (86%); youth support groups (84%); behavior support specialist (84%); play therapy (82%); peer mentoring (80%); dietician/nutrition services (80%); and art therapy (75%). In open-ended responses, one CPA provider mentioned additional assessments and supports were needed for youth needing assessment and stabilization services, but did not specify.

STAS Foster Family Care – Therapy

Table 375. STAS (FFC) – Recommended frequency of therapy sessions

		Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
		N	%	%	%	%	%	%	%	%	%	%	%	%
STAS (FFC)	Individual Therapy													
		45	2%	2%	11%	4%	40%	22%	2%	0%	2%	0%	11%	2%
	Family Therapy													
		40	0%	0%	30%	25%	35%	8%	0%	3%	0%	0%	0%	0%
	Group Therapy													
		39	18%	5%	23%	8%	26%	8%	0%	0%	3%	0%	5%	5%

STAS Foster Family Care – Needed Services

Table 376. STAS (FFC) – Additional recommended services

	Total N	Service needed N	%
Psychological testing and evaluation	50	50	100.0%
Education and tutoring services	45	42	93.3%
Crisis Services / Stabilization	50	45	90.0%
Healthy Relationship Programs / Classes	45	40	88.9%
Recreational therapy	44	38	86.4%
Risk assessments	50	43	86.0%
Youth support groups	45	38	84.4%
Behavior Support Specialist	50	42	84.0%
Play therapy	44	36	81.8%
Peer mentoring	45	36	80.0%
Dietician / Nutrition services	39	31	79.5%
Art therapy	44	33	75.0%
Assistance with HS diploma or GED	45	33	73.3%
Medical specialists	39	27	69.2%
Forensic assessments	50	34	68.0%
Parent support groups	45	28	62.2%
Dance / Movement therapy	44	27	61.4%
Assistance with obtaining a driver's license	45	27	60.0%
Animal therapy	44	26	59.1%
Applied Behavior Analysis (ABA)	50	29	58.0%
Parenting programs/classes	45	26	57.8%
Legal services	45	26	57.8%
Equine therapy	44	25	56.8%
Personal Care Services (PCS)	39	22	56.4%
Occupational Therapy	50	21	42.0%
Neurofeedback	50	21	42.0%
Speech Therapy	50	20	40.0%
Physical / Rehabilitation Therapy	50	20	40.0%
Prenatal and Postnatal Care	39	13	33.3%
Nursing - Other	39	13	33.3%
Private Duty Nursing (PDN)	39	9	23.1%

Note: Services highlighted in orange were identified by at least 75% of CPAs as needed services

STAS Foster Family Care – Maximum Length of Services

Providers were also asked about the recommended maximum length of services for short-term assessment/stabilization. The most common response (30%) was that there should be no maximum services.

Table 377. STAS (FFC) – Recommended maximum length of services

	Total N	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
STAS (FFC)	50	6%	0%	12%	22%	12%	0%	10%	2%	6%	30%

General Recommendations for FFC Service Packages

Case Management Supervision

Providers were also asked how many case managers should be supervised by one supervisor. The mean response was 5.15 case managers for each case supervisor.

Table 378. Case management supervision recommendation

	N	Min	Max	Mean	Std Dev
Number of case managers that should be supervised by one case supervisor	75	2	10	5.15	1.83

Aftercare Services

Providers were asked which aftercare services they would imagine providing across all service packages. The top response noted by 84% of providers was that they would identify and provide referrals for community providers. Additionally, 78% of providers was that they would schedule regular check-ins, provide case management for the child and family and set up appointments with new provided as needed. The majority of CPAs also could imagine setting up initial appointments with providers in the community where the child is transitioning to and providing temporary therapeutic services to avoid gaps in services.

Table 379. What types of aftercare services would you imagine providing?

	N	%
Identifying and providing referrals for community providers	65	84.4%
Setting up initial appointments with providers in community where child is transitioning to	58	75.3%
Scheduling regular check-ins / providing case management for child/family to see how things are going, follow up on after care plan, identify and assist families in setting up appointments with new providers if needed	60	77.9%
Providing temporary therapeutic services until child has established providers in the community or when there is a gap in services for up to six months after child leaves	58	75.3%
Providing therapeutic services for six months after child leaves	48	62.3%
Supporting families in meeting basic needs for up to six months after child leaves	51	66.2%
Access to on-call staff for six months	48	62.3%
Other	10	13.0%

CPA providers who indicated other aftercare services were needed mentioned the following: the need to be able to provide no limit post permanency services involving therapy, social work, family navigation, and medication management/mental health

support; support until age 23; community involvement; educational resources (including mentoring); allowing for foster; biological; and kinship caregiver support through relational coaching and trauma-focused family engagement. One provider said:

> *'[Our Agency] has the capacity to provide post permanency services without a time limit and/or max. We have psychologist, therapist, social workers, and family navigators on staff. We have a contract psychiatrist for medication management." _CPA Provider*

Table 380. Aftercare staffing needs

	N	%
Aftercare director / coordinator	44	62.0%
Aftercare case manager	63	88.7%
Aftercare therapist	38	53.5%
Additional therapists so that the therapist can keep child on caseload for up to six months after leaving	25	35.2%
Other	6	8.5%

Survey Findings: Residential Operations

This section will present findings for residential operations that provide facility-based services. These facilities include general residential operations (GROs), residential treatment centers (RTCs) and emergency shelters. Some topics like capacity, populations served and staffing are discussed per facility type. Other topics such as services, administration and budgets are combined into sections that begin with "Residential operations". Both survey findings and workgroup discussions included.

General Residential Operations

This subsection refers to GROs that are not RTCs or emergency shelters. The following tables present data on the number children served, staffing, staffing recommendations and staff recruitment and retention.

GRO Capacity

On average, providers reported their maximum capacity was 32 youth. However, on average, providers also reported that they had 21 youth at their facility. In open-ended questions, 17 GRO providers said staffing issues were preventing them from operating at capacity, especially recruiting staff qualified to meet the needs of children. Staffing was often mentioned in the context of COVID-related issues (such as following quarantine protocols). Six providers discussed that the children referred were often not a match for the facility, five providers said they kept staff to child ratios lower when serving children with higher needs. Other reasons mentioned included heightened monitoring, child turnover, being a new facility, and fewer child removals resulting in fewer entries into foster care.

Table 381. Typical and maximum number of youth per day at GROs

	N	Min	Max	Mean	Median	Std dev
Number of youth typically placed at GROs on a given day	33	1	65	20.6	16.0	14.05
Max number of youth per day at GROs	33	8	72	32.5	29.0	17.48

GRO Population Served

The following table presents data on the characteristics of youth served. Almost all GROs (87.1%) served youth with basic needs. GROs were less likely to serve youth with primary or complex medical needs.

Table 382. Does your GRO offer services for any of the following youth populations? (N=31)

Youth population	Yes, we serve this population	No, but would like to in the future	No, do not serve and don't intend to
Basic child care services only	87.1%	0.0%	12.9%
Primary Medical Needs (PMN)	9.7%	6.5%	83.9%
Complex medical needs	9.7%	6.5%	83.9%
IDD/Autism	51.6%	16.1%	32.3%
Experienced human trafficking	51.6%	19.4%	29.0%
Pregnant / parenting	22.6%	19.4%	58.1%
Substance use disorders	54.8%	22.6%	22.6%
Sexual aggression / sex offender adjudication	25.8%	6.5%	67.7%
Complex mental health needs	61.3%	19.4%	19.4%
14 years old and older	93.5%	0.0%	6.5%

GRO After-Hours Admissions

In general, GROs reported that 25.5% of admissions happened after hours.

Table 383. Percent of admissions that occur after hours

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of admissions that occur after hours	27	0%	85%	27.2%	25.5%	20.0%	24.47%

Table 384. Percent of admissions that occur after hours by grouping

	N	%
Less than 25%	15	55.6
25% to 49%	6	22.2
50% to 74%	4	14.8
75% or higher	2	7.4

GRO Current Staffing

Staffing across GROs varies. To understand the different staffing structures, a series of questions were asked about treatment directors, psychiatrists, physicians, therapists, nurses and case managers.

Table 385. Clinical staffing summary at GROs

	N	%
Treatment Director (N=31)		
Have a Treatment Director	20	64.5%
Have no Treatment Director	11	35.5%
Psychiatrist (N=31)		
Have a contracted psychiatrist	26	83.9%
Have an in-house psychiatrist	1	3.2%
Have both an in-house and contracted psychiatrist	0	0.0%
Do not have a psychiatrist	4	12.9%
Physician (N=31)		
Have a contracted physician	17	54.8%
Have an in-house physician	0	0.0%
Have both an in-house and contracted physician	0	0.0%
Do not have a physician	14	45.2%
Therapist (N=31)		
Have a contracted therapist	13	41.9%
Have an in-house therapist	13	41.9%
Have both an in-house and contracted therapist	2	6.5%
Do not have a therapist	3	9.7%
Nurse (N=30)		
Have a contracted nurse	3	10.0%
Have an in-house nurse	8	26.7%
Have both an in-house and contracted nurse	0	0.0%
Do not have a nurse	19	63.3%

GRO Treatment Directors

Twenty GRO providers (65%) reported having a treatment director. This section presents the data on treatment directors for GROs.

Table 386. About treatment directors at GROs

	N	%
Credentialing with Medicaid/STAR Health (N=20)		
Credentialed	14	65.0%
In process of becoming credentialed	3	15.0%
Not interested in becoming credentialed	3	15.0%
Number of treatment directors (for GROs with at least 1 treatment director) (N=20)		
1	19	95.0%
2	1	5.0%
Treatment director credentials (N=21)		
Master's degree in a human services field (not licensed)	1	4.8%
Licensed Professional Counselor (LPC)	16	47.6%
Licensed Clinical Social Worker (LCSW)	4	19.0%
Does treatment director receive benefits? (N=20)		
Yes	15	75.0%
No	4	20.0%
Prefer not to say	1	5.0%

Table 387. Treatment director salary at GROs

	N	Min	Max	Mean	Std dev
Salary of treatment director	18	$45,000	$80,000	$65,561.11	$9,457.59

Table 388. Treatment director salary ranges at GROs

	N	%
Less than $50,000	2	11.1%
$50,000 - $59,999	1	5.6%
$60,000 - $69,999	9	50.0%
$70,000 - $79,999	5	27.8%
$80,000 or higher	1	5.6%

GRO Psychiatrists

Twenty-six providers GROs described that 42% of their psychiatrists are available or on-call 24/7 (N=26). The data below describes GRO responses for contracted psychiatrists and in-house psychiatrists.

Table 389. Psychiatrists on call or available 24/7 at GROs (N=26)

	N	%
Do you have psychiatrists that are on-call or available 24/7?		
Yes	11	42.3%
No	15	57.7%

GRO Contracted Psychiatrists

Table 390. About Contracted Psychiatrists At Gros (N=26)

	N	%
Number of contracted psychiatrists at GROs		
1	23	88.5%
2	3	11.5%
Are contracted psychiatrists Medicaid or STAR Health providers?		
Yes	25	96.2%
No	1	3.8%
Do contracted psychiatrists provide services on-site or are youth transported to them?		
Services provided on-site	7	26.9%
Transport youth to off-site appointments	8	30.8%
Both	11	42.3%
How are contracted psychiatrists paid?		
Rate per hour	1	3.8%
Rate per session	1	3.8%
They bill Medicaid/STAR Health directly	22	84.6%
Other	2	7.7%

In open-ended questions, one GRO reported that they paid their contracted psychiatrist and hourly rate of $175. One GRO described that a typical session with a contracted psychiatrist is 45 minutes. Another noted that the psychiatrist bills Medicaid, but they pay $500 monthly to retain his services. Another provider noted that they pay $1,000 a month to retain services.

GRO In-House Psychiatrists

Only one GRO described having an in-house psychiatrist that was Medicaid/STAR Health provider and with 75% of their salary being reimbursed by Medicaid/STAR Health. This GRO did not report the salary or if the in-house psychiatrist received benefits.

GRO Physicians

Fifty-five percent (N=17) on GROs reported having a contracted physician, with no GROs reporting any in-house physicians. Forty-five percent of GROs reported not having a physician. Four GRO providers (24%) reported having a contract physician on-call or available 24/7. The data below is for contracted physicians at GROs.

Table 391. Physicians on-call or available 24/7 at GROs (N=17)

	N	%
Do you have physician that are on-call or available 24/7?		
Yes	4	23.5%
No	13	76.5

Table 392. About contracted physicians at GROs (N=17)

	N	%
Number of contracted physicians at GROs		
1	12	70.6%
2	2	11.8%
3	1	5.9%
4	0	0.0%
5 or more	2	11.8%
Are contracted physicians Medicaid or STAR Health providers?		
Yes	17	100.0%
No	0	0.0%
Do contracted physicians provide services on-site or are youth transported to them?		
Services provided on-site	1	5.9%
Transport youth to off-site appointments	12	70.6%
Both	3	17.6%
Prefer not to say	1	5.9%
How are contracted physicians paid?		
Rate per hour	0	0.0%
Rate per appointment	0	0.0%
They bill Medicaid/STAR Health directly	16	94.1%
Prefer not to say	1	5.9%

GRO Therapists

Thirteen GROs reported having contracted therapists (42%), thirteen GROs had in-house therapists (42%), and two GROs reported having both contracted and in-house therapists (6.5%). Majority of therapists were reported as being available or on-call for GROs (85%). The sections below describe GRO data on contracted therapists and in-house therapists. Three GRO providers mentioned not being able to provide the flexibility and work environment that therapists can get elsewhere. Other important factors included STAR Health/Medicaid billing and credentialing complexities, needing to maintain lower caseloads for working with youth with higher needs, and not having the agency budget or pay for therapy services.

Table 393. Therapist on-call or available 24/7 at GROs (N=27)

	N	%
Do you have therapist that are on-call or available 24/7?		
Yes	23	85.2%
No	4	14.8%

GRO Contracted Therapists

Table 394. About contracted therapists at GROs (N=15)

	N	%
Number of contracted therapists at GROs		
1	7	46.7%
2	3	20.0%
3	1	6.7%
4	4	26.7%
Are contracted therapists Medicaid or STAR Health providers?		
Yes	15	100.0%
No	0	0.0%
Do contracted therapists provide services on-site or are youth transported to them?		
Services provided on-site	1	5.9%
Transport youth to off-site appointments	12	70.6%
Both	3	17.6%
Prefer not to say	1	5.9%
How are contracted therapists paid?		
They bill Medicaid/STAR Health directly	12	80.0%
Other	1	6.7%
Prefer not to say	2	13.3%

The GRO that indicated “other” described that for their contract therapist(s) they bill STAR Health directly for a session and pays for the therapist for case staffing, treatment plan, and travel.

GRO In-House Therapists

Table 395. About in-house therapists at GROs (N=11)

	N	%
Do you have in-house therapists that are not treatment directors? (N=11)		
Yes	7	63.6%
No	4	36.4%
Number of in-house therapists at GROs (N=11)		
1	3	27.3%
2	4	36.4%
3	4	36.4%
Credentials of in-house therapists at GROs		
Licensed Clinical Social Worker (LCSW)	3	27.3%
Licensed Professional Counselor (LPC)	8	72.7%
Licensed Marriage and Family Therapist (LMFT)	1	9.1%
Licensed Chemical Dependency Counselor (LCDC)	2	18.2%
Psychologist	2	18.2%
Other	2	18.2%

The two GROs who indicated “Other” credentials for their in-house therapists reported that they are LPC-A and LPCS.

Table 396. Percent of in-house therapists who are Medicaid/STAR Health providers at GROs

	N	Min	Max	Mean	Std dev
% in-house therapists credentialed with Medicaid/STAR Health	9	0%	100%	66.7%	44.10%
% in-house therapists in process of becoming credentialed	9	0%	66%	16.7%	26.35%
% lack qualifications to become credentialed	9	0%	50%	5.6%	16.67%

Table 397. Length of time for in-house therapists at GROs to become a Medicaid/STAR Health provider

	N	Min	Max	Mean	Std dev
Number of months to become a Medicaid/STAR Health provider	3	6	9	7.00	1.732

Table 398. Percent of in-house therapist's salary typically reimbursed by Medicaid/STAR Health at GROs

	N	Min	Max	Mean	Std dev
% in-house therapist salary typically reimbursed by Medicaid/STAR Health	7	0%	80%	32.86%	27.36%

GROs were asked to identify which activities therapists engaged in that were not billable by Medicaid/STAR Health. Most commonly, providing staff trainings, participating in trainings, and documentation beyond what is allotted by Medicaid/STAR Health were reported. All results are presented in the following table. When asked about other ways therapists spend time, one GRO provider said therapists also served as case managers. A GRO provider also mentioned reading documentation and preparing for team meetings (approximately 3 hours per week) and other mentioned 1 hour per week dedicated to court-related tasks and 1 hour per week dedicated to communication with caseworkers.

Table 399. Non-billable Medicaid/STAR Health services for in-house therapists at GROs (N=11)

Non-billable Medicaid/STAR Health services	N	%
Providing staff training	8	72.7%
Participating in trainings	8	72.7%
Documentation beyond what is allotted by Medicaid/STAR Health	8	72.7%
Sessions that occur on the same day (can only bill for one session)	7	63.6%
Debriefing and providing support for staff	7	63.6%
Supervision	7	63.6%
Participation in treatment team meetings / service planning for child	6	54.5%
Crisis response, de-escalation or processing something that comes up for a child	6	54.5%
Family engagement activities	6	54.5%
Individual therapy sessions if more than once a week	5	45.5%
Group therapy sessions if more than once a week	5	45.5%
Family therapy sessions if more than once a week	5	45.5%
Case management activities	5	45.5%

Table 400. Current and ideal salary for in-house therapists at GROs

	N	Min	Max	Mean	Std dev
Current in-house therapist salary	10	$52,000	$125,000	$69,700	$29,424.29
Ideal in-house therapist salary	10	$54,000	$150,000	$80,900	$36,731.61

Table 401. Summary of salary and benefits of in-house therapists at GROs (N=11)

Salary and benefits	N	%
Typical salary for an in-house therapist at a GRO		
Less than $50,000	1	9.1%
$50,000 – $59,999	6	54.5%
$60,000 – $69,999	2	18.2%
$70,000 or more	2	18.2%
Do in-house therapists receive benefits?		
Yes	11	100.0%
No	0	0.0%
How competitive are in-house therapist salaries in your area?		
Not at all competitive	3	27.3%
Not very competitive	0	0.0%
Somewhat competitive	6	54.5%
Very competitive	2	18.2%
Extremely competitive	0	0.0%

Table 402. Number of hours therapists spend on tasks at GROs

	N	Min	Max	Mean	Std dev
Providing scheduled therapy sessions (individual, group or family)	9	10	23	18.0	4.15
Reporting and documentation	8	3	20	7.1	5.66
Debriefing and providing support to staff	9	1	40	6.7	12.54
Providing crisis response, de-escalation or additional sessions to help a child process or regulate	9	1	10	5.6	3.12
Performing case management	7	0	20	3.9	7.17
Participating in treatment team meetings	9	1	5	2.6	1.27
Engaging birth families outside of therapy sessions	6	0	10	2.2	3.92
Providing staff training and supervision	7	0	4	1.6	1.27
Driving to appointments	7	0	6	1.4	2.23
Engaging foster parents or kinship caregivers outside of therapy sessions	7	0	5	1.4	1.72
Receiving training and supervision	7	1	2	1.4	0.48
Dealing with Medicaid billing complexities	7	0	2	0.4	0.79

Table 403. Percent of time on tasks for in-house therapists at GROs

	N	Min	Max	Mean	Std dev
Providing scheduled therapy sessions (individual, group or family)	6	17.7%	51.0%	36.2%	12.4%
Reporting and documentation	6	4.6%	27.0%	14.9%	7.4%
Providing crisis response, de-escalation or additional sessions to help a child process or regulate	6	4.4%	23.3%	12.0%	7.8%
Debriefing and providing support to staff	6	2.3%	35.4%	10.7%	12.3%
Performing case management	7	0.0%	30.3%	6.3%	10.8%
Participating in treatment team meetings	6	4.4%	8.1%	5.4%	1.4%
Receiving training and supervision	6	1.5%	5.9%	3.2%	1.9%
Providing staff training and supervision	6	0.0%	6.1%	3.0%	2.3%
Engaging birth families outside of therapy sessions	6	0.0%	8.9%	2.6%	3.6%
Driving to appointments	6	0.0%	7.8%	2.2%	3.5%
Engaging foster parents or kinship caregivers outside of therapy sessions	6	0.0%	4.4%	2.0%	1.9%
Dealing with Medicaid billing complexities	6	0.0%	1.8%	0.30%	0.7%

When asked about other ways therapists spend time, one provider said therapists also provide case management, one mentioned reading documentation and preparing for team

meetings (three hours per week), one mentioned court-related tasks and communication with caseworkers (one hour per week each).

GRO Nurses

Eight GROs had an in-house nurse (27%) and three GROs contracted nurses (10%). Among the eleven GROs who staffed nurses, nine (82%) were available or on-call 24/7. The data below presents data about contracted nurses and in-house nurses at GROs.

Table 404. Nurses at GROs on-call or available 24/7 (N=11)

	N	%
Do you have therapist that are on-call or available 24/7?		
Yes	9	81.8%
No	2	18.2%

GRO Contracted Nurses

Table 405. About contracted nurses at GROs (N=3)

	N	%
Number of contracted nurses (for GROs with at least one contracted nurse)		
1	3	100.0%
Are contracted nurses Medicaid/STAR Health providers?		
Yes	2	66.7%
No	1	33.3%
How are contracted nurses paid?		
Rate per appointment	1	33.3%
They bill Medicaid/STAR Health directly	2	66.7%

One GRO indicated that the contracted nurse is paid $100 per appointment and the length of a typical appointment is 30 mines (N=1)

GRO In-House Nurses

Table 406. About in-house nurses at GROs (N=8)

	N	%
Number of in-house nurses (for GROs with at least one contracted nurse)		
1	6	75.0
2	2	25.0
Are in-house nurses Medicaid/STAR Health providers?		
Yes	0	0.0%
No	8	100.0%
In-house nurse credentials		
Registered Nurse (RN), Licensed Vocational Nurse (LVN), or Licensed Practical Nurse (LPN)	7	87.5%
Prefer not to say	1	12.5%
Do in-house nurses receive benefits?		
Yes	8	100.0%
No	0	0.0%

Table 407. In-house nurse salary at GROs

	N	Min	Max	Mean	Std dev
In-house nurse salary	8	$43,000	$75,000	$58,875.00	$12,710.37

GRO Case Management

Most providers (85.7%) noted that case management at their agency was done by a dedicated case manager. One GRO provider said that case managers split their time in their dual role as therapists. “Other” responses included: administrator, therapist and case manager, GRO does not have case managers, and one GRO described that their case manager conducts “recreational activities, school liaison, liaison with the department”.

Table 408. Staff roles that perform case management at GROs (N=28)

Who performs case management at GROs?	N	%
Therapists	1	3.6%
Case managers	24	85.7%
Other	3	10.7%

GRO Salary and Benefits of Case Managers

Table 409. Current case manager salary at GROs

	N	Min	Max	Mean	Std dev
Case manager salary	25	$30,000	$60,000	$43,502.72	$6,453.089

Table 410. About case manager salary and benefits at GROs

	N	%
Case manager salary at GROs (N=25)		
$30,000 - $39,999	7	28.0%
$40,000 - $49,999	11	44.0%
$50,000 - $59,999	6	24.0%
$60,000 or higher	1	4.0%
Do case manager receive benefits?		
Yes	24	96.0%
No	1	4.0%
How competitive is this case manager salary in your area?		
Not at all competitive	4	16.0%
Not very competitive	2	8.0%
Somewhat competitive	10	40.0%
Very competitive	8	32.0%
Extremely competitive	1	4.0%

GRO Case Management Staff Hours

Providers reported that case managers spend most of their time on reporting and documentation; service planning, case coordination and cross-system collaboration; and working with the child. In open-ended responses, one provider said that documentation and preparing for treatment team meetings takes two hours. Two providers mentioned coordinating normalcy activities such as outings, extracurriculars, and recreation. One provider mentioned correspondence with school and CPS. One provider said:

> *'Hours per week vary depending on scheduled and nonscheduled events. Most Case Managers have a rotating on-call to respond to crises and emergencies. Service Planning/Reporting and Documentation varies depending on the needs of the child. One service plan could take 8 hours of documentation time. Holding a service plan meeting takes 1 to 2 hours. Our Case Manager has a total of 5 service plan meetings to be held this week." _ GRO Provider*

Table 411. Number of hours case managers spend on tasks at GROs

	N	Min	Max	Mean	Std dev
Reporting and documentation	24	4	112	14.33	22.23
Service planning, case coordination, and cross-system collaboration	24	2	25	9.00	7.47
Working directly with child	24	0	20	7.88	5.02
Responding to crises or incidents	24	1	18	5.71	4.44
Participating in treatment team meetings	24	1	12	4.25	3.11
Driving to appointments, home visits, courts	23	0	15	3.74	4.47
Receiving training and supervision	23	1	5	2.30	1.11
Engaging birth families	23	0	20	1.83	4.13
Engaging foster parents or kinship caregivers	20	0	12	1.80	3.33
Dealing with Medicaid billing complexities	19	0	3	0.32	0.75

GRO Direct Care Staff

In workshops, GROs noted struggles in retaining direct care staff. The tables below present findings on direct care staff. In open-ended questions, two providers described challenges with staffing ratios depending on the youth or circumstances (e.g. pregnant teen during their third trimester may need emergency ER trip due to complication or could vary if youth has personal connection with a particular caregiver). Another provider said it is difficult for direct care staff to manage many responsibilities while also maintaining supervision and staffing ratios. One provider echoed this concern, saying crises interfere with recreation and supervision.

Table 412. Direct care staff benefits at GROs (N=30)

	N	%
Do full-time direct care staff typically receive benefits?		
Yes	35	83.3%
No	5	16.7%

GRO Direct Care Staff Hours

Direct care staff spend most of their time supervising youth, transporting youth and reporting and document. In open-ended responses, three GRO providers mentioned accommodating changes to meet the everyday needs of children, including being able to adjust ratios for child's needs and for crisis response (crisis response was mentioned twice). Other things mentioned were longer shifts to accommodate around the clock care (16-hour shifts), meeting staff needs to balance responsibilities, and training outside of shift hours.

'For ratios, 1-on-1 time is highly circumstantial. Basic 5-year-old need more 1-on-1 than basic teens. Pregnant teens ratio could be dependent upon the number of pregnant teens in the third trimester or dealing with other complications that may require an immediate trip to the ER. 1 on 1 time with other than basic children may even be dependent upon the personal connection the child has with the caregiver. The number of children in care has been limited to the number of available staff to meet child needs like normalcy, 1-on-1 supervision, etc." _GRO Provider

Table 413. Summary of direct staff time on tasks at GROs

	N	Min	Max	Mean	Std dev
Number of minutes per shift spend on the following tasks					
Supervising youth on-site	24	240	1,500	482.88	259.07
Transporting youth to off-site appointments and activities	24	30	240	101.88	64.86
Reporting and documentation	25	20	300	91.40	71.58
Training and supervision	25	0	480	82.32	126.34
Briefing with incoming / outgoing staff during shift changes	24	15	120	37.29	24.58
Treatment team meetings	25	0	180	35.72	44.91
Percent of time direct care staff spend on the following tasks					
Supervising youth on-site	24	36.36%	82.05%	59.82%	13.76%
Transporting youth off-site	24	4.00%	25.00%	12.49%	6.45%
Reporting and documentation	24	4.17%	23.53%	10.89%	5.26%
Trainings and supervision	24	0.00%	39.02%	8.18%	9.63%
Briefing with incoming / outgoing staff during shift changes	24	1.96%	10.53%	4.67%	2.39%
Treatment team meetings	25	0.00%	11.76%	3.79%	3.24%

GRO Staffing Recommendations

To understand ideal staffing models, providers were asked a series of questions about staff positions. In addition to the tables below, six providers noted in open-ended questions that direct care staff need training on trauma informed care or TBRI. Two providers mentioned a specific youth care worker certification. Other needed trainings were emergency behavioral interventions, pre-service trainings, child development. Only one provider said there should be no additional trainings or certifications for direct care staff. two mentioned EBI, one said pre-service training, one said child development and one said no additional training/certifications.

Table 414. Ideal case manager supervision at GROs

	N	Min	Max	Mean	Std dev
Number of case managers that should be supervised by one case management supervisor	24	1	8	4.04	1.68

Table 415. Ideal years of experience for direct staff at GROs

	N	%
Years of experience that direct care supervisors should have		
1 year	7	23.3%
2 years	16	53.3%
3 years	3	10.0%
4 years.	3	10.0%
5 or more years	1	3.3%

Table 416. Ideal years of experience needed for direct care staff supervisors at GROs

	N	Min	Max	Mean	Std dev
Ideal years of experience needed for direct care supervisors	30	1	5	2.17	1.020

Table 417. Ideal number of direct care staff to one supervisor for GROs

	N	Min	Max	Mean	Std dev
Ideal number of direct care staff that should be supervised by one supervisor	28	1	30	9.32	6.213

GRO Staff Recruitment and Retention

Recruitment and retention of staff was discussed in workgroups and asked about on the survey in relation to therapists, case managers and direct care staff. Top factors noted on the survey include: flexible scheduling, competitive pay based on education and experience, health insurance and paid time off.

In open-ended responses, one provider mentioned having the ability to employ both case managers and therapists (separately) would improve recruitment and retention. One mentioned that lower caseload with youth with higher needs would improve recruitment and retention and another mentioned providing a positive work environment with communication of a shared vision. Another mentioned that experience working in the field and supervisory experience would improve recruitment and retention. One provider mentioned the burden of work outside of regular business hours and performing on-call duties.

Specifically addressing direct care staff, five providers said direct care staff need support for the difficult work they are doing - part of this is understanding the risk and supporting them through those risks (such as investigations or risks related to the pandemic). Three providers mentioned inadequate pay and benefits, which make it difficult to recruit and retain quality staff. Three mentioned positive work environment or work-life balance as important factors. Training and development opportunities were also mentioned. One provider stated:

> *'It is really important to understand the risk that these direct care staff are in every day, not just with the youth they serve, but with the rigorous standards and requirements they must follow. It is so difficult for them to stay in the lowest paying positions with the greatest level of risk - we learned this very clearly with the pandemic." _GRO Provider*

Table 418. Importance of factors impacting GRO therapist recruitment and retention

	N	Min	Max	Mean	Std dev
*Higher scores indicate a higher level of importance					
Flexibility in scheduling	15	3	4	3.60	0.51
Competitive pay based on education and experience	15	3	4	3.60	0.51
Health insurance	15	3	4	3.60	0.51
Paid time off for vacation, holidays, sick leave, or other	15	3	4	3.60	0.51
Emotional support and/or ability to debrief incidents	15	3	4	3.53	0.52
Annual raises built into pay	15	2	4	3.47	0.64
Higher pay if working with children needing specialized services	14	2	4	3.43	0.76
Retirement program such as an annuity, 401(k) or 403(b) plan	15	2	4	3.33	0.62
Being involved in team meetings and planning	15	2	4	3.33	0.62
Recognition for work	15	2	4	3.33	0.62
Professional development opportunities / CEUs	15	2	4	3.27	0.80
Assistance with annual licensing fees	15	1	4	3.27	0.80
Quality supervision	15	2	4	3.27	0.70
Supervision for interns working towards licensure	15	2	4	3.27	0.59
Lower caseloads	15	1	4	3.27	0.88
Quality training and coaching	15	2	4	3.13	0.83

Table 419. Importance of factors impacting GRO case manager recruitment and retention

	N	Min	Max	Mean	Std dev
*Higher scores indicate a higher level of importance					
Quality supervision	28	2	4	3.43	0.63
Paid time off for vacation, holidays, sick leave, or other	28	2	4	3.43	0.63
Competitive pay based on education and experience	28	2	4	3.39	0.63
Emotional support and/or ability to debrief incidents	28	2	4	3.39	0.57
Quality training and coaching	28	2	4	3.36	0.62
Annual raises built into pay	28	2	4	3.36	0.73
Health insurance	28	2	4	3.32	0.61
Recognition for work	28	2	4	3.32	0.61
Flexibility in scheduling	28	2	4	3.29	0.60
Higher pay if working with children needing specialized services	28	1	4	3.18	0.86
Professional development opportunities	28	2	4	3.18	0.61
Lower caseloads	28	2	4	3.14	0.71
Upward mobility within the agency	28	2	4	3.11	0.69
Retirement program such as an annuity, 401(k) or 403(b) plan	28	2	4	3.07	0.77
Reimbursement for travel / mileage	28	1	4	3.00	0.82
Tuition assistance (college, CDA)	28	1	4	2.57	1.0

Table 420. Level of importance of factors impacting the recruitment and retention of direct care staff at GROs

	N	Min	Max	Mean	Std dev
*Higher scores indicate a higher level of importance					
Paid time off for vacation, holidays, sick leave, or other	29	2	4	3.59	0.57
Quality supervision	28	2	4	3.54	0.69
Emotional support and/or ability to debrief incidents	29	2	4	3.52	0.69
Quality training and coaching	29	2	4	3.45	0.69
Recognition for work	29	2	4	3.48	0.57
Annual raises built into pay	29	2	4	3.41	0.73
Competitive pay based on education and experience	29	2	4	3.34	0.72
Flexibility in scheduling	29	1	4	3.28	0.84
Higher pay if working with children needing specialized services	29	2	4	3.28	0.70
Health insurance	29	2	4	3.28	0.70
Being involved in team meetings and planning	29	1	4	3.21	0.77
Professional development opportunities	29	1	4	3.10	0.86
Upward mobility within the agency	29	2	4	3.03	0.73
Retirement program such as an annuity, 401(k) or 403(b) plan	29	1	4	3.00	0.85
Hazard pay	29	1	4	2.97	1.05
Supervision for interns working towards licensure	29	1	4	2.93	1.00
Reimbursement for travel / mileage	28	1	4	2.93	1.12
Lower ratios	29	2	4	2.93	0.80
Tuition assistance (college, CDA)	29	1	4	2.41	1.02

Residential Treatment Centers

Staffing across RTCs varies. To understand the different staffing structures, a series of questions were asked about treatment directors, psychiatrists, physicians, therapists, nurses and case managers.

RTC Capacity

On average, providers reported their maximum capacity was 30 youth. However, on average, providers also reported that they had 17 youth at their facility. In open-ended questions, 35 RTC providers mentioned that issues with staffing such as pay and turnover rate under stressful conditions, prevented them from operating at capacity. Staffing was also mentioned frequently with ratio issues such as keeping staff to child ratios low to

provide better care for youth with higher needs or not having the staff to meet ratio, thus keeping the census low. Another 11 RTC providers mentioned not accepting referrals because the needs of youth could not be met by their facility (such as youth who require 1:1 supervision). Some of these providers mentioned that youth referred are often "not a fit" for their program, so more specificity about the population of youth in care with specific needs and the number of facilities in each area able to meet these needs may be needed. Six RTC providers mentioned being a new facility still building capacity, and five RTC providers mentioned struggling with operating at capacity due to COVID protocol or safety concerns.

Table 421. Typical and maximum number of youth per day at RTCs

	N	Min	Max	Mean	Median	Std dev
Number of youth typically placed at GROs on a given day	75	0	168	16.7	10.0	22.56
Max number of youth per day at GROs	76	5	200	29.6	17.0	28.40

RTC Population Served

The following table presents data on the characteristics of youth served. Almost all RTCs (87.1%) served youth with ages 14 and older. RTCs were less likely to serve youth with primary or complex medical needs.

Table 422. Does your RTC offer services for any of the following youth populations? (N=73)

Youth population	Yes, we serve this population	No, but would like to in the future	No, do not serve and don't intend to
Basic child care services only	26.0%	8.2%	65.8%
Primary Medical Needs (PMN)	11.0%	13.7%	75.3%
Complex medical needs	12.3%	12.3%	75.3%
IDD/Autism	57.5%	11.0%	31.5%
Experienced human trafficking	43.8%	20.5%	35.6%
Pregnant / parenting	13.7%	5.5%	80.8%
Substance use disorders	60.3%	6.8%	32.9%
Sexual aggression / sex offender adjudication	52.1%	6.8%	41.1%
Complex mental health needs	84.9%	1.4%	13.7%
14 years old and older	91.8%	2.7%	5.5%

RTC After-Hours Admissions

In general, RTCs reported that 24.3% of admissions happened after hours.

Table 423. Percent of admissions that occur after hours at RTCs

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of admissions that occur after hours	54	0%	100%	26.4%	24.3%	20.0%	25.66%

Table 424. Percent of admissions that occur after hours at RTCs by grouping

	N	%
Less than 25%	29	53.7
25% to 49%	11	20.4
50% to 74%	10	18.5
75% or higher	4	7.4

RTC Current Staffing

Staffing across RTCs varies. To understand the different staffing structures, a series of questions were asked about treatment directors, psychiatrists, physicians, therapists, nurses and case managers.

Table 425. Clinical Staffing at RTCs

	N	%
Treatment Director (N=72)		
Have a Treatment Director	69	95.8%
Have no Treatment Director	3	4.2%
Psychiatrist (N=69)		
Have a contracted psychiatrist	58	84.1%
Have an in-house psychiatrist	2	2.9%
Have both an in-house and contracted psychiatrist	2	2.9%
Do not have a psychiatrist	7	10.1%
Physician (N=69)		
Have a contracted physician	32	46.4%
Have an in-house physician	3	4.3%
Have both an in-house and contracted physician	1	1.4%
Do not have a physician	33	47.8%
Therapist (N=68)		
Have a contracted therapist	33	48.5%
Have an in-house therapist	21	30.9%
Have both an in-house and contracted therapist	8	11.8%
Do not have a therapist	6	8.8%
Nurse (N=65)		
Have a contracted nurse	12	18.5%
Have an in-house nurse	19	29.2%
Have both an in-house and contracted nurse	2	3.1%
Do not have a nurse	32	49.2%

RTC Treatment Director

Majority of RTCs reported having a treatment director (96%). The majority of those RTCs had one treatment director (88%) and seven had two treatment directors (10%). Five treatment directors were Medicaid/STAR Health providers, 5 were in the process of becoming credentialed, 19 were not interested in becoming Medicaid/STAR Health Providers and 4 lacked the qualifications.

Table 426. About treatment directors at RTCs

	N	%
Number of treatment directors (for RTCs with at least 1 treatment director) (N=68)		
1	60	88.2%
2	7	10.3%
3	1	1.5%
Credentialing with Medicaid/STAR Health (N=62)		
Credentialed	34	54.8%
In process of becoming credentialed	5	8.1%
Not interested in becoming credentialed	19	30.6%
Lacks qualifications	4	6.5%
Treatment director credentials at RTCs (N=75)		
Licensed Professional Counselor (LPC)	32	42.7%
Licensed Clinical Social Worker (LCSW)	10	13.3%
Licensed Master Social Worker (LMSW)	9	12.0%
Other	8	10.7%
Master's degree in a human services field (not licensed)	6	8.0%
Certified education diagnostician with a master's degree in special education or human services field	3	4.0%
Licensed Sex Offender Treatment Provider (LSOTP)	2	2.7%
Psychologist	2	2.7%
Psychiatrist	1	1.3%
Licensed Registered Nurse	1	1.3%
Licensed Chemical Dependency Counselor	1	1.3%

The next two tables provide a summary of the salaries for treatment directors.

Table 427. Typical treatment director salary for RTCs

	N	Min	Max	Mean	Std dev
Typical salary for a treatment director	53	$24,000	$122,000	$64,244.34	$18,071.62

Table 428. Summary of treatment director salary and benefits for RTCs

Salary and benefits	N	%
Typical salary for a treatment director (N=53)		
Less than $50,000	13	24.5%
$50,000 – $59,999	5	9.4%
$60,000 – $69,999	12	22.6%
$70,000 – $79,999	14	26.4%
$80,000 or higher	9	17.0%
Does treatment director receive benefits? (N=55)		
Yes	33	60.0%
No	22	40.0%

RTC Psychiatrists

Majority of the providers (90%) reported that their RTC had least one psychiatrist, with most psychiatrists being contracted (94%). Thirty-five of the RTC providers (57%) reported that their psychiatrists are on-call or available 24/7. The data below discusses contracted psychiatrists and in-house psychiatrists in separate sections.

Table 429. RTC psychiatrists that are available or on-call 24/7 (N=62)

	N	%
Yes	35	56.5%
No	24	38.7%
Prefer not to say	3	4.8%

RTC Contracted Psychiatrists

The hourly rates reported by the nine RTCs ranged from $30 to $250 per hour. Length of a typical session is 45 minutes. The RTCs who indicated “Other” had several variations on how they paid contract psychiatrists with the responses listed below:

- Contracted psychiatrists are paid between $25-$50 per session above what they can bill for via Medicaid
- Contracted psychiatrist are paid every 2 weeks
- Contracted psychiatrist receive a monthly rate based off hours
- Contracted psychiatrist is paid by Medicaid for their clients served. Their RTC contracts with him in addition to what he is billing and paid him $22,300 in FY21.
- Contracted psychiatrists receive a monthly rate based off hours
- RTC has contract with UT Health and pay a monthly a set rate for RTC/GRO services. They come on campus for in person appointments and available on call to help as needed. We pay $1,000.00 a month
- RTC does not pay the contracted psychiatrists

Table 430. About contracted psychiatrists at RTCs (N=60)

	N	%
Number of contracted psychiatrists (for RTCs with at least one contracted psychiatrist)		
1	53	88.3%
2	5	8.3%
3	1	1.7%
4	1	1.7%
Are contracted psychiatrists Medicaid/STAR Health providers?		
Yes	56	93.3%
No	4	6.7%
Do your contracted psychiatrists provide services on-site or do you have to transport youth off-site?		
Services provided on-site	29	48.3%
Transport youth to off-site appointments	8	13.3%
Both	22	36.7%
Prefer not to say	1	1.7%
How are contracted psychiatrists paid?		
Rate per hour	9	15.0%
Rate per session	1	1.7%
They bill Medicaid directly	43	71.7%
Other	7	11.7%

RTC In-House Psychiatrists

Table 431. About in-house psychiatrists at RTCs (N=4)

	N	%
Number of in-house psychiatrists (for RTCs with at least one in-house psychiatrist)		
1	3	75.0%
2	0	0.0%
3	0	0.0%
4	1	25.0%
Are in-house psychiatrists Medicaid/STAR Health providers?		
Yes	4	100.0%
No	0	0.0%

RTC Physicians

Thirty-six out of 69 providers (52%) reported that their RTC either contracted physician or had an in-house physician. Twenty-two RTC providers (61%) said that the physician was available or on-call 24/7. Details about contracted physicians and in-house physicians are reported below.

Table 432. Physicians that are available or on-call 24/7 at RTCs (N=36)

	N	%
Do you have physicians that are on-call or available 24/7?		
Yes	14	38.9%
No	22	61.1%

RTC Contracted Physicians

One RTC described they typically pay a contracted physician $125 per appointment. Two RTCs described that a typical length of an appointment is 40 minutes and 90 minutes.

Table 433. About contracted physicians at RTCs (N=33)

	N	%
Number of contracted physicians (for RTCs with at least one contracted physician)		
1	17	51.5%
2	10	30.3%
3	3	9.1%
4	2	6.1%
5 or more	1	3.0%
Do your contracted physicians provide services on-site or do you have to transport youth off-site?		
Services provided on-site	2	6.1%
Transport youth to off-site appointments	23	69.7%
Both	8	24.2%
Are contracted physicians Medicaid/STAR Health providers?		
Yes	29	90.6%
Some of them	1	3.1%
No	2	6.3%
Prefer not to say	1	3.1%
How are contracted physicians paid?		
Rate per appointment	3	9.1%
They bill Medicaid/STAR Health directly	17	81.8%
Other	1	3.0%
Prefer not to say	2	6.1%

RTC In-House Physicians

One RTC reported their in-house physician salary is $35,000, but the salary was less than full-time. No RTCs reported that an in-house physician salary is reimbursed by Medicaid/STAR Health.

Table 434. About in-house psychiatrists at RTCs (N=4)

	N	%
Number of in-house physicians (for RTCs with at least one in-house physician)		
1	3	75.0%
2	0	0.0%
3	0	0.0%
4	1	25.0%
Are in-house physicians Medicaid/STAR Health providers?		
Yes	2	50.0%
No	2	50.0%
Do in-house physicians receive benefits?		
Yes	2	50.0%
No	0	0.0%
Prefer not to say	2	50.0%

RTC Therapists

The majority of RTCs had at least one therapist (91%). Thirty-three RTCs reported contracting with a therapist, twenty-one reported having an in-house therapist, and eight reported having both an in-house and contracted therapist.

One RTC provider mentioned late hours for therapists needing to be addressed to prevent burnout. Another provider said therapists worked approximately 50 hours per week, with additional tasks including preparing for therapy sessions, learning treatment modalities for specialized issues, case consultation, supervision, relationship building with children (all adding up to about 3 hours per week). Other tasks mentioned included safety planning, CANS assessments, investigations, audits (by SSCC and Youth for Tomorrow). One provider said that therapists at their agency not only provided therapy, but also case management and supervisors of direct care staff (see quote below for more).

> *'Our therapist/supervisors wear 3 hats in their position. They are the therapist to their residents who live at the cottage they are assigned, they are their case managers and engage in all communication and treatment planning with legal teams and families, and they are the supervisors to the staff members who work directly at their cottage (this is between 4-6 staff depending on the cottage they work at). In addition, we work closely with local colleges and provide internship opportunities to students and therapists will also supervise interns on occasion as well. Therapists attend*

court hearings, different activities provided to the residents on campus or in the community (i.e.: graduations, quinceaneras, etc.)." _RTC provider

A total of 49 RTCs reported that they had a therapist available or on-call 24/7 (83%). Details about in-house and contracted therapists are reported in the following tables.

RTC Contracted Therapists

One RTC reported that contracted therapists were paid an hourly rate of $50. One RTC described that contracted therapists "bill Medicaid directly and is then provided a fee over and above he Medicaid rate per session". The length of a typical session with a contracted therapist was described as 45 and 50 minutes by two RTCs.

Table 435. About contracted therapists at RTCs (N=40)

	N	%
Number of contracted therapists (for RTCs with at least one contracted therapist)		
1	16	40.0%
2	11	27.5%
3	6	15.0%
4	4	10.0%
5 or more	3	7.5%
Are contracted therapists Medicaid/STAR Health providers?		
Yes	35	87.5%
Some of them	2	5.0%
No	3	7.5%
How are contracted therapists paid?		
Rate per hour	1	2.5%
Rate per session	3	7.5%
They bill Medicaid/STAR Health directly	34	85.0%
Other	1	2.5%
Prefer not to say	1	2.5%

RTC In-House Therapists

The percentage of therapists who were Medicaid/STAR Health providers ranged from 0 to 100%, with an average of 55%.

Table 436. About in-house therapists at RTCs

	N	%
Number of in-house therapists (for RTCs with at least one in-house therapist) (N=19)		
1	6	31.6%
2	3	15.8%
3	1	5.3%
4	3	15.8%
5 or more	6	31.7%
Credentials of in-house therapists (N=51)		
Licensed Master Social Worker (LMSW)	8	38.1%
Licensed Clinical Social Worker (LCSW)	10	47.6%
Licensed Professional Counselor (LPC)	18	85.7%
Licensed Marriage and Family Therapist (LMFT)	3	14.3%
Licensed Chemical Dependency Counselor (LCDC)	4	19.0%
Licensed Sex Offender Treatment Provider (LSOTP)	2	9.5%
Affiliate Sex Offender Treatment Provider (ASOTP)	1	4.8%
Psychologist	1	4.8%
Other	4	19.0%

Other credentials that were listed for in-house therapists at RTCs are LAC, LPC-A, LPC-associate, TF-CBT, CCTP, C-DBT, LPC-S, LSOTP-S (N=4).

Table 437. Percent of in-house therapists who are Medicaid/STAR Health providers at RTCs

	N	Min	Max	Mean	Std dev
% in-house therapists credentialed with Medicaid/STAR Health	19	0%	100%	55.3%	43.68%
% in-house therapists in process of becoming credentialed	19	0%	100%	16.3%	28.79%
% lack qualifications to become credentialed	19	0%	100%	7.4%	23.30%

The length of time it took for in-house therapists to become Medicaid/STAR Health providers ranged from 2 to 9 months, with an average of 4.6 months at RTCs.

Table 438. Length of time for Medicaid/STAR Health credentialing for RTCs

	N	Min	Max	Mean	Std dev
Months to become credentialed	14	2	9	4.6	2.06

The percent of a therapist's in-house salary that is typically reimbursed by Medicaid/STAR Health for STAR Health providers ranged from 0 to 100%, with an average of 49% being reimbursed.

Table 439. Percent of salary reimbursed by Medicaid for in-house STAR Health therapists at RTCs

	N	Min	Max	Mean	Std dev
% salary reimbursed by Medicaid	13	0%	100%	48.9%	35.62%

RTCs were asked to identify which activities therapists engaged in that were not billable by Medicaid/STAR Health. Most commonly, participating in treatment team meetings/service planning for child, participating in trainings, debriefing or providing staff support, and crises response and were listed. All results are presented in the following table.

Non-billable services mentioned included transportation, school meetings, off-site activities, leading meetings and trainings, equine therapy, court hearings, safety plans, communication and documentation. One mentioned they have yet to bill Medicaid and are not sure what is covered.

Table 440. Non-billable Medicaid/STAR Health services for in-house therapists at RTCs

Non-billable Medicaid/STAR Health services	N	%
Participation in treatment team meetings / service planning for child	18	85.7%
Participating in trainings	18	85.7%
Debriefing and providing support for staff	17	81.0%
Crisis response, de-escalation or processing something that comes up for a child	17	81.0%
Documentation beyond what is allotted by STAR Health / Medicaid	15	71.4%
Providing staff training	15	71.4%
Family engagement activities	13	61.9%
Supervision	12	57.1%
Case management activities	12	57.1%
Individual therapy sessions if more than once a week	12	57.1%
Group therapy sessions if more than once a week	11	52.4%
Sessions that occur on the same day (can only bill for one session)	10	47.6%
Family therapy sessions if more than once a week	9	42.9%
Other	5	23.8%

The typical salary of in-house therapists at RTCs ranged from $40,000 to $85,000. The ideal salary for an in-house therapist at RTCs ranged from $50,000 to $85,000.

Table 441. Average in-house therapist typical and ideal salary at RTCs

	N	Min	Max	Mean	Std dev
Typical salary for in-house therapists	17	$40,000	$85,000	$56,588.24	$10,308.12
Ideal salary for in-house therapists	15	$50,000	$85,000	$66,666.67	$9,385.91

Table 442. Summary of in-house therapist salary and benefits at RTCs

Salary and benefits	N	%
Typical salary for an in-house therapist at a RTC (N=17)		
Less than $50,000	3	17.6%
$50,000 – $59,999	8	47.1%
$60,000 – $69,999	4	23.5%
$70,000 or more	2	11.8%
Do in-house therapists receive benefits? (N=20)		
Yes	19	95.5%
No	1	5.0%
How competitive are in-house therapist salaries in your area? (N=20)		
Not at all competitive	3	15.0%
Not very competitive	6	30.0%
Somewhat competitive	8	40.0%
Very competitive	3	15.0%
Extremely competitive	3	15.0%

RTC Therapist Hours

Table 443. Number of hours therapists spend on tasks at RTCs

	N	Min	Max	Mean	Std dev
Providing scheduled therapy sessions (individual, group or family)	18	4	40	17.44	7.96
Providing crisis response, de-escalation or additional sessions to help a child process or regulate	18	0	25	6.53	7.07
Reporting and documentation	18	2	20	6.33	4.63
Performing case management	18	0	20	5.39	6.56
Participating in treatment team meetings	18	1	10	4.00	2.61
Debriefing and providing support to staff	18	0	15	3.78	3.46
Engaging foster parents or kinship caregivers outside of therapy sessions	18	0	2	2.92	4.61
Engaging birth families outside of therapy sessions	18	0	10	2.39	2.55
Providing staff training and supervision	17	0	10	2.18	2.46
Receiving training and supervision	18	0	8	2.00	1.85
Driving to appointments	17	0	8	0.884	2.06
Dealing with Medicaid billing complexities	18	0	5	0.61	1.24

RTC Nurses

Thirty-three RTC providers reporting having a nurse (51%) with 25 RTC providers stating that nurses were on-call or available 24/7 (76%). Among those who reported having a nurse, 12 providers contracted with a nurse (19%), nineteen providers had an in-house nurse (29%), and two providers both contracted with a nurse and had an in-house nurse (3%). Details about contracted nurse and in-house nurses for RTCs is in the section below.

Table 444. CPAs that have a nurse available or on-call 24/7 (N=33)

	N	%
Do you have a nurse available or on-call 24/7?		
Yes	25	75.8%
No	8	24.2%

RTC Contracted Nurses

Contract nurses at RTCs were paid between $32 and $50 an hour (N=3). Rates per appointment was not reported. The RTC that indicated “Other” reported that they pay a monthly contractual rate of $1,500. The length of a typical appointment ranged from 20 – 30 minutes (N=2).

Table 445. About contracted nurses at RTCs (N=14)

	N	%
Number of contracted nurses (for RTCs with at least one contracted nurse)		
1	10	71.4%
2	3	21.4%
3	1	7.1%
Are contracted nurses Medicaid/STAR Health providers?		
Yes	6	42.9%
No	8	57.1%
How are contracted nurses paid?		
Rate per hour	3	21.4%
Rate per appointment	2	14.3%
They bill Medicaid/STAR Health directly	4	28.6%
Other	1	7.1%
Prefer not to say	4	28.6%

RTC In-House Nurses

Table 446. About in-house nurses at RTCs (N=21)

	N	%
Number of in-house nurses (for RTCs with at least one in-house nurse)		
1	14	66.7%
2	4	19.0%
3	1	4.8%
5 or more	2	9.5%
2	14	66.7%
Is your in-house nurse a Medicaid/STAR Health provider?		
Yes	2	9.5
No	19	90.5
Credentials of in-house nurses		
Registered Nurse (RN), Licensed Vocational Nurse (LVN), or Licensed Practical Nurse (LPN)	20	95.2%
Advanced Practice Registered Nurse (APRN)	2	9.5%
Medical / Health Care Technician, Nurse's Aide	3	14.3%
Does your in-house nurse receive benefits?		
Yes	17	81.0%
No	4	19.0%

RTCs indicated that in-house nurse salary ranged from $6,240 to $86,000 (N=19). Two RTCs described that 100% of their in-house nurses' salaries were reimbursed by Medicaid/STAR Health.

Table 447. Salary of in-house nurses at RTCs

	N	Min	Max	Mean	Std dev
In-house nurse salary	18	$6,240	$86,000	$55,235.56	$20,090.30

RTC Case Management

Most providers (88.9%) noted that case management at their agency was done by a dedicated case manager. In open ended questions, RTCs who indicated "Other" in the table below described the following, with one describing that they have no case managers:

- "Ideally we would have a dedicated case manager, however, the reality is the job functions of a case manager are typically divided among administrative staff as needed"
- "They do not have case managers."
- "We have case managers, but the therapists are also required to do some case management."
- "We have one case manager who does most of the case management but the therapists also provide some case management services."

Table 448. Staff roles of who provide case management at RTCs (N=63)

Who performs case management within your agency?	N	%
Therapists	4	6.3%
Case managers	56	88.9%
Other	3	4.8%

RTC Salary and Benefits of Case Managers

Table 449. Average case manager salary at RTCs

	N	Min	Max	Mean	Std dev
Typical salary for case managers	50	$28,800	$66,000	$42,364.00	$8,027.88

Table 450. Summary of case manager salary and benefits at RTCs

Salary and benefits	N	%
Typical salary for case managers at a RTC (N=50)		
Less than $30,000	1	2.0%
$30,000 - $39,000	18	36.0%
$40,000 - $49,000	20	40.0%
$50,000 - $59,000	8	16.0%
$60,000 or higher	3	6.0%
Do case managers receive benefits? (N=54)		
Yes	21	38.9%
No	33	61.1%
How competitive is this case manager salary in your area? (N=57)		
Not at all competitive	12	21.1%
Not very competitive	12	21.1%
Somewhat competitive	24	42.1%
Very competitive	5	8.8%
Extremely competitive	4	7.0%

RTC Case Management Staff Hours

Five RTC providers said that case managers played multiple roles (such as therapists or direct care). Three providers mentioned communicating and coordinating with CPS, two mentioned supporting clients with normalcy such as extracurriculars, celebrations, or school events. Three mentioned external communication outside of the agency such as with schools or CPS. Other things mentioned included on-call duties or crisis support, transport or travel, and documentation and licensing compliance.

Table 451. Number of hours case managers spend on tasks at RTCs

	N	Min	Max	Mean	Std dev
Reporting and documentation	50	1	40	12.56	9.53
Working directly with child	50	1	50	12.06	10.10
Service planning, case coordination, and cross-system collaboration	50	1	50	11.86	9.76
Responding to crises or incidents	50	0	40	8.26	9.13
Participating in treatment team meetings	50	1	20	5.56	5.60
Driving to appointments, home visits, courts	50	0	40	5.54	7.81
Engaging foster parents or kinship caregivers	48	0	30	4.48	6.20
Receiving training and supervision	50	0	40	3.98	6.13
Engaging birth families	49	0	20	2.86	4.38
Dealing with Medicaid billing complexities	48	0	20	2.31	4.77

RTC Direct Care

In workshops, GROs noted struggles in retaining direct care staff. The tables below present findings on direct care staff. In open-ended questions, RTC providers were asked to share thoughts about direct care staff. Major themes included atypical schedules that may impact how staff time is captured (4 days on, 4 days off; different length of shift times), many responsibilities of direct care staff who are essential to the operation but severely underpaid, and hazardous nature of their job. The many responsibilities of direct care staff make it difficult to maintain staffing ratios, complete trainings.

The hazardous nature of the job takes a personal toll on direct care staff, pulling them away from family and personal time, and some direct care staff have unresolved childhood trauma themselves. Five RTC providers indicated that staff work atypical schedules (eg., 4 days on and 4 days off). Shift times vary at each agency depending on the need. One said shifts could be 15 hour or 10 hours. Because of these variations staff time may not be captured accurately in the data above. Six RTC providers said direct care staff have many job responsibilities that are no accounted for and acknowledge that DC staff are underpaid for work and job responsibilities.

Training, heightened monitoring, compliance pull staff away from their core job responsibilities or require staff to work additional hours (paid). One provider described that for the first 6 months, DC staff require at least 40 hours of instructional pre-service training and at least 20 hours of weekly on-the-job shadowing and coaching prior to working directly with youth. Two providers said it's difficult to juggle 24/7 supervision while also having other responsibilities (training). Part-time staff have particular difficulty completing training as they have other jobs.

Table 452. Direct care staff benefits at RTCs

	N	%
Do full-time direct care staff typically receive benefits? (N=56)		
Yes	36	47.4%
No	20	26.3%

RTC Direct Care Staff Hours

Though asked about other ways direct care staff spend time, ten RTC providers mentioned the need to accommodate RTC staff, such as providing protected time for breaks and lower ratios to reduce burden and handle vicarious trauma. Five RTC providers said direct care staff provide a catch-all for meeting the everyday needs of children. Three mentioned unusual shift schedules to accommodate around the clock care. two mentioned the many hours of training required before someone can work in an RTC and two mentioned accommodating for crisis response when something happens with a child (such as adjusting ratios).

> *'It is important to note that to provide a trauma-informed intervention it requires more time and energy to intervene as a staff member while also balancing the other important necessities of supervision, documentation,*

scheduling, leading activities, and other day-to-day responsibilities. It is also important to mention that our direct care staff are pulled regularly to meet with licensing, DFPS investigations, heightened monitoring, etc. so the time they spend getting interviewed for those things are not accounted for above." _RTC Provider

'The direct care staff are an essential part of the organization. They take a lot of their personal time to contribute to the facility to service the clients we serve. The pay definitely is not in line with the experience of working with the youth in care so one has to have the compassion needed to be nurturing and caring it has not been so much about the funds they make." _RTC Provider

Table 453. Direct care staff time summary

	N	Min	Max	Mean	Std dev
Number of minutes per shift spend on the following tasks					
Supervising youth on-site	55	60	5,760	617.91	823.28
Transporting youth to off-site appointments and activities	55	0	960	120.82	133.24
Reporting and documentation	55	15	480	109.00	92.12
Training and supervision	55	0	480	85.73	95.67
Treatment team meetings	55	0	180	44.36	41.97
Briefing with incoming / outgoing staff during shift changes	55	10	180	36.02	26.04
Percent of time direct care staff spend on the following tasks					
Supervising youth on-site	55	14.29%	87.50%	56.77%	18.99%
Transporting youth off-site	55	0.00%	31.86%	12.78%	7.91%
Reporting and documentation	55	2.37%	43.24%	12.08%	8.40%
Trainings and supervision	55	0.00%	46.15%	9.09%	8.96%
Treatment team meetings	55	0.00%	18.18%	4.94%	4.32%
Briefing with incoming / outgoing staff during shift changes	55	0.88%	16.67%	4.34%	2.79%

RTC Staffing Recommendations

To understand ideal staffing models, providers were asked a series of questions about staff positions. In addition to the tables below, one provider said more of a medical background/certification, and another said *'If they don't have a high school diploma it shouldn't disqualify them. If the hiring team felt she met the qualifications, she should be given the same opportunity."*

Table 454. Supervision of case managers at RTCs

	N	Min	Max	Mean	Std dev
Number of case managers that should be supervised by one case supervisor	54	0	20	3.83	3.24

Table 455. Direct care supervision summary

	N	%
How many years of experience should direct care supervisors have? (N=61)		
No prior experience is necessary	1	1.6%
1 year	22	36.1%
2 years	24	39.3%
3 years	8	13.1%
4 years	2	3.3%
5 or more years	4	6.6%
How many direct care staff should be supervised by one supervisor (N=62)		
2	5	8.1%
3	4	6.5%
4	3	4.8%
5	11	17.7%
6	9	14.5%
7	4	6.5%
8	6	9.7%
10	7	11.3%
12	4	6.5%
15	5	8.1%
16	1	1.6%
20	1	1.6%
25	1	1.6%
30	1	1.6%

Table 456. Ideal year of experience for direct care supervisors for RTCs

	N	Min	Max	Mean	Std dev
Ideal years of experience needed for direct care supervisors	61	0	5	2.0	1.14

Table 457. Ideal number of direct care staff that should be supervised by one supervisor at RTCs

	N	Min	Max	Mean	Std dev
Ideal number of direct care staff that should be supervised by one supervisor	62	2	30	8.1	5.41

RTC Staff Recruitment and Retention

Recruitment and retention of staff was discussed in workgroups and asked about on the survey in relation to therapists, case managers and direct care staff. Top factors noted on the survey include: competitive pay based on education and experience, emotional support and/or ability to debrief incidents and being involved in team meetings and planning.

In open-ended responses, seven RTC providers mentioned the specialty to work with their populations being important for recruiting and retaining therapists, including keeping caseloads low. Flexibility and work environment related factors were mentioned four times, including work-life balance and telehealth options. Other important factors included Medicaid/STAR health credentialing and billing issues, agency pay/budget, and just not being able to find therapists under the current demand.

> *'One of the biggest concerns our therapists express is that at times their therapeutic recommendation is not considered by CPS, CASA, attorneys, etc. This is very frustrating for them when it happens. Again, it does not happen across the board, but it happens fairly regularly." _RTC Provider*

> *'Since we are a 24-hour facility this means that we have to rotate on-calls in the evenings and on the weekends to provide guidance, coaching and advice when crisis arise on campus. On-calls are held by our therapists and program directors which can be taxing when focusing on a work/life balance and retention." _RTC Provider*

Table 458. Importance of factors impacting RTC therapist recruitment and retention

	N	Min	Max	Mean	Std dev
*Higher scores indicate a higher level of importance					
Competitive pay based on education and experience	59	1	4	3.46	0.70
Emotional support and/or ability to debrief incidents	59	2	4	3.37	0.69
Being involved in team meetings and planning	59	1	4	3.31	0.73
Flexibility in scheduling	59	2	4	3.31	0.65
Quality supervision	59	1	4	3.25	0.80
Health insurance	59	1	4	3.24	0.88
Higher pay if working with children needing specialized services	59	1	4	3.22	0.87
Paid time off for vacation, holidays, sick leave, or other	59	1	4	3.22	0.81
Recognition for work	59	1	4	3.19	0.75
Quality training and coaching	59	1	4	3.17	0.85
Professional development opportunities / CEUs	57	1	4	3.16	0.84
Annual raises built into pay	59	1	4	3.14	0.90
Retirement program such as an annuity, 401(k) or 403(b) plan	59	1	4	3.02	0.90
Assistance with annual licensing fees	59	1	4	2.83	0.87
Supervision for interns working towards licensure	59	1	4	2.85	0.96
Reimbursement for travel / mileage	59	1	4	2.81	1.03
Lower caseloads	59	1	4	2.81	0.88
Upward mobility within the agency	59	1	4	2.78	0.85

Four RTC providers mentioned case managers needing specific training, specialization, or experience to prepare them for the job, such as training to work with children with IDD or training in minimum standards. Three mentioned work environment and culture being important factors and three mentioned case managers currently have to wear multiple hats (therapist and case manager or supervisor who also serves as a case manager). One provider mentioned better pay and another mentioned more manageable caseloads as ways to improve recruitment and retention.

> *'Looking at the needs of the agency such as personnel and clientele and see if they would be a good fit for your organization structure and mission. Having input from them that is valued, recognized and implemented when appropriate would make them feel more part of the change agent system."*
> *_RTC Provider*

Table 459. Importance of factors impacting RTC case manager recruitment and retention

	N	Min	Max	Mean	Std dev
*Higher scores indicate a higher level of importance					
Competitive pay based on education and experience	61	2	4	3.46	.594
Paid time off for vacation, holidays, sick leave, or other	61	2	4	3.46	.594
Emotional support and/or ability to debrief incidents	61	2	4	3.43	.590
Quality supervision	61	1	4	3.36	.731
Recognition for work	61	2	4	3.36	.549
Health insurance	61	2	4	3.34	.704
Higher pay if working with children needing specialized services	61	1	4	3.30	.782
Annual raises built into pay	61	2	4	3.28	.710
Quality training and coaching	61	1	4	3.25	.767
Flexibility in scheduling	61	1	4	3.25	.675
Professional development opportunities	61	1	4	3.15	.813
Upward mobility within the agency	61	1	4	3.03	.836
Retirement program such as an annuity, 401(k) or 403(b) plan	61	1	4	2.98	.806
Reimbursement for travel / mileage	61	1	4	2.97	.875
Tuition assistance (college, CDA)	61	1	4	2.49	1.010

Eight RTC providers said that training and experience were important factors to recruiting and retaining direct care staff - both to prepare them for the work and to support their future goals. Eight providers mentioned the need to provide support for difficult work, describing the mental and physical toll an RTC takes on direct care staff (with two mentioning the stress of operating under current licensing and monitoring expectations). Six providers mentioned that pay and benefits need to improve - some stating that the state needs to pay providers better so that they can accommodate better pay and benefits. Five providers also mentioned work environment and work-life balance (like support for difficult work) being important for direct care staff, with one stating:

> *'Helping direct care staff understand the skills and experience they will learn in working with this population that can be utilized in their future careers, in educational decisions to return to school, etc. Helping direct care staff know that this experience is hard but prepares them for most jobs within the field of child welfare, counseling, social work, etc._ RTC Provider*

Table 460. Level of importance of factors impacting the recruitment and retention of direct care staff at RTCs

	N	Min	Max	Mean	Std dev
*Higher scores indicate a higher level of importance					
Quality supervision	60	2	4	3.47	0.60
Emotional support and/or ability to debrief incidents	61	1	4	3.46	0.62
Annual raises built into pay	62	1	4	3.44	0.72
Recognition for work	61	2	4	3.44	0.59
Higher pay if working with children needing specialized services	61	1	4	3.39	0.76
Competitive pay based on education and experience	61	1	4	3.38	0.78
Paid time off for vacation, holidays, sick leave, or other	61	1	4	3.38	0.66
Quality training and coaching	60	1	4	3.33	0.73
Being involved in team meetings and planning	61	1	4	3.23	0.72
Flexibility in scheduling	61	1	4	3.21	0.76
Upward mobility within the agency	61	2	4	3.20	0.73
Health insurance	61	1	4	3.15	0.87
Hazard pay	60	1	4	3.07	0.99
Professional development opportunities	61	1	4	3.03	0.86
Lower ratios	61	1	4	3.02	0.90
Reimbursement for travel / mileage	61	1	4	2.97	0.93
Retirement program such as an annuity, 401(k) or 403(b) plan	61	1	4	2.89	0.92
Supervision for interns working towards licensure	61	1	4	2.79	1.04
Tuition assistance (college, CDA)	61	1	4	2.51	0.978

Emergency Shelters

Staffing across RTCs varies. To understand the different staffing structures, a series of questions were asked about treatment directors, psychiatrists, physicians, therapists, nurses and case managers.

Emergency Shelters Capacity

On average, providers reported their maximum capacity was 22 youth. However, on average, providers also reported that they had 11 youth at their facility. In open-ended questions, 18 Emergency Shelter providers said that issues with staffing prevented them from operating at capacity. These issues included staff turnover and difficulty recruiting staff due to payment and risk-level. Ten emergency shelter providers mentioned not

operating at capacity due to children who were referred not being a match for their facility or the services they provide.

Table 461. Typical and maximum number of youth per day at emergency shelters

	N	Min	Max	Mean	Median	Std dev
Number of youth typically placed at emergency shelter on a given day	46	0	37	11.0	8.5	8.88
Max number of youth per day at emergency shelters	46	7	62	22.3	17.5	13.14

Emergency Shelters Population Served

The following table presents data on the characteristics of youth served. Almost all emergency shelters (91.1%) served youth with basic service needs only. They were less likely to serve youth with primary or complex medical needs.

Table 462. Does your emergency shelter offer services for any of the following youth populations? (N=45)

Youth population	Yes, we serve this population	No, but would like to in the future	No, do not serve and don't intend to
Basic child care services only	91.1%	2.2%	6.7%
Primary Medical Needs (PMN)	20.0%	8.9%	71.1%
Complex medical needs	11.1%	8.9%	80.0%
IDD/Autism	64.4%	8.9%	26.7%
Experienced human trafficking	64.4%	15.6%	20.0%
Pregnant / parenting	42.2%	15.6%	42.2%
Substance use disorders	64.4%	6.7%	28.9%
Sexual aggression / sex offender adjudication	33.3%	6.7%	60.0%
Complex mental health needs	62.2%	11.1%	26.7%
14 years old and older	91.1%	4.4%	4.4%
Short-term assessment / stabilization	53.2%	19.1%	23.4%

Emergency Shelters After-Hours Admissions

In general, emergency shelters reported that 60.5% of admissions happened after hours.

Table 463. Percent of admissions that occur after hours in emergency shelters

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of admissions that occur after hours	39	5%	95%	59.6%	60.5%	65.0%	26.69%

Table 464. Percent of after-hour admissions in emergency shelters by grouping

	N	%
Less than 25%	4	10.3
25% to 49%	7	17.9
50% to 74%	14	35.9
75% or higher	14	35.9

Emergency Shelters Current Staffing

Staffing across emergency shelters varies. To understand the different staffing structures, a series of questions were asked about treatment directors, psychiatrists, physicians, therapists, nurses and case managers.

Table 465. Clinical staffing at emergency shelters

	N	%
Treatment Director (N=43)		
Have a Treatment Director	10	23.3%
Have no Treatment Director	33	76.7%
Psychiatrist (N=44)		
Have a contracted psychiatrist	18	40.9%
Do not have a psychiatrist	26	59.1%
Physician (N=43)		
Have a contracted physician	11	25.6%
Do not have a physician	32	74.4%
Therapist (N=42)		
Have a contracted therapist	23	54.8%
Have an in-house therapist	13	31.0%
Have both an in-house and contracted therapist	1	2.4%
Do not have a therapist	5	11.9%
Nurse (N=42)		
Have a contracted nurse	8	19.0%
Have an in-house nurse	5	11.9%
Do not have a nurse	29	69.0%

Emergency Shelter Treatment Directors

Only 10 emergency shelters reported having a treatment director. The majority of those had one treatment director (70%) and seven had two treatment directors (30%). Eight treatment directors were Medicaid/STAR Health providers, 1 was in the process of

becoming credentialed, and 4 were not interested in becoming Medicaid/STAR Health Providers.

Table 466. About treatment directors at emergency shelters

	N	%
Number of treatment directors (for ES with at least 1 treatment director) (N=10)		
1	7	70.0%
2	3	30.0%
Credentialing with Medicaid/STAR Health (N=13)		
Credentialed	8	61.5%
In process of becoming credentialed	1	7.7%
Not interested in becoming credentialed	4	30.8%
Credentials of treatment directors at emergency shelters (N=13)		
Licensed Professional Counselor (LPC)	6	46.2%
Master's degree in a human services field (not licensed)	2	15.4%
Other	2	15.4%
Licensed Master Social Worker (LMSW)	1	7.7%
Licensed Clinical Social Worker (LCSW)	1	7.7%
Psychologist	1	7.7%

Table 467. Typical treatment director salary at emergency shelters

	N	Min	Max	Mean	Std dev
Typical salary for a treatment director	8	$40,000	$78,200	$62,150.00	$12,102.30

Table 468. Summary of treatment director salary and benefits for emergency shelters (N=9)

Salary and benefits	N	%
Typical salary for a treatment director		
Less than $50,000	2	22.2
$50,000 – $59,999	1	11.1
$60,000 – $69,999	4	44.4
$70,000 – $79,999	2	22.2
Does treatment director receive benefits?		
Yes	7	77.8%
No	2	22.2%

Emergency Shelter Psychiatrists

Forty-one percent (N=18) reported that their emergency shelter had a psychiatrist, all of whom were contracted. One emergency shelter reported that contracted psychiatrist is paid an hourly rate of $175. Two emergency shelters that indicated "other" on how they pay contracted psychiatrists described the following:

- We contract with an agency that provides psychiatric services. They bill Medicaid for the psychiatrist but we pay the agency $75 for a diagnostic assessment and $25 for a med check. All services are provided via tele-med.
- We pay our contract therapist a set fee each month at the shelter; it is $2883.00.

The data below presents data about contracted psychiatrists.

Table 469. Psychiatrists that are available or on-call 24/7 at emergency shelters(N=18)

	N	%
Do you have psychiatrists that are on-call or available 24/7?		
Yes	5	27.8%
No	12	66.7%
Prefer not to say	1	5.6%

Emergency Shelter Contracted Psychiatrists

Table 470. About contracted psychiatrists at emergency shelters (N=18)

	N	%
Number of contracted psychiatrists (for ES with at least one contracted psychiatrist)		
1	15	83.3%
2	2	11.1%
3	1	5.6%
Are contracted psychiatrists Medicaid/STAR Health providers?		
Yes	16	88.9%
No	1	5.6%
Prefer not to say	1	5.6%
Do your contracted psychiatrists provide services on-site or do you have to transport youth off-site?		
Services provided on-site	4	22.2%
Transport youth to off-site appointments	5	27.8%
Both	9	50.0%
How are contracted psychiatrists paid?		
Rate per hour	1	5.6%
They bill Medicaid directly	14	77.8%
Other	3	16.7%

Emergency Shelter Physicians

Eleven emergency shelter providers (26%) reported that they had a physician with all being contracted physicians. Out of the eleven providers, 2 providers (20%) indicated that the physicians were on-call or available 24/7. Details about contracted physicians are reported below. Emergency shelter providers did not indicate the rates or length of appointments with contracted physicians.

Emergency Shelter Contracted Physicians

Table 471. Physicians who are available or on-call 24/7 at emergency shelters (N=10)

	N	%
Do you have physicians that are on-call or available 24/7?		
Yes	2	20.0%
No	8	80.0%

Table 472. About contracted physicians at emergency shelters (N=11)

	N	%
Number of contracted physicians (for ES with at least one contracted physician)		
1	8	72.7
2	0	0.0%
3	2	18.2
4	1	9.1
Do your contracted physicians provide services on-site or do you have to transport youth off-site?		
Services provided on-site	2	18.2
Transport youth to off-site appointments	6	54.5
Both	2	18.2
Prefer not to say	1	9.1
Are contracted physicians Medicaid/STAR Health providers?		
Yes	11	100.0%
No	0	0.0%
How are contracted physicians paid?		
They bill Medicaid/STAR Health directly	10	90.9%
Prefer not to say	1	9.1%

Emergency Shelter Therapists

The majority of emergency shelters had at least one therapist (86%). Twenty-three emergency shelters reported contracting with a therapist (55%), thirteen reported having

an in-house therapist (31%), and one reported having both an in-house and contracted therapist (2.4%). A total of 17 emergency shelters reported that they had a therapist available or on-call 24/7 (47%). Details about in-house and contracted therapists are reported in the sections below.

Table 473. Therapists that are on-call or available 24/7 at emergency shelters (N=36)

	N	%
Do you have therapists that are on-call or available 24/7?		
Yes	17	47.2%
No	19	52.8%

Emergency Shelter Contracted Therapists

In addition to the information in the table below, one emergency shelter that responded with "other" described the following on how contracted therapists are paid: "Some therapists bill Medicaid directly. We bill for some therapists and pay them 90% of the Medicaid payment."

Table 474. About contracted therapists at emergency shelters (N=24)

	N	%
Number of contracted therapists (for ES with at least one contracted therapist)		
1	13	54.2%
2	6	25.0%
3	1	4.2%
4	3	12.5%
5 or more	1	4.2%
Do your contracted therapists provide services on-site or do you have to transport youth off-site?		
Services provided on-site	18	75.0%
Transport youth to off-site appointments	1	4.2%
Both	5	20.8%
Are contracted therapists Medicaid/STAR Health providers?		
Yes	23	95.8%
Some of them	1	4.2%
No	0	7.5%
How are contracted therapists paid?		
They bill Medicaid/STAR Health directly	23	95.8%
Other	1	4.2%

Emergency Shelter In-House Therapists

Emergency shelters were asked to identify which activities therapists engaged in that were not billable by Medicaid/STAR Health. Most commonly, participating in treatment team meetings/service planning for child, participating in trainings, debriefing or providing staff support, and crises response and were listed. The typical salary of in-house therapists at emergency shelters ranged from $45,000 to $65,000. All results are presented in the following tables.

Table 475. About in-house therapists at emergency shelters (N=14)

	N	%
Number of in-house therapists (for RTCs with at least one in-house therapist)		
1	7	50.0
2	3	21.4
3	3	21.4
4	1	7.1
Credentials of in-house therapists		
Licensed Professional Counselor (LPC)	9	64.3%
Licensed Master Social Worker (LMSW)	5	35.7%
Licensed Clinical Social Worker (LCSW)	3	21.4%
Other	3	21.4%
Licensed Marriage and Family Therapist (LMFT)	1	7.1%
Licensed Chemical Dependency Counselor (LCDC)	1	7.1%

Other credentials for in-house therapists at emergency shelters included Licensed Professional Counselor – Associate, LPC-Associates, LMFT-Associate, and LPC-I (N=3).

Table 476. Percent of in-house therapists who are Medicaid/STAR Health providers at emergency shelters

	N	Min	Max	Mean	Std dev
% in-house therapists credentialed with Medicaid/STAR Health	13	0%	100%	33.3%	40.25%
% in-house therapists in process of becoming credentialed	13	0%	100%	12.8%	28.99%
% lack qualifications to become credentialed	12	0%	100%	22.2%	35.06%

Table 477. Percent of salary reimbursed by Medicaid for in-house STAR Health therapists at emergency shelters

	N	Min	Max	Mean	Std dev
% salary reimbursed by Medicaid	6	25%	100%	48.2%	27.75%

Table 478. Non-billable Medicaid/STAR Health services for in-house therapists at emergency shelters

Non-billable Medicaid/STAR Health services	N	%
Debriefing and providing support for staff	8	61.5%
Crisis response, de-escalation or processing something that comes up for a child	8	61.5%
Participation in treatment team meetings / service planning for child	8	61.5%
Participating in trainings	8	61.5%
Providing staff training	7	53.8%
Supervision	7	53.8%
Sessions that occur on the same day (can only bill for one session)	6	46.2%
Case management activities	6	46.2%
Individual therapy sessions if more than once a week	5	38.5%
Documentation beyond what is allotted by STAR Health / Medicaid	5	38.5%
Family engagement activities	4	30.8%
Group therapy sessions if more than once a week	3	23.1%
Family therapy sessions if more than once a week	2	15.4%
Other	1	7.7%

Table 479. Average in-house therapist typical and ideal salary at emergency shelters

	N	Min	Max	Mean	Std dev
Typical salary for in-house therapists	12	$45,000	$65,000	$54,796.67	$5,557.12
Ideal salary for in-house therapists	13	$5,000	$80,000	$63,307.69	$8,148.46

Table 480. Summary of in-house therapist salary and benefits at emergency shelters

	N	%
Typical salary for an in-house therapist at an emergency shelter (N=13)		
Less than $50,000	2	15.4
$50,000 – $59,999	8	61.5
$60,000 – $69,999	3	23.1
Do in-house therapists receive benefits? (N=14)		
Yes	12	85.7%
No	2	14.3%
How competitive are in-house therapist salaries in your area? (N=14)		
Not at all competitive	3	21.4%
Not very competitive	3	21.4%
Somewhat competitive	7	50.0%
Very competitive	1	7.1%
Extremely competitive	0	0.0%

Emergency Shelter Therapist Staff Hours

Two providers said that therapists filled multiple staff roles or saw multiple client populations. One provider mentioned therapists providing on call crisis support (as part of being integrated into the shelter programming). Other tasks mentioned included reading documentation and preparing for team meetings (3 hours per week) and preparing for individual or group sessions (1 hour per week).

> *'We would like to point out that our in house exempt therapists work over 40-hour weeks because they are on-call and deal with crisis as they arise. They are integrated into the shelter's programing to meet the needs of the youth we serve." _Emergency Shelter Provider*

Table 481. Number of hours therapists spend on tasks at emergency shelters

	N	Min	Max	Mean	Std dev
Providing scheduled therapy sessions (individual, group or family)	14	3.00	30.00	15.2	7.22
Providing crisis response, de-escalation or additional sessions to help a child process or regulate	14	0.00	15.00	5.3	4.95
Reporting and documentation	14	0.00	15.00	4.6	4.07
Performing case management	14	0.00	15.00	2.8	4.04
Participating in treatment team meetings	14	0.00	8.00	2.6	2.205
Debriefing and providing support to staff	14	0.00	8.00	2.6	2.03
Providing staff training and supervision	13	0.00	4.00	1.6	1.193
Receiving training and supervision	14	0.00	3.00	1.5	0.94
Engaging birth families outside of therapy sessions	14	0.00	5.00	0.9	1.64
Driving to appointments	14	0.00	5.00	0.8	1.48
Engaging foster parents or kinship caregivers outside of therapy sessions	14	0.00	3.00	0.6	0.94
Dealing with Medicaid billing complexities	14	0.00	2.00	0.4	0.63

Table 482. Percent of time on tasks for in-house therapists at emergency shelters

	N	Min	Max	Mean	Std dev
Providing scheduled therapy sessions (individual, group or family)	13	8%	100%	44.1%	23.96%
Providing crisis response, de-escalation or additional sessions to help a child process or regulate	13	0%	30%	10.6%	7.85%
Reporting and documentation	13	0%	17%	9.1%	5.37%
Participating in treatment team meetings	13	0%	20%	7.2%	5.80%
Debriefing and providing support to staff	13	0%	16%	6.7%	4.47%
Performing case management	13	0%	26%	6.6%	8.52%
Providing staff training and supervision	13	0%	11%	4.6%	3.64%
Receiving training and supervision	13	0%	7%	4.1%	2.53%
Engaging birth families outside of therapy sessions	14	0%	13%	2.4%	4.21%
Driving to appointments	14	0%	13%	2.0%	3.75%
Engaging foster parents or kinship caregivers outside of therapy sessions	13	0%	8%	1.2%	2.25%
Dealing with Medicaid billing complexities	14	0%	7%	1.0%	1.95%

Emergency Shelter Nurses

Thirteen emergency shelters (31%) reported having a nurse, eight providers indicated they had a contracted nurse (19%) and five had an in-house nurse (12%). Nine emergency shelter providers reported that their nurses were on-call or available 24/7 (69%). One emergency

shelter provider reported an hourly rate of $25 for a contracted nurse. Two providers show indicated other explained that they pay contracted nurse:

- $300 a month
- We have a comprehensive care contract with University Health System to provide onsite medical care and management. The cost to Respite Care of San Antonio is $562,754 for 2022.

The information below describes the contracted nurse and in-house nurse data from emergency shelter providers.

Table 483. Nurses that are on-call or available 24/7 at emergency shelters (N=13)

	N	%
Do you have nurses that are on-call or available 24/7?		
Yes	9	69.2%
No	4	30.8%

Emergency Shelter Contracted Nurses

Table 484. About contracted nurses at emergency shelters (N=8)

	N	%
Number of contracted nurses (for ES with at least one contracted nurse)		
1	7	87.5%
5 or more	1	12.5%
Do your contracted nurses provide services on-site or do you have to transport youth off-site?		
Services provided on-site	4	50.0%
Transport youth to off-site appointments	1	12.5%
Both	3	37.5%
Are contracted nurses Medicaid/STAR Health providers?		
Yes	6	75.0%
No	2	25.0%
How are contracted nurses paid?		
Rate per hour	1	12.5%
They bill Medicaid/STAR Health directly	5	62.5%
Other	2	25.0%

Emergency Shelter In-House Nurses

Table 485. About in-house nurses at emergency shelters (N=5)

	N	%
Number of in-house nurses (for ES with at least one in-house nurse)		
1	5	100.0%
Is your in-house nurse a Medicaid/STAR Health provider?		
Yes	0	0.0%
No	5	100.0%
Credentials of in-house nurses		
Advanced Practice Registered Nurse (APRN)	1	20.0%
Registered Nurse (RN), Licensed Vocational Nurse (LVN), or Licensed Practical Nurse (LPN)	4	80.0%
Prefer not to say	1	20.0%
Does your in-house nurse receive benefits?		
Yes	4	80.0%
No	1	20.0%

Table 486. In-house nurse salary at emergency shelters

	N	Min	Max	Mean	Std dev
Typical salary for in-house nurse	4	$48,000	$75,000	$60,650.00	$11,852.85

Emergency Shelter Case Management

Most providers (80.5%) noted that case management at their agency was done by a dedicated case manager. In open ended questions, seven providers who indicated “other” reported the following:

- All case management is done by our Medical Consenter and Shelter Manager.
- in process of hiring a case manager / social worker currently done by Director
- Our shelter supervisor and manager provide most of the case management duties, although the therapist assists and at times direct care do as well.
- Our team leads help provide case management
- Service planning team to include case manager, program director, licensed counselors, child care administrator
- They do not have case managers
- We have blend of therapists and case managers who help preform these duties
- We have one case manager and two therapists who all have some functions of case management

Table 487. Staff roles of who provide case management at emergency shelters (N=41)

Who performs case management within your agency?	N	%
Therapists	1	2.4%
Case managers	33	80.5%
Other	7	17.1%

Emergency Shelter Case Manager Salary and Benefits

Table 488. Case manager salary at emergency shelters

	N	Min	Max	Mean	Std dev
Case manager salary	34	$26,000	$60,000.00	$40,411.29	$7,810.44

Table 489. Summary of case manager salary and benefits at emergency shelters

Salary and benefits	N	%
Typical salary for case managers at an emergency shelter (N=35)		
Less than $30,000	3	8.6%
$30,000 - $39,000	14	40.0%
$40,000 - $49,000	15	42.9%
$50,000 - $59,000	2	5.7%
$60,000 or higher	1	2.9%
Do case managers receive benefits? (N=34)		
Yes	22	64.7%
No	12	35.3%
How competitive is this case manager salary in your area? (N=34)		
Not at all competitive	6	18.8%
Not very competitive	7	21.9%
Somewhat competitive	16	50.0%
Very competitive	3	9.4%
Extremely competitive	0	0.0%

Emergency Shelter Case Manager Staff Hours

Emergency shelter providers mentioned a variety of other ways case managers spend time, including uncompensated weekend on-call, documentation and preparation for treatment team meetings, placement referrals and staffing, normalcy planning (mentioned by two providers), transportation, relationship building, and communication with therapists.

Table 490. Case manager hours on tasks at emergency shelters

	N	Min	Max	Mean	Std dev
Service planning, case coordination, and cross-system collaboration	31	2	32	10.3	7.78
Reporting and documentation	31	1	20	9.6	5.61
Working directly with child	31	2	40	8.1	7.21
Participating in treatment team meetings	32	0	32	4.8	6.27
Responding to crises or incidents	31	0	15	3.9	3.18
Driving to appointments, home visits, courts	31	0	15	3.8	4.50
Receiving training and supervision	31	0	10	2.6	1.88
Engaging foster parents or kinship caregivers	31	0	10	1.3	2.10
Engaging birth families	31	0	5	0.9	1.41
Dealing with Medicaid billing complexities	31	0	5	0.5	1.26

Emergency Shelter Direct Care Staff

In workshops, providers noted struggles in retaining direct care staff. The tables that follow present findings on direct care staff. In open-ended questions, providers were asked to share anything else about direct care staff. Major themes were additional tasks completed by direct care staff (communicating with back up staff, helping with homework, cooking/meal prep, personal hygiene, life skills, recreation). A few emergency shelter providers said that COVID, burnout, and challenging job negatively impact retention with one provider saying that they must over hire to help ensure they have enough staff and currently are paying overtime for staff who are covering other shifts. Two providers described a need for more resources and support to help ensure direct care staff get paid more to help with retention and that they are vital to their operation.

Table 491. Direct care staff benefits at emergency shelters

	N	%
Do full-time direct care staff typically receive benefits? (N=40)		
Yes	28	59.6%
No	12	25.5%

Emergency Shelter Direct Care Staff Hours

Though asked about other ways direct care staff spend time, four emergency shelter providers mentioned the need to support staff in balancing responsibilities, risks, and challenges in the work. Four emergency shelter providers mentioned meeting the everyday needs of children which change often. Two mentioned training, which must happen outside of scheduled shifts. Other things mentioned were unusual hours to accommodate around the clock care and crisis response.

'This is a hard position to hire and retain. It is one of the hardest and challenging positions at the shelter and it pays the lowest. All of this creates challenges. We also get limited help and support for out stakeholders when requested. Kids are often left at the shelter with no solid idea of their plans. The direct care staff and supervisors help with all basic needs and then with everything else they need to make their stay safe and positive. Shelter dynamics change daily and so do staff so the fatigue for direct care staff is real. Caregiver burnout is real and we need resources to help address this." _Emergency Shelter Provider

Table 492. Direct staff time summary at emergency shelters

	N	Min	Max	Mean	Std dev
Number of minutes per shift spend on the following tasks					
Supervising youth on-site	39	180	1500	425.5	206.18
Transporting youth to off-site appointments and activities	39	18	240	107.9	60.26
Reporting and documentation	39	15	300	72.2	53.01
Training and supervision	39	0	480	69.3	94.85
Briefing with incoming / outgoing staff during shift changes	39	10	120	32.0	28.02
Treatment team meetings	39	0	120	24.7	27.35
Percent of time direct care staff spend on the following tasks					
Treatment team meetings	39	0%	9%	3.0%	2.85%
Trainings and supervision	39	0%	38%	8.4%	8.68%
Reporting and documentation	39	3%	25%	9.8%	5.30%
Transporting youth off-site	39	3%	33%	15.3%	7.99%
Supervising youth on-site	39	32%	87%	59.2%	12.88%
Briefing with incoming / outgoing staff during shift changes	39	1%	13%	4.3%	2.65%

Emergency Shelter Staffing Recommendations

To understand ideal staffing models, providers were asked a series of questions about staff positions. In terms of training, 11 emergency shelter providers mentioned CPR/First Aid, eight mentioned EBI techniques, four mentioned trauma informed care, two mentioned medication training. Other types of training or certifications included initial and ongoing training, normalcy, reporting abuse, transportation, etc.

'CPR/First Aid, Restraint Training, Trauma Informed Care, Recognizing/Reporting Sexual Abuse, Psychotropic medication, Normalcy, Sexual Harassment Prevention, Disaster and Emergency Response and Active Shooter Training, Healthy Relationships and Attachment training, Transportation training" _Emergency Shelter Provider

Table 493. Supervision of case managers at emergency shelters

	N	Min	Max	Mean	Std dev
Number of case managers that should be supervised by one case supervisor	34	0	6	3.1	1.53

Table 494. Direct care supervision summary at emergency shelters (N=42)

	N	%
How many years of experience should direct care supervisors have?		
No prior experience is necessary	1	2.4%
1 year	14	33.3%
2 years	19	45.2%
3 years	4	9.5%
4 years	2	4.8%
5 or more years	2	4.8%
How many direct care staff should be supervised by one supervisor		
3	2	4.8%
4	5	11.9%
5	7	16.7%
6	8	19.0%
7	1	2.4%
8	8	19.0%
9	2	4.8%
10	2	4.8%
12	4	9.5%
15	1	2.4%
20	1	2.4%
25	1	2.4%

Table 495. Ideal year of experience for direct care supervisors for emergency shelters

	N	Min	Max	Mean	Std dev
Ideal years of experience needed for direct care supervisors	42	0	5	2.0	1.08

Table 496. Ideal number of direct care staff that should be supervised by one supervisor at emergency shelters

	N	Min	Max	Mean	Std dev
Ideal number of direct care staff that should be supervised by one supervisor	42	3	25	7.8	4.36

Emergency Shelter Staff Recruitment and Retention

Recruitment and retention of staff was discussed in workgroups and asked about on the survey in relation to therapists, case managers and direct care staff. Top factors noted on the survey include: flexibility in scheduling, paid time off, and competitive pay based on education and experience.

In open-ended responses, three providers most frequently mentioned not being able to provide the flexibility and work environment therapists want, this was sometimes coupled with the inability to pay therapists adequately (mentioned two times). Other issues mentioned included training/specialization to work with population or having contract only therapists.

Four Emergency shelter providers mentioned pay being a big factor in recruiting and retaining case managers, expressing the need for more dedicated funding for case management. Three providers mentioned work-life balance, burnout prevention (including mental health support) and positive work environment. Other factors mentioned included reducing state requirements, caseloads, and training or experience to prepare them for the job.

> *'It is difficult to find individuals trained in "true" case management unless the salary we are able to pay is increased and more competitive. Also, the nature of the work we do - it is difficult to retain because of high level of burn out." _ Emergency Shelter Provider*

Table 497. Importance of factors impacting therapist recruitment and retention in emergency shelters

	N	Min	Max	Mean	Std dev
*Higher scores indicate a higher level of importance					
Flexibility in scheduling	14	2	4	3.64	0.63
Paid time off for vacation, holidays, sick leave, or other	14	2	4	3.64	0.63
Competitive pay based on education and experience	14	3	4	3.57	0.51
Health insurance	14	2	4	3.57	0.65
Annual raises built into pay	14	2	4	3.50	0.76
Professional development opportunities / CEUs	14	2	4	3.50	0.65
Recognition for work	14	2	4	3.50	0.65
Emotional support and/or ability to debrief incidents	14	2	4	3.50	0.76
Retirement program such as an annuity, 401(k) or 403(b) plan	14	2	4	3.36	0.75
Quality training and coaching	14	2	4	3.29	0.73
Quality supervision	14	1	4	3.29	0.91
Being involved in team meetings and planning	14	2	4	3.21	0.89
Higher pay if working with children needing specialized services	14	2	4	3.14	0.86
Supervision for interns working towards licensure	14	1	4	3.14	0.86
Reimbursement for travel / mileage	14	1	4	3.07	1.07
Assistance with annual licensing fees	14	1	4	3.07	0.92
Lower caseloads	14	1	4	2.71	0.91
Upward mobility within the agency	14	1	4	2.57	0.94

Table 498. Importance of factors impacting case manager recruitment and retention in emergency shelters

	N	Min	Max	Mean	Std dev
*Higher scores indicate a higher level of importance					
Paid time off for vacation, holidays, sick leave, or other	42	2	4	3.43	0.67
Annual raises built into pay	42	2	4	3.40	0.67
Competitive pay based on education and experience	42	2	4	3.40	0.67
Emotional support and/or ability to debrief incidents	42	2	4	3.40	0.70
Quality supervision	42	2	4	3.38	0.66
Quality training and coaching	42	2	4	3.33	0.65
Recognition for work	42	2	4	3.31	0.72
Higher pay if working with children needing specialized services	42	1	4	3.26	0.89
Health insurance	42	1	4	3.21	0.71
Professional development opportunities	42	2	4	3.21	0.57
Flexibility in scheduling	42	1	4	3.19	0.77
Retirement program such as an annuity, 401(k) or 403(b) plan	42	1	4	3.10	0.79
Upward mobility within the agency	42	1	4	2.86	0.84
Reimbursement for travel / mileage	42	1	4	2.86	0.93
Lower caseloads	42	1	4	2.83	0.91
Tuition assistance (college, CDA)	42	1	4	2.43	0.94

Nine emergency shelter providers mentioned direct care staff need support for difficult work - especially dealing with vicarious trauma and with the high risk of being investigated which effects their work and personal life. Closely related, eight providers mentioned work environment and work-life balance being important to balance out the high risk-low reward job of direct care. Five providers mentioned pay and benefits being important for recruitment and retention and five mentioned training and experience. Two mentioned that the pandemic has made recruitment and retention difficult.

> *'THE biggest challenge I have had in recruiting and retaining direct care staff is the retention piece. Many people think the job of direct care staff is simply to babysit; however, the actual job of the direct care staff is to provide the care for each child 24/7. Many of the children who come to an emergency shelter are new to foster care or struggle in placements due to their trauma. All of the children who admit to an emergency shelter are in crisis. Therefore, staff have to be trained and skilled in trauma informed practices and crisis intervention. These children who come from hard places come with very difficult behaviors and coping mechanisms, which means direct care staff often receive the brunt of their anger and maladaptive behaviors. Also, direct*

care staff who stay in the position for a long time are usually motivated to do so by their dedication to helping children. The intrinsic reward for them keeps them doing the job they do. My staff rely on my support to help process any emotions they have after crises or to simply vent about anything they need. They feel motivated when we are able to attend trainings that equip them for their work. The support from the administration is vital, but they specifically feel it when the leadership is able to work alongside them during difficult times." _Emergency Shelter Provider

'Pay is very important, especially for emergency shelters, being that there is only one rate no matter the LOC of the child in placement, its hard to provide care for higher LOC and not be able to pay the staff at a fair rate." _Emergency Shelter Provider

Table 499. Level of importance of factors impacting the recruitment and retention of direct care staff at emergency shelters

	N	Min	Max	Mean	Std dev
*Higher scores indicate a higher level of importance					
Quality supervision	42	2	4	3.52	0.55
Emotional support and/or ability to debrief incidents	41	2	4	3.51	0.60
Paid time off for vacation, holidays, sick leave, or other	42	2	4	3.50	0.71
Recognition for work	42	2	4	3.50	0.60
Annual raises built into pay	42	2	4	3.48	0.63
Competitive pay based on education and experience	42	2	4	3.48	0.59
Higher pay if working with children needing specialized services	42	1	4	3.48	0.71
Health insurance	42	1	4	3.38	0.73
Quality training and coaching	42	1	4	3.38	0.73
DC recruit and retain - Professional development opportunities	42	2	4	3.19	0.67
Retirement program such as an annuity, 401(k) or 403(b) plan	42	1	4	3.12	0.94
Lower ratios	42	2	4	3.12	0.77
Being involved in team meetings and planning	42	2	4	3.10	0.656
Flexibility in scheduling	42	1	4	3.05	0.80
Upward mobility within the agency	42	2	4	3.00	0.77
Hazard pay	41	1	4	3.00	1.07
Reimbursement for travel / mileage	42	1	4	2.88	0.97
Supervision for interns working towards licensure	42	1	4	2.69	1.00
Tuition assistance (college, CDA)	42	1	4	2.52	0.99

Residential Operations Administration

Residential Operations Administrative Staff

In addition to the direct care staff discussed above, providers were asked about administrative staff who are not accounted for in their current cost reports. Subsequent tables provide information about information and technology staff, development and fundraising staff, communications and marketing staff, compliance and licensing staff, and security staff.

Residential Operations Information and Technology Staff

Table 500. Information/technology staff and salaries

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Type of staff							
Full-time staff who only do IT	57	0	5	0.9	0.7	1.0	1.24
Full-time staff who do IT as one part of their job	57	0	5	1.0	0.9	1.0	1.25
Part-time staff who only do IT	57	0	5	0.4	0.3	0.0	0.88
Part-time staff who do IT as one part of their job	57	0	5	0.3	0.1	0.0	0.84
Salary							
Salary and fringe for IT staff	57	$0	$1,800,000	$84,940	$52,692	$50,000	$235,918

Residential Operations Development and Fundraising Staff

Table 501. Development/fundraising staff and salaries

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Type of staff							
Full-time staff who only do development/fundraising work	63	0	5	1.54	1.4	1.0	1.67
Full-time staff who do development/fundraising as one part of their job	63	0	5	0.84	0.7	1.0	1.11
Part-time staff who only do development/fundraising	63	0	4	0.25	0.1	0.0	0.84
Part-time staff who do development/fundraising as one part of their job	63	0	5	0.27	0.1	0.0	0.92
Salary							
Salary and fringe for development/fundraising staff	63	$0	$2,000,000	$173,877	$125,963	$67,000	$293,496

Residential Operations Communications and Marketing Staff

Table 502. Communication/marketing staff and salaries

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Type of staff							
Full-time staff who only do communication/marketing work	61	0	5	0.8	0.6	0.0	1.25
Full-time staff who do communication/marketing as one part of their job	61	0	5	1.0	0.9	1.0	1.22
Part-time staff who only do communication/marketing	61	0	2	0.1	0.1	0.0	0.39
Part-time staff who do communication/marketing as one part of their job	61	0	5	0.2	0.1	0.0	0.73
Salary							
Salary and fringe for communication/marketing staff	61	$0	$800,000	$72,201	$57,382	$45,600	$112,848

Residential Operations Security Staff

Table 503. Security staff and salaries

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Type of staff							
Full-time staff who only do security work	26	0	5	0.5	0.3	0.0	1.07
Full-time staff who do security as one part of their job	26	0	5	1.8	1.7	1.0	1.84
Part-time staff who only do security	26	0	5	0.5	0.3	0.0	1.42
Part-time staff who do security as one part of their job	26	0	5	0.5	0.3	0.0	1.10
Contracted security staff	26	0	5	0.9	0.7	0.0	1.42
Salary							
Salary and fringe for security staff	26	$0	$199,000	$43,474	$37,249	$35,873	$52,744

Residential Operations Compliance and Licensing Staff

Table 504. Compliance/licensing staff and salaries

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Type of staff							
Full-time staff who only do compliance/licensing work	90	0	5	0.9	0.7	0.0	1.36
Full-time staff who do compliance/licensing as one part of their job	90	0	5	1.6	1.5	1.0	1.54
Part-time staff who only do compliance/licensing	90	0	5	0.3	0.1	0.0	1.03
Part-time staff who do compliance/licensing as part of their job	90	0	5	0.3	0.1	0.0	1.04
Salary							
Salary and fringe for compliance/licensing staff	90	$0	$850,013	$100,953	$81,646	$65,000	$127,900

Residential Operations Staff Training

Providers reported spending an average of $18,593 on staff training in the last year. Trainings were accessed in a variety of ways with online, train the trainer models and in-house trainings being the most common.

Table 505. Amount spent on staff training last year

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Amount spent	73	$0	$100,000	$18,593	$15,099	$7,500	$26,405

Table 506. Percent of agencies reporting staff engage in training type (N=73)

	N	%
Online training	117	75.0
Trainings developed in-house and provided by dedicated training staff	106	67.9
Staff who have been trained-to-train an external model and provide training on-site	89	69.5
External trainer comes to train staff on-site	93	72.7
Staff attend local trainings in the community	62	48.4
Staff attend regional trainings in the state	53	41.4
Staff attend national trainings out-of-state	15	11.7

Residential Operations Accreditation

In workshops, accreditation was mentioned as an expense that is not covered by DFPS reimbursement. In the survey, almost half of the providers responded that they are not accredited or seeking accreditation (48.3%). Both workshop participants and survey respondents noted that accreditation is pulls staff away from other duties.

Table 507. Accreditation statuses and accrediting entities

	N	%
Percent of agencies that are accredited		
Currently accredited	44	36.7%
Working on accreditation	18	15.0%
Not accredited or working on accreditation	58	48.3%
Accrediting entity for those already accredited		
Council on Accreditation (COA)	33	75.0%
Commission on Accreditation of Rehabilitation Facilities (CARF)	9	20.5%
The Joint Commission	1	2.3%
Other	1	2.3%
Accrediting entity for those working towards accreditation		
Council on Accreditation (COA)	6	33.3%
Commission on Accreditation of Rehabilitation Facilities (CARF)	9	50.0%
The Joint Commission	2	11.1%
Other	4	22.2%

Table 508. Reasons for not being accredited or working on accreditation

	N	%
Cost prohibitive	31	12.2%
Pulls staff away from primary duties	18	42.9%
Not worth the time	5	11.9%
Other reason	11	4.3%

Residential Operations Case Management Systems

Case management systems are also an item that is not considered on provider cost reports. However, 68% of providers noted that their agency uses at least one case management system, with Extended Reach being the most commonly used.

Table 509. Case management systems used

	N	%
Percent of agencies that use case management systems		
Do not use any system	39	32.0%
Use one system	77	63.1%
Use two systems	4	3.3%
Use three systems	2	1.6%
Case management systems used		
Custom system	6	7.1%
Apricot	0	0.0%
ASI	0	0.0%
Binti	0	0.0%
Casebook	5	6.0%
Charity Tracker	1	1.2%
Client Track	2	2.4%
D365	1	1.2%
EMR Bear	1	1.2%
Evolve	5	6.0%
Excel	1	1.2%
Extended Reach	55	65.5%
FamCare	1	1.2%
HMIS	1	1.2%
KPUI	1	1.2%
Salesforce	0	0.0%
SAM	0	0.0%

Table 510. Reasons for not using case management system

	N	%
Cost prohibitive	23	52.3%
Too time consuming to figure out	4	9.1%
Have not done the research	7	15.9%
Too small to need one	24	5.9%
Systems don't do everything we need	5	10.7%
Other reason	5	11.4%

Table 511. Costs for case management systems

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Initial cost for case management system	60	$0	$1,400,000	$65,738	$36,005	$8,000	$192,760
Annual cost for current case management systems	60	$0	$126,000	$24,483	$21,722	$12,000	$28,586
Costs for updates in last year that were outside of annual costs	60	$0	$80,000	$10,705	$7,487	$3,000	$19,781

Residential Operations Service Provision

Residential Operations Treatment Models

Most GROs (85%) reported using at least one evidence-informed practice. Of those who use an evidence-informed practice, TBRI was the most often used practice. In open-ended responses, providers noted that the cost of training is high and balancing the need for flexibility/various models to meet children where they are is difficult. Providers also noted it is difficult to balance employee time (training costs salaries and coverage). Cost of training is high and balancing the need for flexibility/various models to meet children where they are is difficult. The funding and support needed to both keep up with required trainings by the state and provide quality initial and ongoing training for employees, especially when the turnover rate is so high, is not there for many agencies.

> *'With the roll out of TBRI to be utilized in central Texas across all fields it is important to note the cost associated with keeping staff trained. Due to turnover in our field we often have to send staff to receive the full week TBRI training so that they can provide TBRI training to our new direct care staff. This is costly. It is currently $3,500 per person and this does not include any travel expenses if the training is not offered in Austin. It is also important to note that since we have committed to TBRI it leaves little to no budget for therapists to gain additional training in other treatment modalities that could be helpful in working with our population." _RTC Provider*

> *'We strive to educate ourselves and utilize different models for each individual. We understand that one model will not work for all. We deal with unique youth, and therefore we must meet them where they are from in all areas." _RTC Provider*

> *'They all come with a significant cost. We believe the investment in these training/treatment result in better outcomes for our youth at the shelter." _Emergency Shelter Provider*

> *'Children want normalcy but we are always trying to find the leverage between RCCL/violations and allowing our children to simply enjoy being children." _Emergency Shelter Provider*

Residential Operations Current Models

Table 512. Residential operations number of evidence-informed practices

	GRO		RTC		Emergency shelter	
	N	%	N	%	N	%
Does not use an evidence-informed practice	3	15.0%	12	26.1%	4	13.3%
Uses 1 evidence-informed practice	5	25.0%	14	30.4%	14	46.7%
Uses 2 evidence-informed practices	5	25.0%	10	21.7%	3	10.0%
Uses 3 evidence-informed practices	3	15.0%	3	6.5%	4	13.3%
Uses 4 evidence-informed practices	3	15.0%	3	6.5%	1	3.3%
Uses 5 evidence-informed practices	1	5.0%	4	8.7%	4	13.3%

Table 513. Residential operations current treatment models (N=94)

Treatment Model	Number of providers
TBRI	54
TF-CBT	26
Trauma Informed Care	15
EMDR	8
DBT	6
Motivational Interviewing	6
SAMA	4
Crisis Prevention Intervention	3
Power Source	3
Reality Therapy	3
Sanctuary Trauma Informed Care	3
SFBT	3
Ukeru	3
EQ2	2
Person Centered Therapy	2
Play Therapy	2
Positive Behavioral Interventions and Supports	2
Residential Child and Youth Professional	2
Strengths Model	2
12 steps	1
Aggression Replacement Training	1
Applied Behavior Analysis	1
Bringing in the Bystander	1
Building Bridges Initiative	1
EBT	1
Family Systems	1
Family Teaching Model	1
Handle with Care	1
Incentive Programs	1
Love and Logic	1
MAB	1
PAPH	1
PAX Tools	1
Positive Parenting	1
Positive Youth Development	1
Safety Contracts / Coping Skills	1
SATORI	1
Somatic Experiencing	1
Structured Teaching	1
Therapeutic Crisis Intervention	1
Trauma Focus Therapy	1
Triple P	1

Residential Operations Ideal Treatment Models

Table 514. Residential operations ideal treatment models (N=32)

Treatment Model	Number of providers
TBRI	7
Art/Music Therapy	4
DBT	4
EMDR	4
Neurofeedback	4
Collaborative Problem Solving	3
CARE	2
Equine	2
Experiential Therapy	2
Neurotherapy	2
NMT	2
Parents as Teachers	2
Play Therapy	2
AIMS Vocational and Aptitude Testing	1
Family Finding	1
My Life My Choice Prevention	1
Parents as teachers	1
PRT - Primary Restraint Technique	1
RCYCP	1
Readtropia (Balanced Literary approach to reading)	1
Safe and Sound Protocol	1
Sand Tray Therapy	1
STAR Curriculum (ABA Based)	1
Strength Based Therapy	1
Trauma Informed Care	1
Ukeru	1
Video Modeling	1
Vizzle (TEKS aligned) Standards curriculum	1

Residential Operations Cost of Treatment Model

Table 515. GRO costs associated with treatment models within last year

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Last year's costs associated with treatment models used by your GRO	73	$0	$100,000	$14,358	$10,626	$4,500	$26,152

Residential Operations Emergency Behavior Intervention

Table 516. Emergency Behavior Interventions (EBI)

	N	%
Satori Alternatives to Managing Aggression (SAMA)	37	28.7%
Behavior Crisis Management Technique Model	12	9.3%
Handle with Care	15	11.6%
Managing Aggressive Behavior (MAB)	11	8.5%
Prevention of Aggressive and Physical Holds (PAPH)	15	11.6%
Developed in-house	4	3.1%
Crisis Prevention Institute - Nonviolent Crisis Intervention (CPI)	24	18.6%
Trust Based Relational Intervention (TBRI)	3	2.3%
Emergency Behavior Intervention (EBI)	1	0.8%
The Mandt System	1	0.8%
Professional Crisis Management (PCM)	1	0.8%
Safe Crisis Management	2	1.6%
Texas Behavior Support Initiative (TBSI)	1	0.8%
Therapeutic Crisis Intervention	1	0.8%
Treat Aggression with Care Training (TACT)	1	0.8%

Residential Operations Normalcy

In workshops, providers and foster parents discussed at length the costs associated with normal activities. Using their information, the research team designed a series of questions to understand various costs including staff who coordinate activities, basic needs items, activities and summer camps. All workshops discussed the higher costs for older youth related to clothes, hygiene and activities. All workshops also discussed challenges to youth driving and working. Thus, a series of questions focused on the costs for older youth.

Residential Operations Age Groups Served

Table 517. Age groups served by residential operations

	N	%
Birth through 4 years old	21	16.5%
5 through 13 years old	97	76.4%
14 years old and older	116	91.3%

Residential Operations Staff Who Coordinate Normalcy Activities

Table 518. Numbers of staff who coordinate normalcy activities

	N	Min	Max	Mean	Std dev
Full-time staff whose job is only coordination of activities	123	0	5	0.7	1.19
Full-time staff who coordinate activities as one part of their job	123	0	5	2.2	1.70
Part-time staff whose job is only coordination of activities	123	0	5	0.3	0.88
Part-time staff who coordinate activities as one part of their job	123	0	5	0.4	1.22

Table 519. Percent of staff GROs have to coordinate normalcy activities (N=123)

	0	1	2	3	4	5
Full-time staff whose job is only coordination of activities	67.5%	17.1%	5.7%	4.9%	2.4%	2.4%
Full-time staff who coordinate activities as one part of their job	17.1%	24.4%	22.0%	13.8%	4.1%	18.7%
Part-time staff whose job is only coordination of activities	87.8%	5.7%	2.4%	1.6%	0.8%	1.6%
Part-time staff who coordinate activities as one part of their job	82.9%	5.7%	3.3%	2.4%	1.6%	4.1%

Residential Operations Annual Normalcy Costs

Providers were asked how much their agency spends per child in a year on activities, camps, holidays, birthday, clothing, hygiene, and hair care. Some outliers were removed from this analysis because they represented a total cost spent per agency rather than a per child. The costs per child are broken down by age group in the next three tables.

Table 520. Annual costs for items for children less than 5 years old

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Clothing	17	$30	$1,871	$320	$250	$150	$449
Hygiene products	17	$0	$240	$78	$73	$50	$77
Hair care	17	$0	$120	$43	$41	$30	$39
Birthdays	17	$20	$200	$84	$81	$100	$51
Holidays	17	$0	$1,200	$210	$167	$100	$292
Milestones (i.e. graduations)	17	$0	$360	$81	$70	$45	$108
Normalcy activities	17	$0	$500	$157	$146	$100	$136
Summer camp	17	$0	$600	$84	$60	$0	$168

Table 521. Annual costs for items for children 5 to 13 years old

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Clothing	61	$40	$1,991	$479	$432	$360	$416
Hygiene products	61	$0	$2,000	$222	$167	$120	$335
Hair care	61	$0	$2,000	$190	$154	$109	$274
Birthdays	61	$5	$600	$139	$124	$100	$127
Holidays	61	$0	$1,200	$296	$267	$200	$288
Milestones (i.e. graduations)	61	$0	$1,000	$151	$125	$100	$191
Normalcy activities	61	$10	$3,187	$474	$373	$300	$629
Summer camp	61	$0	$3,700	$195	$94	$0	$565

Table 522. Annual costs for items for children 14 years old and older

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Clothing	76	$40	$2,071	$562	$509	$500	$492
Hygiene products	76	$0	$2,500	$245	$184	$150	$368
Hair care	76	$0	$2,500	$243	$179	$150	$403
Birthdays	76	$0	$1,200	$149	$127	$100	$166
Holidays	76	$0	$3,000	$367	$298	$200	$474
Milestones (i.e. graduations)	76	$0	$1,000	$215	$198	$180	$196
Normalcy activities	76	$10	$3,187	$629	$531	$300	$780
Summer camp	76	$0	$3,700	$203	$108	$0	$537

Table 523. How residential operations cover costs for normalcy

	N	Use in-kind donations	Find sponsors	Find other entities*	Our agency pays for this	Youth or youth's family pays for this
Costs of activities	119	64.7%	58.0%	34.5%	91.6%	4.2%
Costs of clothing, hygiene and haircare	125	49.6%	36.8%	33.6%	96.8%	4.0%
Costs of celebration and milestone cost	124	46.0%	41.9%	26.6%	97.6%	4.0%

*Includes child welfare boards, support agencies

Residential Operations Activities

Table 524. Frequency of youth engaging in activities

	N	Daily	A few times a week	Once a week	A few times a month	Once a month
Extracurricular activities	122	18.9%	31.1%	12.3%	21.3%	8.2%
Faith-based services	123	0.0%	9.8%	45.5%	22.0%	8.9%
Movies, concerts	123	0.8%	10.6%	14.6%	43.9%	22.8%
School events	121	3.3%	9.9%	8.3%	31.4%	18.2%
Visits to area attractions (zoos, museums, community fairs)	121	0.0%	5.8%	12.4%	34.7%	28.9%
Going out to eat	122	0.0%	10.7%	19.7%	36.9%	18.9%

Table 525. Percent of youth who attend summer camp and ideal percent of attendance

	N	Min	Max	Mean	Std dev
Youth who attend summer camp	110	0%	100%	19.3%	32.46%
Youth who would ideally attend summer camp	110	0%	100%	53.7%	41.85%

Table 526. Frequency of activities in one-week period

	N	Min	Max	Mean	Std dev
On campus activities	120	1	29	5.4	4.15
Off campus activities	119	0	7	2.1	1.16

Table 527. Percent of budget spent for on-campus and off-campus activities

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of annual budget spent for on-campus activities	120	0%	97%	10.9%	8.4%	5.0%	16.26%
Percent of annual budget spent for off-campus activities	119	0%	46%	10.5%	9.5%	5.0%	11.79%

Residential Operations Specialized Cost Considerations for Older Youth

Hair

Table 528. Frequency of haircare services for youth at residential operations

	N	Never	2x a year	Once every 3 months	Every other month	Less than monthly	Once a month	Twice a month	Weekly	Daily	As needed / requested
How often do African American youth see a stylist who specializes in black hair?	122	5.7%	0.8%	9.0%	13.1%	0.8%	32.0%	9.0%	1.6%	0.8%	27.0%
How often do youth with short hair receive haircuts?	122	0.0%	0.0%	0.0%	13.1%	2.5%	43.4%	31.1%	0.0%	0.0%	9.8%
How often do youth with long hair receive haircuts?	125	0.0%	0.8%	6.4%	0.0%	1.6%	3.2%	1.6%	0.0%	0.0%	86.4%

Additionally, nine providers specified that staff, volunteers, or community partnerships that help them meet the hair/styling needs of African American youth. One provider mentioned they do not have youth with long hair and two providers specified that a volunteer comes onsite to provide haircuts.

Allowance

Ages 5 – 13

Five providers specified that allowance is given weekly, one specified allowance every 2 weeks ($10). Amounts ranged from $3 to $10 per week. Nine providers described a level, behavior, or chore system for earning allowance and three mentioned allowance that youth could only use at an onsite store.

Ages 14+

Five providers specified that allowance is given weekly, one specified allowance every 2 weeks ($10). Amounts ranged from $3 to $15 per week. Nine providers described a level, behavior, or chore system for earning allowance and three mentioned allowance that youth could only use at an onsite store.

Table 529. Allowance information for youth 5 through 13 years old (N=89)

	N			%	
Receive allowance	55			61.8%	
Frequency of allowance (N=54)					
Weekly allowance	30			55.6%	
Monthly allowance	11			20.4%	
Other	13			24.1%	
Amount of allowance	N	Min	Max	Mean	Std dev
Weekly	29	$3.00	$20.00	$8.41	$4.73
Monthly	9	$20.00	$100.00	$38.33	$25.25

Table 530. Allowance information for youth ages 14 and older (N=103)

	N			%	
Receive allowance	60			58.3%	
Frequency of allowance (N=56)					
Weekly allowance	31			55.4%	
Monthly allowance	15			26.8%	
Other	10			17.9%	
Amount of allowance	N	Min	Max	Mean	Std dev
Weekly	29	$5.00	$35.00	$11.52	$6.69
Monthly	14	$7.00	$200.00	$42.29	$50.95

Employment

Table 531. Percent of youth who have jobs when age-appropriate

	N	%
Yes	70	63.6%
No	40	36.4%

Table 532. Number of days a week youth typically work

	N	Min	Max	Mean	Std dev
Days a week that youth work	69	2	5	3.3	0.87

Table 533. How agencies manage transporting youth to work

	N	%
Extra staff on that shift so we stay in ratio while transporting youth	28	40.6%
We bring other youth with us in the vehicle to stay in ratio	32	46.4%
Other	9	13.0%

Driving

Table 534. Percent of youth who complete driver's education

	N	%
Always	6	6.1
Most of the time	18	18.2
About half of the time	6	6.1
Some of the time	41	41.4
Never	28	28.3

Table 535. How agencies manage transporting youth to driver's education

	N	%
Extra staff on that shift so we stay in ratio while transporting youth	33	43.4%
We bring other youth with us in the vehicle to stay in ratio	33	43.4%
Other	10	13.2%

Table 536. Means youth have to obtain a car (N=80)

	N	%
Use in-kind donations to cover costs	7	8.8%
Find sponsors to help cover costs	13	16.3%
Find other entities to help (Child welfare boards, support agencies)	6	7.5%
Our agency pays for this	5	6.3%
The youth/youth's family pays for this	20	25.0%
Youth cannot have a car	41	51.3%
Other	13	16.3%

Table 537. Percent of agencies who help with vehicle costs (N=40)

	N	%
Vehicle maintenance costs	6	15.0%
Care insurance costs	3	7.7%

Preparation for Adulting Living (PAL)

Table 538. Percent of agencies who offer PAL classes

	N	%
Yes	56	50.0%
No	56	50.0%

Table 539. Frequency of youth attendance at PAL classes

	N	%
Once a week	16	30.8%
Every other week	3	5.8%
Once a month	6	11.5%
Other	22	42.3%
Never	5	9.6%

Table 540. Percent of adults who typically transport youth to PAL classes

	N	%
We have extra staff on that shift so we stay in ratio while transporting youth	8	15.1%
We bring other youth with us in the vehicle to stay in ratio	15	28.3%
Other	23	43.4%
Does not apply	7	13.2%

Residential Operations Budget

In asking about budgets, GRO providers were asked to mention anything not captured in budget questions. GRO providers mentioned accounting for property damage and providing normalcy/basic needs. One provider gave the following quote for both GROs and ES (may want just a portion of this):

> *'...services have been designed to address survivor needs in a comprehensive and holistic way. We have a $30 million annual budget and +/- 360 employees. The totality of the costs associated with emergency shelter are hard to quantify. Necessary services may be provided across multiple programs, e.g. a sibling group of 4 that were removed from their foster home this past week were able to go directly into our emergency shelter where they can continue with their therapist and continue to see people they know"_GRO and ES Provider*

Six RTC providers mentioned additional costs related to kids with higher needs, often requiring lower ratios to maintain better care and safety. Other things mentioned included

overtime or hazard pay (related to caring for children with higher needs), capital expenses and property damage, and overall inflation (i.e. insurance).

> *'... anything that is related to IDD/Special needs costs 30-100%." _RTC Provider*

> *'In general we have additional costs to provide the quality of care that we like to provide to the residents which includes: normalcy activities like sports, extracurriculars, art classes, etc.; additional food options due to allergies and sensory issues; sensory items to help with therapeutic interventions; individual coping skills like MP3 players, weighted blankets, weighted vests, fidgets, etc.; independent living skills items like driving lessons, driving classes, food handlers license, work clothing/shoes, etc.; educational items like FFA or specific class related expenses, graduation ceremony and celebrations, prom, homecoming, quinceañeras, etc.; Diversity, Equity and Inclusion activities for our residents; additional hair care products for residents with texturized hair; haircuts; summer recreation/activities for residents including camps and normal experiences; and anything extra needed for the residents that we do not receive funding for from DFPS."_RTC Provider*

Residential Operations Annual Budget

There was a wide range in budgets. In order to provide context for budget numbers, several calculations were made. The first calculation shows the annual budget data. Because the range of budgets was so wide, interpreting the trimmed mean of $1.5 million is likely the most accurate way to understand the average annual budget. Another way to look at this data was to divide the annual budget by the number of children currently placed with the agency. In doing so, the budget numbers per child have a smaller range and a more normal curve.

Table 541. Annual budget

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Annual budget	102	$25,000	$12,728,000	$1,733,859	$1,505,073	$1,305,500	$1,785,306
Annual budget by number of children currently placed in agency	102	$3,125	$1,700,000	$165,587	$115,074	$89,000	$276,284

Table 542. Percent of agency budgets within ranges

	N	%
Less than $100,000	4	3.9%
$100,000 - $199,999	2	2.0%
$200,000 - $299,999	2	2.0%
$300,000 - $399,999	6	5.9%
$400,000 - $499,999	88	86.3%
$500,000 or higher	4	3.9%

Residential Operations Administrative Costs

Agencies were asked to note the percent of their annual budget that covered administrative costs. The mean was 24.2%.

Table 543. Percent of budget that is administrative costs

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of budget that are administrative costs	98	0.0%	80.0%	24.2%	22.9%	17.5%	18.4%

Table 544. Percent of budget that is administrative costs within ranges

	N	%
Less than 25%	57	58.2%
25% to 49%	27	27.6%
50% to 74%	12	12.2%
75% or higher	2	2.0%

Residential Operations Income Sources

Providers were asked about different sources of funding that support their organization. On average, they reported that 56.3% of their budget comes from DFPS funding while almost none comes from Medicaid/STAR Health. For those that do fundraise, an average of 28.6% of their budget comes from fundraising and donations.

Table 545. Percent of income paid by DFPS

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of income that is paid by DFPS	129	0.0%	100%	56.3%	57.0%	57.0%	37.0%

Table 546. Percent of budget paid by DFPS within ranges

	N	%
Less than 25%	29	22.5%
25% to 49%	23	17.8%
50% to 74%	24	18.6%
75% or higher	53	41.1%

Table 547. Percent of income paid by Medicaid/STAR Health

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of income that is paid by Medicaid/STAR Health	129	0%	100%	2.1%	0.4%	0.0%	10.5%
Percent of income that is paid by Medicaid/STAR Health IF any income is paid	20	0.1%	100%	11.5%	7.5%	4.0%	23.1%

Table 548. Percent of budget paid by Medicaid/STAR Health within ranges

	N	%
None	109	84.5%
1 to 25%	17	13.2%
25% to 49%	1	0.8%
50% to 74%	1	0.8%
75% or higher	1	0.8%

Table 549. Percent of income paid by private fundraising/donations

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of income that is paid by private fundraising/ donations	129	0%	90%	14.9%	12.2%	1.0%	22.20%
Percent of income that is paid by private fundraising/ donations IF any income is paid	67	1%	90%	28.6%	26.9%	25.0%	23.6%

Table 550. Percent of budget paid by private fundraising/donations within ranges

	N	%
None	62	48.1%
1 to 25%	31	24.0%
25% to 49%	23	17.8%
50% to 74%	10	7.8%
75% or higher	3	2.3%

Table 551. Percent of income paid by other income sources

	N	Min	Max	Mean	5% trimmed mean	Median	Std dev
Percent of income that is paid by other income sources	129	0%	100%	8.1%	5.3%	0.0%	17.5%
Percent of income that is paid by other income sources IF any income is paid	42	2%	100%	25.0%	22.4%	20.0%	22.9%

Table 552. Percent of budget paid by other funding sources within ranges

	N	%
None	87	67.4%
1 to 25%	27	20.9%
25% to 49%	10	7.8%
50% to 74%	3	2.3%
75% or higher	2	1.6%

Survey Findings: General Residential Operations – Tier I

Facility-Based Treatment Service Packages

In addition to questions about the current costs, providers were asked to think about each service package in relation to what they would need to provide services. Providers answered questions about ideal staffing, caseloads, salaries and services. In this section, we present findings for each general residential operation service package in Tier 1.

Primary Setting – Basic Child Care Operations (BCCO) – GRO Tier 1 Service Package

Brief Description: Basic Child Care Operations include general residential operations that are facility-based (including cottage-homes). They provide for a child's basic living needs, including food, shelter, education, vocational, and extracurricular needs which may vary based on age and developmental level. This section examines costs related to caring for children in Basic Child Care Operations (BCCO).

Basic Child Care Operation – GRO Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for youth in basic child care operations. Most providers indicated that specialized staff were at least somewhat needed. As for treatment directors, 73% did not think a treatment director is needed. In terms of other staff, providers thought it was at least somewhat important to have a psychiatrist (66%), physician (64%) or nurse (51%) for children needing basic child care. Providers indicated they would ideally like a psychiatrist (76%), physician (78%) and/or nurse (60%). For physicians and psychiatrists, contracted staff was the preference. For nurses, 52% of providers preferred in-house nurses.

Ninety percent of providers reported that therapists were at least somewhat important (with 68% indicating either very important or extremely important) and 94% reported wanting a therapist. A little over half of providers (52%) reported that therapists would ideally be contracted and 57% felt a therapist needed to be on call after hours.

For case managers, 27% of providers preferred for case managers to have a bachelor's degree, 27% preferred a bachelor's degree in human services, and 22% preferred a master's degree in human services. Providers (88%) noted that no additional certifications were needed for case managers. For providers who said that case managers did need additional certifications, they specified the following training, certifications, or qualifications: Trust-Based Relational Intervention®, Satori Alternatives to Managing Aggression (an EBI), relationship building, mental health qualifications, social worker licensure, CPR certification, and basic childcare certification.

For direct care staff, 42% preferred for direct care staff to have a high school diploma or GED. Providers (73%) noted that no additional certifications were needed for direct care staff.

BCCO – GRO Treatment Director

Table 553. BCCO (GRO) - Should a treatment director be required? *(N=48)*

	N	%
Yes	13	27.1%
No	35	72.9%

BCCO – GRO Psychiatrists

Table 554. BCCO (GRO) - How important is to have a psychiatrist? (N=50)

	N	%
Not important	17	34.0%
Somewhat important	11	22.0%
Very important	11	22.0%
Extremely important	11	22.0%

Table 555. BCCO (GRO) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=50)		
Yes	38	76.0%
No	12	24.0%
If yes, would you prefer to contract with them or have them in-house? (N=38)		
Contract	33	86.8%
In-house	5	13.2%

Table 556. BCCO (GRO) - Should a psychiatrist be on-call or available 24/7? (N=38)

	N	%
Yes	20	52.6%
No	18	47.4%

BCCO – GRO Physicians

Table 557. BCCO (GRO) - How important is it to have a physician? (N=50)

	N	%
Not important	18	36.0%
Somewhat important	13	26.0%
Very important	10	20.0%
Extremely important	9	18.0%

Table 558. BCCO (GRO) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=50)		
Yes	39	78.0%
No	11	22.0%
If yes, would you prefer to contract with them or have them in-house? (N=39)		
Contract	35	89.7%
In-house	4	10.3%

Table 559. BCCO (GRO) - Should a physician be on-call or available 24/7? (N=39)

	N	%
Yes	22	56.4%
No	17	43.6%

BCCO – GRO Therapists

Table 560. BCCO (GRO) - How important is having a therapist? (N=50)

	N	%
Not important	5	10.0%
Somewhat important	11	22.0%
Very important	19	38.0%
Extremely important	15	30.0%

Table 561. BCCO (GRO) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=49)		
Yes	46	93.9%
No	3	6.1%
If yes, would you prefer to contract with them or have them in-house? (N=46)		
Contract	24	52.2%
In-house	22	47.8%

Table 562. BCCO (GRO) - Should a therapist be on-call or available 24/7?(N=46)

	N	%
Yes	26	56.5%
No	20	43.5%

BCCO – GRO Nurses

Table 563. BCCO (GRO) - How important is having a nurse? (N=47)

	N	%
Not important	23	48.9%
Somewhat important	11	23.4%
Very important	8	17.0%
Extremely important	5	10.6%

Table 564. BCCO (GRO) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=48)		
Yes	29	60.4%
No	19	39.6%
If yes, would you prefer to contract with them or have them in-house? (N=29)		
Contract	14	48.3%
In-house	15	51.7%

Table 565. BCCO (GRO) - Should a nurse be on-call or available 24/7? (N=29)

	N	%
Yes	17	58.6%
No	12	41.4%

BCCO – GRO Case Management Staff

Table 566. BCCO (GRO) - Recommended level of education for case managers

	Minimum level (N=47)		Preferred level (N=45)	
	N	%	N	%
High School Diploma or GED	6	12.8%	2	4.4%
Associate's Degree	3	6.4%	4	8.9%
Bachelor's Degree	21	44.7%	12	26.7%
Bachelor's Degree (human service field)	14	29.8%	12	26.7%
Master's Degree	1	2.1%	5	11.1%
Master's Degree (human service field)	0	0.0%	10	22.2%
Other	2	4.3%	0	0.0%

Table 567. BCCO (GRO) - Do case managers need any certifications? (N=49)

	N	%
No certifications needed	43	87.8%
Certifications needed	6	12.2%

BCCO – GRO Direct Care Staff

Table 568. BCCO (GRO) - Recommended level of education for direct care staff

	Minimum level (N=46)		Preferred level (N=45)	
	N	%	N	%
High School Diploma or GED	43	93.5%	19	42.2%
Associate's Degree	1	2.2%	9	20.0%
Bachelor's Degree	1	2.2%	10	22.2%
Bachelor's Degree (human services field)	0	0.0%	7	15.6%
Other	1	2.2%	0	0.0%

Table 569. BCCO (GRO) - Do direct care staff need any certifications? (N=44)

	N	%
No certifications needed	32	72.7%
Certifications needed*	12	27.3%

Note: A summary of recommended certifications for direct care staff is provided at the end of this section under general findings.

Basic Child Care Operation – GRO Ideal Caseloads and Competitive Pay

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal (48%), the mean response for the typical caseload was 14 youth. However, the ideal caseload was 10 and the maximum caseload was 14 youth. For case managers, the mean response for typical caseload was 13 children. The ideal caseload was 11 youth and the maximum caseload was 16 youth. Providers were also asked how many case managers should be supervised by one supervisor. The mean response was 4 case managers.

For salaries, providers reported a mean of $74,933 for a competitive therapist salary without benefits. For case managers, the mean competitive salary without benefits was $43,516. For direct care, providers were asked about competitive hourly rates for entry level and experienced direct care staff. Providers reported a mean competitive hourly rate of $13.60 for entry level direct care staff and $16.41 for experienced direct care staff.

BCCO – GRO Therapist Caseloads

Table 570. BCCO (GRO) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	12	3	25	13.7	15	3*	7.48
Ideal caseload	15	0	20	10.1	10	12	5.59
Max caseload	15	0	30	14.4	15	10*	7.84

*Multiple modes exist. The smallest value is shown.

BCCO – GRO Therapist Competitive Salary

Table 571. BCCO (GRO) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	15	$50,000	$150,000	$74,933	$65,000	$65,000	$31,100

BCCO – GRO Case Manager Caseloads

Table 572. BCCO (GRO) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	24	1	25	13.1	12	12*	6.72
Ideal caseload	33	1	20	11.0	12	15	5.11
Max caseload	32	1	30	15.9	15	15	6.77

*Multiple modes exist. The smallest value is shown.

BCCO – GRO Case Manager Competitive Salary

Table 573. BCCO (GRO) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	31	$27,500	$60,000	$43,516	$45,000	$45,000	$9,118

BCCO – GRO Direct Care Competitive Hourly Rate

Table 574. BCCO (GRO) - Competitive hourly rate for direct care staff

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive hourly rate - entry level	40	$10.00	$18.00	$13.60	$14.50	$15.00	$2.22
Competitive hourly rate - experienced	40	$12.00	$25.00	$16.41	$16.00	$15.00	$2.85

Basic Child Care Operation – GRO Staffing Ratios and 1:1 Supervision

Providers were asked what the ideal awake and sleep youth to staff ratios should be for youth in basic child care operations. The mean ideal awake ratio for one staff was 7 youth and the mean ideal sleep ratio for one staff was 12 youth. Providers were also asked the percentage of time they thought one to one supervision was needed, where one staff member supervised one youth. Providers reported a mean of 14% for the percentage of time that one to one supervision was needed.

BCCO – GRO Staffing Ratios

Table 575. BCCO (GRO) - Ideal number of children per staff ratios

	N	Min	Max	Mean	Median	Mode	Std dev
Ideal awake ratio	43	3	10	6.7	7	8	1.66
Ideal sleep ratio	43	6	20	11.6	12	8	3.83

BCCO – GRO 1:1 Supervision

Table 576. BCCO (GRO) - Percent of time 1:1 supervision is needed

	N	Min	Max	Mean	Median	Mode	Std dev
% of time 1:1 supervision is needed	34	0%	50%	14.2%	10%	0%	15.95%

Basic Child Care Operation – GRO Services

Providers were asked about the recommended frequency of therapy for children needing basic child care. For individual therapy, 56%% of providers suggested therapy should be once per week. Twenty-six percent of providers felt family therapy should be once a month, 23% felt that it should be twice per month and 23% felt that it should be once per week. One-third of providers (36%) felt group therapy was needed once per week. Providers were also asked about services they would recommend for children in basic child care. The following services were noted by 75% or more of the providers: education and tutoring services (90%); recreational therapy (81%), psychological testing and evaluation (81%), and assistance with high school diploma or GED (76%). Providers mentioned the following additional services needed for youth in basic care: translation, and substance use disorder services. One provider said services need to be child specific and able to combine with other services. Providers were also asked about the recommended maximum length of services for youth in basic child care operations. The most common response (34%) was that there should be no maximum length of services.

BCCO – GRO Therapy

Table 577. BCCO (GRO) - Recommended frequency of therapy sessions

		Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
		N	%	%	%	%	%	%	%	%	%	%	%	%
BCCO (GRO)	Individual Therapy													
		43	7%	2%	16%	12%	56%	5%	2%	0%	0%	0%	0%	0%
	Family Therapy													
		43	5%	14%	26%	23%	23%	2%	0%	0%	0%	0%	0%	7%
	Group Therapy													
		42	7%	12%	19%	14%	36%	12%	0%	0%	0%	0%	0%	0%

BCCO – GRO Needed Services

Table 578. BCCO (GRO) - Additional recommended services

	Total N	Service needed N	%
Education and tutoring services	41	37	90.2%
Recreational therapy	43	35	81.4%
Psychological testing and evaluation	42	34	81.0%
Assistance with HS diploma or GED	41	31	75.6%
Healthy Relationship Programs / Classes	41	30	73.2%
Dietician / Nutrition services	26	19	73.1%
Youth support groups	41	29	70.7%
Peer mentoring	41	28	68.3%
Play therapy	43	29	67.4%
Assistance with obtaining a driver's license	41	27	65.9%
Crisis Services / Stabilization	42	25	59.5%
Animal therapy	43	25	58.1%
Behavior Support Specialist	42	24	57.1%
Risk assessments	42	23	54.8%
Personal Care Services (PCS)	26	14	53.8%
Nursing - Other	26	14	53.8%
Art therapy	43	23	53.5%
Dance / Movement therapy	43	20	46.5%
Parenting programs / classes	41	19	46.3%
Parent support groups	41	16	39.0%
Equine therapy	43	16	37.2%
Legal services	41	12	29.3%
Applied Behavior Analysis (ABA)	42	12	28.6%
Occupational Therapy	42	12	28.6%
Speech Therapy	42	10	23.8%
Physical / Rehabilitation Therapy	42	9	21.4%
Medical specialists	26	5	19.2%
Prenatal and Postnatal Care	26	4	15.4%
Neurofeedback	42	6	14.3%
Forensic assessments	42	5	11.9%
Private Duty Nursing (PDN)	26	2	7.7%

Note: Services highlighted in orange were identified by at least 75% of GROs as a needed service.

BCCO – GRO Maximum Length of Services

Table 579. BCCO (GRO) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
BCCO (GRO)	44	5%	2%	5%	14%	18%	7%	9%	5%	2%	34%

Primary Setting – Complex Medical Needs (CMN)/Primary Medical Needs (PMN) – GRO Tier 1 Service Package

Brief Description: This facility-based treatment setting will offer time-limited services for children and youth who have Complex Medical Needs such as Diabetes and Eating Disorders that require regular clinical intervention to support day-to-day activities. The organization must have an evidence-informed treatment model and provide after-care services to support transition to a less restrictive setting.

Note: Primary Medical Needs (PMN) are currently included in the Complex Medical Needs (CMN) package; however, to validate if this structure makes the most sense, PMN and CMN were asked about separately on this survey. Information on the costs and services for both PMN and CMN will be provided in this section.

Primary Medical Needs (PMN)

PMN – GRO Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for youth with Primary Medical Needs. Most providers indicated that specialized staff were needed. Seventy-seven percent of providers indicated that a treatment director should be required. In terms of other staff, providers thought it was very important or extremely important to have a psychiatrist (71%), physician (67%), therapist (65%) or nurse (65%) for youth with Primary Medical Needs. Providers indicated they would ideally like a psychiatrist (91%), physician (100%) therapist (95%), and nurse (90%). Providers indicated that contract staff was preferred for psychiatrists (80%) and physicians (70%). The preference of having a nurse in-house or contracted was split (50%). For therapists, 53% of providers preferred in-house therapists.

For case managers, 38% of providers preferred for case managers to have a bachelor's degree, 25% preferred a master's degree in human services, and 18% preferred a master's degree. Providers (65%) noted that no additional certifications were needed for case managers. For those that did think additional certifications were needed, they specified the following additional certifications, training and qualifications: trust-Based Relational Intervention®, relationship building, Satori Alternatives for Managing Aggression (an EBI), and training/certification for working with children with medical needs.

For direct care staff, 53% of providers preferred for direct care staff to have a high school diploma or GED. Providers (75%) noted that certifications were needed for direct care staff.

PMN – GRO Treatment Director

Table 580. PMN (GRO) - Should a treatment director be required? (N=22)

	N	%
Yes	17	77.3%
No	5	22.7%

PMN – GRO Psychiatrists

Table 581. PMN (GRO) - How important is to have a psychiatrist? (N=21)

	N	%
Not important	2	9.5%
Somewhat important	4	19.0%
Very important	8	38.1%
Extremely important	7	33.3%

Table 582. PMN (GRO) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=22)		
Yes	20	90.9%
No	2	9.1%
If yes, would you prefer to contract with them or have them in-house? (N=20)		
Contract	16	80.0%
In-house	4	20.0%

Table 583. PMN (GRO) - Should a psychiatrist be on-call or available 24/7? (N=20)

	N	%
Yes	13	65.0%
No	7	35.0%

PMN – GRO Physicians

Table 584. PMN (GRO) - How important is it to have a physician? (N=21)

	N	%
Not important	3	14.3%
Somewhat important	4	19.0%
Very important	4	19.0%
Extremely important	10	47.6%

Table 585. PMN (GRO) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=21)		
Yes	21	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=21)		
Contract	15	71.4%
In-house	6	28.6%

Table 586. PMN (GRO) - Should a physician be on-call or available 24/7? (N=21)

	N	%
Yes	15	71.4%
No	6	28.6%

PMN – GRO Therapists

Table 587. PMN (GRO) - How important is having a therapist? (N=20)

	N	%
Not important	2	10.0%
Somewhat important	5	25.0%
Very important	5	25.0%
Extremely important	8	40.0%

Table 588. PMN (GRO) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=20)		
Yes	19	95.0%
No	1	5.0%
If yes, would you prefer to contract with them or have them in-house? (N=19)		
Contract	9	47.4%
In-house	10	52.6%

Table 589. PMN (GRO) - Should a therapist be on-call or available 24/7? (N=19)

	N	%
Yes	15	78.9%
No	4	21.1%

PMN – GRO Nurses

Table 590. PMN (GRO) - How important is having a nurse? (N=19)

	N	%
Not important	2	10.5%
Somewhat important	2	10.5%
Very important	9	47.4%
Extremely important	6	31.6%

Table 591. PMN (GRO) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=20)		
Yes	18	90.0%
No	2	10.0%
If yes, would you prefer to contract with them or have them in-house? (N=18)		
Contract	9	50.0%
In-house	9	50.0%

Table 592. PMN (GRO) - Should a nurse be on-call or available 24/7? (N=18)

	N	%
Yes	15	83.3%
No	3	16.7%

PMN – GRO Case Management Staff

Table 593. PMN (GRO) - Recommended level of education for case managers

	Minimum level (N=18)		Preferred level (N=16)	
	N	%	N	%
High School Diploma or GED	3	16.7%	0	0.0%
Associate's Degree	2	11.1%	1	6.3%
Bachelor's Degree	6	33.3%	6	37.5%
Bachelor's Degree (human service field)	3	16.7%	0	0.0%
Master's Degree	2	11.1%	3	18.8%
Master's Degree (human service field)	1	5.6%	4	25.0%
Other	1	5.6%	2	12.5%

Table 594. PMN (GRO) - Do case managers need any certifications? (N=20)

	N	%
No certifications needed	13	65.0%
Certifications needed	7	35.0%

PMN – GRO Direct Care Staff

Table 595. PMN (GRO) - Recommended level of education for direct care staff

	Minimum level (N=16)		Preferred level (N=17)	
	N	%	N	%
High School Diploma or GED	14	87.5%	9	52.9%
Associate's Degree	1	6.3%	3	17.6%
Bachelor's Degree	1	6.3%	1	5.9%
Bachelor's Degree (human services field)	0	0.0%	3	17.6%
Other	0	0.0%	1	5.9%

Table 596. PMN (GRO) - Do direct care staff need any certifications?

	N	%
No certifications needed	4	25.0%
Certifications needed	12	75.0%

PMN – GRO Ideal Caseloads and Competitive Pay

Providers were asked about the ideal caseloads and pay for therapists, case managers, and direct care staff. For those providers who indicated in-house therapists would be ideal (53%), the mean response for the typical caseload was 7 youth. However, the ideal caseload was 5 and the maximum caseload was 10 youth. For case managers, the mean response for typical caseload was 7 youth. The ideal caseload was 7 youth and the maximum caseload was 11 youth.

For in-house therapist salaries, providers reported a mean of $62,500 for a competitive therapist salary without benefits. For case managers, the mean competitive salary without benefits was $46,000. For direct care, providers were asked about competitive hourly rates for entry level and experienced direct care staff. Providers reported a mean competitive hourly rate of $14.14 for entry level direct care staff and $17.07 for experienced direct care staff.

PMN – GRO Therapist Caseloads

Table 597. PMN (GRO) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	3	3	10	7.0	8	3*	3.61
Ideal caseload	5	0	8	4.6	5	0*	3.21
Max caseload	6	0	20	9.5	10	10	6.57

*Multiple modes exist. The smallest value is shown.

PMN – GRO Therapist Competitive Salary

Table 598. PMN (GRO) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	2	$60,000	$65,000	$62,500	$62,500	$60,000.00*	$3,536

*Multiple modes exist. The smallest value is shown.

PMN – GRO Case Manager Caseloads

Table 599. PMN (GRO) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	7	3	15	7.0	5	3*	4.36
Ideal caseload	12	1	13	6.7	6	5	3.55
Max caseload	11	5	20	10.5	10	10*	4.37

*Multiple modes exist. The smallest value is shown.

PMN – GRO Competitive Salary

Table 600. PMN (GRO) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	12	$30,000	$60,000	$46,000	$45,000	$35,000*	$10,100

*Multiple modes exist. The smallest value is shown.

PMN – GRO Direct Care Competitive Hourly Rate

Table 601. PMN (GRO) - Competitive hourly rate for direct care staff

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive hourly rate - entry level	14	$12.00	$18.00	$14.14	$14.00	$12.00*	$1.88
Competitive hourly rate - experienced	14	$14.00	$25.00	$17.07	$16.50	$15.00	$2.84

*Multiple modes exist. The smallest value is shown.

PMN – GRO Staffing Ratios and 1:1 Supervision

Providers were asked what the ideal awake and sleep youth to staff ratios should be for youth with Primary Medical Needs. The mean ideal awake ratio for one staff was 5 youth and the mean ideal sleep ratio for one staff was 10 youth. Providers were also asked the percentage of time they thought one to one supervision was needed, where one staff member supervised one youth. Providers reported a mean of 30% for the percentage of time that one to one supervision was needed.

PMN – GRO Staffing Ratios

Table 602. PMN (GRO) - Ideal number of children per staff

	N	Min	Max	Mean	Median	Mode	Std dev
Ideal awake ratio	17	2	10	5.4	5	5	2.00
Ideal sleep ratio	17	2	20	10.1	10	10	4.31

PMN – GRO 1:1 Supervision

Table 603. PMN (GRO) - Percent of time 1:1 supervision is needed

	N	Min	Max	Mean	Median	Mode	Std dev
% of time 1:1 supervision is needed	8	1%	100%	30.1%	28%	30%	31.38%

PMN – GRO Services

Providers were asked about the recommended frequency of therapy for youth with Primary Medical Needs. For individual therapy, 69% of providers suggested therapy should be once per week. Thirty-eight percent of providers felt family therapy should be once a month. Half of providers (50%) felt group therapy was needed once per week. Providers were also asked about the recommended maximum length of services for youth with Primary Medical Needs. The most common response (38%) was that there should be no maximum services.

PMN – GRO Therapy

Table 604. PMN (GRO) - Recommended frequency of therapy sessions

		Total N	None %	1x every other month %	1x per month %	2x per month %	1x per week %	2x per week %	3x per week %	4x per week %	5x per week %	6x per week %	Daily %	Prefer not to say %
PMN (GRO)	Individual Therapy													
		16	6%	0%	13%	6%	69%	6%	0%	0%	0%	0%	0%	0%
	Family Therapy													
		16	6%	0%	38%	31%	19%	0%	0%	0%	0%	0%	0%	6%
	Group Therapy													
		16	6%	0%	25%	6%	50%	13%	0%	0%	0%	0%	0%	0%

PMN – GRO Maximum Length of Services

Table 605. PMN (GRO) - Recommended maximum length of services

	Total N	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
PMN (GRO)	16	0%	0%	0%	6%	19%	6%	31%	0%	0%	38%

PMN – GRO Aftercare

Providers were asked about the recommended length of aftercare and estimated caseload for an aftercare case manager for youth with Primary Medical Needs. Forty-seven percent of providers indicated that there should be 6 months of aftercare with the mean caseload of 10 youth.

Table 606. PMN (GRO) - Recommended length of aftercare

	Total N	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months %	No max %
PMN (GRO)	19	16%	0%	5%	16%	0%	0%	47%	0%	0%	0%	0%	0%	11%	5%

Table 607. PMN (GRO) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std dev
PMN (GRO) estimated aftercare caseload	13	2	20	10	6

Complex Medical Needs (CMN)

CMN – GRO Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for youth with complex medical needs. Most providers indicated that specialized staff were needed. Eighty-seven percent of providers indicated that a treatment director should be required. In terms of other staff, providers thought it was very important or extremely important to have a psychiatrist (77%), physician (80%), therapist (90%) or nurse (72%) for youth with complex medical needs. Providers indicated they would ideally like a psychiatrist (91%), physician (95%), therapist (95%), and nurse (90%). Providers indicated that contract staff was preferred for psychiatrists (68%) and physicians (63%). The preference of having therapists in-house or contracted was split (50%). For nurses, 65% of providers preferred in-house therapists.

For case managers, 35% of providers preferred for case managers to have a bachelor's degree and 24% preferred a master's degree in the human services field. Providers (53%) noted that no additional certifications were needed for case managers. For providers that did say additional certifications were needed, they specified the following training, certifications, or qualifications: training/certification for medical needs, mental health qualifications, first aid/CPR certification, and case management certification.

For direct care staff, 31% of providers preferred for direct care staff to have a high school diploma or GED and 25% preferred bachelor's degree in the human services field. Providers (82%) noted that certifications were needed for direct care staff.

CMN – GRO Treatment Director

Table 608. CMN (GRO) - Should a treatment director be required? (N=23)

	N	%
Yes	3	13.0%
No	20	87.0%

CMN – GRO Psychiatrists

Table 609. CMN (GRO) - How important is it to have a psychiatrist? (N=22)

	N	%
Not important	2	9.1%
Somewhat important	3	13.6%
Very important	9	40.9%
Extremely important	8	36.4%

Table 610. CMN (GRO) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=21)		
Yes	19	90.5%
No	2	9.5%
If yes, would you prefer to contract with them or have them in-house? (N=19)		
Contract	13	68.4%
In-house	6	31.6%

Table 611. CMN (GRO) - Should a psychiatrist be on-call or available 24/7? (N=19)

	N	%
Yes	17	89.5%
No	2	10.5%

CMN – GRO Physicians

Table 612. CMN (GRO) - How important is it to have a physician? (N=20)

	N	%
Not important	3	15.0%
Somewhat important	1	5.0%
Very important	5	25.0%
Extremely important	11	55.0%

Table 613. CMN (GRO) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=20)		
Yes	19	95.0%
No	1	5.0%
If yes, would you prefer to contract with them or have them in-house? (N=19)		
Contract	12	63.2%
In-house	7	36.8%

Table 614. CMN (GRO) - Should a physician be on-call or available 24/7? (N=19)

	N	%
Yes	16	84.2%
No	3	15.8%

CMN – GRO Therapists

Table 615. CMN (GRO) - How important is having a therapist? (N=20)

	N	%
Not important	0	0.0%
Somewhat important	2	10.0%
Very important	11	55.0%
Extremely important	7	35.0%

Table 616. CMN (GRO) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=19)		
Yes	18	94.7%
No	1	5.3%
If yes, would you prefer to contract with them or have them in-house? (N=18)		
Contract	9	50.0%
In-house	9	50.0%

Table 617. CMN (GRO) - Should a therapist be on-call or available 24/7? (N=18)

	N	%
Yes	14	77.8%
No	4	22.2%

CMN – GRO Nurses

Table 618. CMN (GRO) - How important is having a nurse? (N=18)

	N	%
Not important	2	11.1%
Somewhat important	3	16.7%
Very important	3	16.7%
Extremely important	10	55.6%

Table 619. CMN (GRO) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=19)		
Yes	17	89.5%
No	2	10.5%
If yes, would you prefer to contract with them or have them in-house? (N=17)		
Contract	6	35.3%
In-house	11	64.7%

Table 620. CMN (GRO) - Should a nurse be on-call or available 24/7? (N=17)

	N	%
Yes	15	88.2%
No	2	11.8%

CMN – GRO Case Management Staff

Table 621. CMN (GRO) - Recommended level of education for case managers

	Minimum level (N=18)		Preferred level (N=17)	
	N	%	N	%
High School Diploma or GED	4	22.2%	0	0.0%
Associate's Degree	2	11.1%	1	5.9%
Bachelor's Degree	5	27.8%	6	35.3%
Bachelor's Degree (human services field)	4	22.2%	3	17.6%
Master's Degree	2	11.1%	2	11.8%
Master's Degree (human services field)	1	5.6%	4	23.5%
Other	0	0.0%	1	5.9%

Table 622. CMN (GRO) - Do case managers need any certifications? (N=19)

	N	%
No certifications needed	10	52.6%
Certifications needed	9	47.4%

CMN – GRO Direct Care Staff

Table 623. CMN (GRO) - Recommended level of education for direct care staff

	Minimum level (N=17)		Preferred level (N=16)	
	N	%	N	%
High School Diploma or GED	13	76.5%	5	31.3%
Associate's Degree	2	11.8%	3	18.8%
Bachelor's Degree	1	5.9%	3	18.8%
Bachelor's Degree (human services field)	1	5.9%	4	25.0%
Other	0	0.0%	1	6.3%

Table 624. CMN (GRO) - Do direct care staff need any certifications? (N=17)

	N	%
No certifications needed	3	17.6%
Certifications needed	14	82.4%

CMN – GRO Ideal Caseloads and Competitive Pay

Providers were asked about the ideal caseloads and pay for therapists, case managers, and direct care staff. For those providers who indicated in-house therapists would be ideal (50%), the mean response for the typical caseload was 9 youth. However, the ideal caseload was 7 and the maximum caseload was 10 youth. For case managers, the mean response for typical caseload was 8 youth. The ideal caseload was 8 youth and the maximum caseload was 12 youth.

For in-house therapist salaries, providers reported a mean of $63,333 for a competitive therapist salary without benefits. For case managers, the mean competitive salary without benefits was $48,727. For direct care, $15.13 was considered a competitive hourly rate for entry level staff and $18.20 was a competitive hourly rate experienced direct care staff.

CMN – GRO Therapist Caseloads

Table 625. CMN (GRO) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	7	1	30	9.3	8	1	10.13
Ideal caseload	9	0	20	6.7	5	4*	5.96
Max caseload	9	0	30	10.3	10	6*	8.46

*Multiple modes exist. The smallest value is shown.

CMN – GRO Competitive Salary

Table 626. CMN (GRO) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	6	$50,000	$70,000	$63,333	$65,000	$65,000.00*	$7,528

*Multiple modes exist. The smallest value is shown.

CMN – GRO Case Manager Caseloads

Table 627. CMN (GRO) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	9	1	19	8.0	8	1*	6.50
Ideal caseload	12	3	20	8.3	8	3*	5.05
Max caseload	12	3	24	11.8	12	12	6.34

*Multiple modes exist. The smallest value is shown.

CMN – GRO Competitive Salary

Table 628. CMN (GRO) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	11	$40,000	$60,000	$48,727	$48,000	$40,000*	$6,973

*Multiple modes exist. The smallest value is shown.

CMN – GRO Direct Care Competitive Hourly Rate

Table 629. CMN (GRO) - Competitive hourly rate for direct care staff

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive hourly rate - entry level	15	$11.00	$20.00	$15.13	$15.00	$12.00*	$3.09
Competitive hourly rate - experienced	15	$12.50	$25.00	$18.20	$17.00	$25.00	$4.12

*Multiple modes exist. The smallest value is shown.

CMN – GRO Staffing Ratios and 1:1 Supervision

Providers were asked what the ideal awake and sleep youth to staff ratios should be for youth with complex medical needs. The mean ideal awake ratio for one staff was 4 youth and the mean ideal sleep ratio for one staff was 8 youth. Providers were also asked the percentage of time they thought one to one supervision was needed, where one staff member supervised one youth. Providers reported a mean of 32% for the percentage of time that one to one supervision was needed.

CMN – GRO Staffing Ratios

Table 630. CMN (GRO) - Ideal number of children per staff ratios

	N	Min	Max	Mean	Median	Mode	Std dev
Ideal awake ratio	17	1	8	4.3	5	5	1.7%
Ideal sleep ratio	17	1	15	8.4	8	8	4.5%

CMN – GRO 1:1 Supervision

Table 631. CMN (GRO) - Percent of time 1:1 supervision is needed

	N	Min	Max	Mean	Median	Mode	Std dev
% of time 1:1 supervision is needed	9	5%	100%	32.2%	20%	20%	29.4%

CMN – GRO Services

Providers were asked about the recommended frequency of therapy for youth with complex medical needs. Providers suggested individual therapy (50%), family therapy (29%), and group therapy (47%) should be provided once per week. Providers were also asked about the recommended maximum length of services for youth with complex medical needs. The most common response (41%) was that there should be no maximum services.

CMN – GRO Therapy

Table 632. CMN (GRO) - Recommended frequency of therapy sessions

		Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
		N	%	%	%	%	%	%	%	%	%	%	%	%
CMN (GRO)	Individual Therapy													
		18	0%	6%	6%	6%	50%	28%	0%	0%	0%	0%	6%	0%
	Family Therapy													
		17	0%	6%	24%	24%	29%	18%	0%	0%	0%	0%	0%	0%
	Group Therapy													
		17	12%	6%	12%	6%	47%	18%	0%	0%	0%	0%	0%	0%

CMN – GRO Maximum Length of Services

Table 633. CMN (GRO) - Recommended maximum length of services

	Total	30 days	45 days	60 days	3 months	6 months	9 months	12 months	18 months	24+ months	No max
	N	%	%	%	%	%	%	%	%	%	%
CMN (GRO)	17	0%	0%	6%	6%	12%	0%	24%	6%	6%	41%

CMN – GRO Aftercare

Providers were asked about the recommended length of aftercare and estimated caseload for an aftercare case manager for youth with complex medical needs. The common responses were 6 months (22%) and more than 12 months (22%) of aftercare. The average caseload for an aftercare case manager was 15 youth.

Table 634. CMN (GRO) - Recommended length of aftercare

	Total	No aftercare	1 month	2 months	3 months	4 months	5 months	6 months	7 months	8 months	9 months	10 months	11 months	12+ months	No max
	N	%	%	%	%	%	%	%	%	%	%	%	%	%	%
CMN (GRO)	18	17%	0%	0%	11%	0%	0%	22%	0%	0%	11%	0%	0%	22%	17%

Table 635. CMN (GRO) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std dev
CMN (GRO) estimated aftercare caseload	14	2	25	15	8

Both Primary and Complex Medical Needs (PMN /CMN)

Providers were also asked about services they would recommend for children with medical needs. The following services were noted by 75% or more of the providers: education and tutoring services (87%), recreational therapy (84%), and physical and/or rehabilitation therapy (76%). In open-ended responses, providers mentioned the following additional services needed for youth with primary or complex medical needs: translation, and substance use disorder services. One provider said services need to be child specific and able to combine with other services.

PMN / CMN – GRO Needed Services

Table 636. PMN/CMN (GRO) - Additional recommended services

	Total N	Service needed N	%
Education and tutoring services	23	20	87.0%
Recreational therapy	25	21	84.0%
Physical / Rehabilitation Therapy	25	19	76.0%
Dietician / Nutrition services	24	17	70.8%
Healthy Relationship Programs / Classes	23	16	69.6%
Youth support groups	23	16	69.6%
Play therapy	25	17	68.0%
Psychological testing and evaluation	25	16	64.0%
Occupational Therapy	25	16	64.0%
Personal Care Services (PCS)	24	15	62.5%
Nursing - Other	24	15	62.5%
Assistance with HS diploma or GED	23	14	60.9%
Animal therapy	25	15	60.0%
Risk assessments	25	15	60.0%
Dance / Movement therapy	25	14	56.0%
Speech Therapy	25	14	56.0%
Assistance with obtaining a driver's license	23	12	52.2%
Peer mentoring	23	12	52.2%
Parenting programs / classes	23	12	52.2%
Medical specialists	24	12	50.0%
Crisis Services / Stabilization	25	12	48.0%
Behavior Support Specialist	25	12	48.0%
Legal services	23	10	43.5%
Art therapy	25	10	40.0%
Equine therapy	25	10	40.0%
Parent support groups	23	9	39.1%
Applied Behavior Analysis (ABA)	25	9	36.0%
Private Duty Nursing (PDN)	24	7	29.2%
Neurofeedback	25	7	28.0%
Forensic assessments	25	5	20.0%
Prenatal and Postnatal Care	24	3	12.5%

Note: Services highlighted in orange were identified by at least 75% of GROs as a needed service.

PMN / CMN – GRO Increased Costs

Providers were asked what additional costs should be considered when working with youth with medical needs. Providers indicated food/dietary needs (64%) and supplies (60%) as the most common categories for increased costs. There were no increased costs specified in the open text response option for other costs.

Table 637. PMN / CMN (GRO) - Are there increased costs associated with any of the following? (N=25)

	N	%
Food/dietary needs	16	64.0%
Supplies	15	60.0%
Insurance	9	36.0%
Vehicle depreciation	9	36.0%
Property damage	7	28.0%
None of the above	7	28.0%
Security	6	24.0%
Licenses/permits	5	20.0%
Other	1	4.0%

Primary Setting – Intellectual and Developmental Disabilities/Autism (IDD/A) – GRO Tier 1 Service Package

Brief Description: Facility-based treatment services that are time-limited services for children and youth who have IDD and/or Autism who require regular intervention to support day-to-day activities. The organization must have an evidence-informed treatment model and provide after-care services to support transition to a less restrictive setting. This section examines needs and costs specific to the provision of this service package.

IDD/Autism – GRO Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for youth with IDD/Autism. Most providers indicated that specialized staff were needed. As for treatment directors, 81% thought a treatment director was needed. In terms of other staff, half of providers thought it was extremely important to have a psychiatrist (50%), one-third extremely important to have a physician (29%), and one-third thought it was somewhat important to have a nurse (34%) for youth with IDD/Autism. Providers indicated they would ideally like a psychiatrist (100%), physician (90%) and/or nurse (81%). Providers preferred contracted staff over in-house staff for physicians, psychiatrists, and nurses.

Providers (55%) reported that therapists were extremely important when working with youth with IDD/Autism and 97% reported wanting a therapist. A little over half of providers (51%) reported that therapists would ideally be contracted and 80% felt a therapist needed to be on call after hours.

For case managers, 25% of providers preferred for case managers to have a bachelor's degree, 28% preferred a bachelor's degree in human services, and 27% preferred a master's degree in human services. Providers (72%) noted that no additional certifications were needed for case managers. For providers who said that case managers did need additional certifications, they specified the following training, certifications, or qualifications: Trust-Based Relational Intervention®, Satori Alternative Methods for Aggression (an EBI), relationship building, mental health qualifications, IDD/Autism training, behavioral management, CPR certification, licensed social worker, certified case management, and Child Care Administration License.

For direct care staff, 26% preferred for direct care staff to have a bachelor's degree and 28% preferred for direct care staff to have a bachelor's degree in the human services field. Providers (60%) noted that additional certifications were needed for direct care staff.

IDD/A – GRO Treatment Director

Table 638. IDD/A (GRO) - Should a treatment director be required? (N=64)

	N	%
Yes	52	81.3%
No	12	18.7%

IDD/A – GRO Psychiatrists

Table 639. IDD/A (GRO) - How important is to have a psychiatrist? (N=68)

	N	%
Not important	6	8.8%
Somewhat important	10	14.7%
Very important	18	26.5%
Extremely important	34	50.0%

Table 640. IDD/A (GRO) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=69)		
Yes	69	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=69)		
Contract	60	87.0%
In-house	9	13.0%

Table 641. IDD/A (GRO) - Should a psychiatrist be on-call or available 24/7? (N=69)

	N	%
Yes	49	71.0%
No	20	29.0%

IDD/A – GRO Physicians

Table 642. IDD/A (GRO) - How important is it to have a physician? (N=68)

	N	%
Not important	17	25.0%
Somewhat important	14	20.6%
Very important	17	25.0%
Extremely important	20	29.4%

Table 643. IDD/A (GRO) - Ideal physician - Youth with IDD / Autism

	N	%
Would you ideally have a physician when working with this population? (N=68)		
Yes	61	89.7%
No	7	10.3%
If yes, would you prefer to contract with them or have them in-house? (N=61)		
Contract	56	91.8%
In-house	5	8.2%

Table 644. IDD/A (GRO) - Should a physician be on-call or available 24/7? (N=61)

	N	%
Yes	36	59.0%
No	25	41.0%

IDD/A – GRO Therapists

Table 645. IDD/A (GRO) - How important is having a therapist? (N=67)

	N	%
Not important	2	3.0%
Somewhat important	11	16.4%
Very important	17	25.4%
Extremely important	37	55.2%

Table 646. IDD/A (GRO) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=67)		
Yes	65	97.0%
No	2	3.0%
If yes, would you prefer to contract with them or have them in-house? (N=65)		
Contract	33	50.8%
In-house	32	49.2%

Table 647. IDD/A (GRO) - Should a therapist be on-call or available 24/7? (N=65)

	N	%
Yes	52	80.0%
No	13	20.0%

IDD/A – GRO Nurses

Table 648. IDD/A (GRO) - How important is having a nurse? (N=64)

	N	%
Not important	17	26.6%
Somewhat important	22	34.4%
Very important	13	20.3%
Extremely important	12	18.7%

Table 649. IDD/A (GRO) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=64)		
Yes	52	81.3%
No	12	18.7%
If yes, would you prefer to contract with them or have them in-house? (N=52)		
Contract	30	57.7%
In-house	22	42.3%

Table 650. IDD/A (GRO) - Should a nurse be on-call or available 24/7? (N=52)

	N	%
Yes	37	71.2%
No	15	28.8%

IDD/A – GRO Case Management Staff

Table 651. IDD/A (GRO) - Recommended level of education for case managers

	Minimum level (N=60)		Preferred level (N=59)	
	N	%	N	%
High School Diploma or GED	7	11.7%	1	1.7%
Associate's Degree	5	8.3%	2	3.3%
Bachelor's Degree	26	43.3%	15	25.0%
Bachelor's Degree (human services field)	15	25.0%	17	28.3%
Master's Degree	5	8.3%	8	13.3%
Master's Degree (human services field)	2	3.3%	16	26.7%
Other	0	0.0%	0	0.0%

Table 652. IDD/A (GRO) - Do case managers need any certifications? (N=65)

	N	%
No certifications needed	47	72.3%
Certifications needed	18	27.7%

IDD/A – GRO Direct Care Staff

Table 653. IDD/A (GRO) - Recommended level of education for direct care staff

	Minimum level (N=60)		Preferred level (N=57)	
	N	%	N	%
High School Diploma or GED	44	73.3%	12	21.1%
Associate's Degree	9	15.0%	12	21.1%
Bachelor's Degree	2	3.3%	15	26.3%
Bachelor's Degree (human services field)	3	5.0%	16	28.1%
Other	2	3.3%	2	3.5%

Table 654. IDD/A (GRO) - Do direct care staff need any certifications? (N=60)

	N	%
No certifications needed	24	40.0
Certifications needed	36	60.0

IDD/Autism – GRO Ideal Caseloads and Competitive Pay

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal (49%), the mean response for the typical caseload was 9 youth. However, the ideal caseload was 8 and the maximum caseload was 12 youth. For case managers, the mean response for typical caseload was 12 children. The ideal caseload was 10 children and the maximum caseload was 14 children.

For salaries, providers reported a mean of $65,357 for a competitive therapist salary without benefits. For case managers, the mean competitive salary without benefits was $46,946. For direct care, providers were asked about competitive hourly rates for entry level and experienced direct care staff. Providers reported a mean competitive hourly rate of $14.40 for entry level direct care staff and $17.24 for experienced direct care staff.

IDD/A – GRO Therapist Caseloads

Table 655. IDD/A (GRO) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	16	1	30	8.8	7	1	8.33
Ideal caseload	23	0	20	7.6	6	5	5.22
Max caseload	22	0	30	11.8	10	10	7.64

IDD/A – GRO Therapist Competitive Salary

Table 656. IDD/A (GRO) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	14	$50,000	$85,000	$65,357	$65,000	$65,000	$8,196

IDD/A – GRO Case Manager Caseloads

Table 657. IDD/A (GRO) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	28	1	26	11.7	10	10	7.29
Ideal caseload	42	1	26	10.1	10	5	5.68
Max caseload	40	1	30	14.3	13	10	7.61

IDD/A – GRO Competitive Salary

Table 658. IDD/A (GRO) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	46	$30,000	$80,000	$46,946	$45,000	$45,000	$9,244

IDD/A – GRO Direct Care Competitive Hourly Rate

Table 659. IDD/A (GRO) - Competitive hourly rate for direct care staff

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive hourly rate - entry level	53	$9.00	$20.00	$14.40	$15.00	$12.00*	$2.65
Competitive hourly rate - experienced	53	$11.00	$25.00	$17.24	$17.00	$15.00	$3.14

*Multiple modes exist. The smallest value is shown.

IDD/Autism – GRO Staffing Ratios and 1:1 Supervision

Providers were asked what the ideal awake and sleep youth to staff ratios should be for youth with IDD/Autism. The mean ideal awake ratio for one staff was 5 youth and the mean ideal sleep ratio for one staff was 10 youth. Providers were also asked the percentage of time they thought one to one supervision was needed, where one staff member supervised one youth. Providers reported a mean of 47% for the percentage of time that one to one supervision was needed.

IDD/A – GRO Staffing Ratios

Table 660. IDD/A (GRO) - Ideal number of children per staff ratios

	N	Min	Max	Mean	Median	Mode	Std dev
Ideal awake ratio	56	2	8	4.5	5	5	1.50
Ideal sleep ratio	56	2	16	10.0	10	10	3.83

IDD/A – GRO 1:1 Supervision

Table 661. IDD/A (GRO) - Percent of time 1:1 supervision is needed

	N	Min	Max	Mean	Median	Mode	Std dev
% of time 1:1 supervision is needed	45	1%	100%	47.4%	50%	50%	30.51%

IDD/Autism – GRO Increased Costs

Providers were asked what additional costs should be considered when working with youth with IDD/Autism. Providers indicated property damage (71%), supplies (62%) and food/dietary needs (53%) as the most common categories for increased costs. For providers that selected other, the following were mentioned: therapeutic and activities, recreation/sports, special events, increased supply costs (waterproof bedding, additional incontinence supplies, adaptive equipment), 1 on 1 ratio with staff, additional staff to visit and help when needed with issues during school hours, extra supervision when escalated.

Table 662. IDD/A (GRO) - Are there increased costs associated with any of the following? (N=55)

	N	%
Property damage	39	70.9%
Supplies	34	61.8%
Food/dietary needs	29	52.7%
Vehicle depreciation	25	45.5%
Insurance	22	40.0%
Licenses/permits	16	29.1%
Security	16	29.1%
None of the above	8	14.5%
Other	4	7.3%

IDD/Autism – GRO Services

Providers were asked about the recommended frequency of therapy for children with IDD/Autism. For individual therapy, 36% of providers suggested therapy should be once per week and 31% suggested twice per week. Twenty-seven percent of providers felt family therapy should be once per month and 25% felt that it should be twice per month. Twenty-seven percent of providers felt group therapy should be once per month and 25% felt that it should be twice per month. Providers were also asked about services they would recommend for children with IDD/Autism. The following services were noted by 75% or more of the providers: psychological testing and evaluation (93%); educational and tutoring services (91%), behavior support specialist (89%), art therapy (84%), animal therapy (82%), play therapy (80%), recreational therapy (77%), and crisis services/stabilization (75%). Providers mentioned the following additional services needed for youth with IDD/Autism: case management to oversee multiple services, social skills training, translation services, substance use disorder services, support with Medicaid waivers/HCS, and support for normalcy (outings). One provider said services need to be child specific and able to combine with other services.

IDD/A – GRO Therapy

Table 663. IDD/A (GRO) - Recommended frequency of therapy sessions

		Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
		N	%	%	%	%	%	%	%	%	%	%	%	%
IDD/A (GRO)	Individual Therapy													
		55	4%	2%	4%	4%	36%	31%	9%	0%	0%	0%	7%	4%
	Family Therapy													
		51	2%	6%	14%	25%	27%	20%	0%	0%	0%	2%	0%	4%
	Group Therapy													
		51	2%	6%	14%	25%	27%	20%	0%	0%	0%	2%	0%	4%

IDD/A – GRO Needed Services

Table 664. IDD/A (GRO) - Additional recommended services

	Total N	Service needed N	%
Psychological testing and evaluation	56	52	92.9%
Education and tutoring services	54	49	90.7%
Behavior Support Specialist	56	50	89.3%
Art therapy	56	47	83.9%
Animal therapy	56	46	82.1%
Play therapy	56	45	80.4%
Recreational therapy	56	43	76.8%
Crisis Services / Stabilization	56	42	75.0%
Speech Therapy	56	41	73.2%
Personal Care Services (PCS)	47	34	72.3%
Assistance with HS diploma or GED	54	39	72.2%
Healthy Relationship Programs / Classes	54	39	72.2%
Risk assessments	56	40	71.4%
Occupational Therapy	56	40	71.4%
Dance / Movement therapy	56	36	64.3%
Equine therapy	56	35	62.5%
Peer mentoring	54	33	61.1%
Dietician / Nutrition services	47	28	59.6%
Applied Behavior Analysis (ABA)	56	33	58.9%
Physical / Rehabilitation Therapy	56	32	57.1%
Youth support groups	54	29	53.7%
Parenting programs / classes	54	28	51.9%
Parent support groups	54	28	51.9%
Assistance with obtaining a driver's license	54	27	50.0%
Nursing - Other	47	23	48.9%
Medical specialists	47	20	42.6%
Legal services	54	20	37.0%
Neurofeedback	56	17	30.4%
Forensic assessments	56	12	21.4%
Prenatal and Postnatal Care	47	4	8.5%
Private Duty Nursing (PDN)	47	2	4.3%

Note: Services highlighted in orange were identified by at least 75% of GROs as a needed service.

IDD/A – GRO Maximum Length of Services

Table 665. IDD/A (GRO) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
IDD/A (GRO)	57	0%	2%	2%	4%	11%	9%	19%	12%	7%	35%

IDD/Autism – GRO Aftercare

When asked about the recommended length of time youth with IDD/Autism should have aftercare services, providers most commonly said six months (34%). The mean estimated caseload for case managers providing aftercare services was 11 youth.

Table 666. IDD/A (GRO) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months %	No max %
IDD/A (GRO)	56	11%	2%	2%	11%	2%	0%	34%	0%	0%	0%	0%	2%	21%	16%

Table 667. IDD/A (GRO) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std dev
IDD/A (GRO) estimated aftercare caseload	45	0	50	11	9

Primary Setting - Human Trafficking (HT) – GRO Tier 1 Service Package

Brief Description: This facility-based treatment setting licensed to provide time-limited services for children, youth, and young adults who have experienced human trafficking (or may be at increased risked). The organization must have an evidence-informed treatment model and provide after-care services to support transition to a less restrictive setting. Clinical, case management, and direct delivery staff should be well-versed in treatment model and trained in de-escalation techniques. If the organization is licensed to provide services to youth and young adults ages 14 and older, the program model must include transition support services that includes additional staff training and support to assist with experiential learning (based on child's individual needs) such as learning to drive, obtaining a license, obtaining and supporting employment, encouraging extracurricular and age-appropriate normalcy activities. This section examines the needs and costs specific to the provision of this service package.

Human Trafficking – GRO Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for youth who have experienced human trafficking. Most providers indicated that specialized staff were needed. As for treatment directors, 84% thought a treatment director was needed. In terms of other staff, half of providers thought it was extremely important to have a psychiatrist (54%), one-third extremely important to have a physician (34%), and one-third thought it was somewhat important to have a nurse (33%) for youth who have experienced human trafficking. Providers indicated they would ideally like a psychiatrist (98%), physician (89%) and/or nurse (79%). Providers preferred contracted staff over in house staff for physicians, psychiatrists, and nurses.

Providers (67%) reported that therapists were extremely important when working with youth who have experienced human trafficking and 100% reported wanting a therapist. A little over half of providers (55%) reported that therapists would ideally be in-house and 78% felt a therapist needed to be on call after hours.

For case managers, 27% of providers preferred for case managers to have a bachelor's degree, 25% preferred a bachelor's degree in human services, and 27% preferred a master's degree in human services. Providers (76%) noted that no additional certifications were needed for case managers For providers who said that case managers did need additional certifications, they specified the following training, certifications, or qualifications: Trust-Based Relational Intervention, Satori Alternatives to Managing Aggression, relationship building, mental health, behavioral health support/management training, and human trafficking specific training.

For direct care staff, 34% preferred for direct care staff to have a bachelor's degree and in the human services field. Providers (63%) noted that additional certifications were needed for direct care staff.

HT – GRO Treatment Director

Table 668. HT (GRO) - Should a treatment director be required? (N=62)

	N	%
Yes	52	83.9%
No	10	16.1%

HT – GRO Psychiatrists

Table 669. HT (GRO) - How important is to have a psychiatrist? (N=65)

	N	%
Not important	5	7.7%
Somewhat important	3	4.6%
Very important	22	33.8%
Extremely important	35	53.8%

Table 670. HT (GRO) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=63)		
Yes	62	98.4%
No	1	1.6%
If yes, would you prefer to contract with them or have them in-house? (N=62)		
Contract	52	83.9%
In-house	10	16.1%

Table 671. HT (GRO) - Should a psychiatrist be on-call or available 24/7? (N=62)

	N	%
Yes	46	74.2%
No	16	25.8%

HT – GRO Physicians

Table 672. HT (GRO) - How important is it to have a physician? (N=62)

	N	%
Not important	18	29.0%
Somewhat important	8	12.9%
Very important	15	24.2%
Extremely important	21	33.9%

Table 673. HT (GRO) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=62)		
Yes	55	88.7%
No	7	11.3%
If yes, would you prefer to contract with them or have them in-house? (N=55)		
Contract	46	83.6%
In-house	9	16.4%

Table 674. HT (GRO) - Should a physician be on-call or available 24/7? (N=55)

	N	%
Yes	34	61.8%
No	21	38.2%

HT – GRO Therapists

Table 675. HT (GRO) - How important is having a therapist? (N=61)

	N	%
Not important	2	3.3%
Somewhat important	2	3.3%
Very important	16	26.2%
Extremely important	41	67.2%

Table 676. HT (GRO) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=60)		
Yes	60	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=60)		
Contract	27	45.0%
In-house	33	55.0%

Table 677. HT (GRO) - Should a therapist be on-call or available 24/7?(N=60)

	N	%
Yes	47	78.3%
No	13	21.7%

HT – GRO Nurses

Table 678. HT (GRO) - How important is having a nurse? (N=58)

	N	%
Not important	13	22.4%
Somewhat important	19	32.8%
Very important	16	27.6%
Extremely important	10	17.2%

Table 679. HT (GRO) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=58)		
Yes	46	79.3%
No	12	20.7%
If yes, would you prefer to contract with them or have them in-house? (N=46)		
Contract	26	56.5%
In-house	20	43.5%

Table 680. HT (GRO) - Should a nurse be on-call or available 24/7? (N=46)

	N	%
Yes	34	73.9%
No	12	26.1%

HT – GRO Case Management Staff

Table 681. HT (GRO) - Recommended level of education for case managers

	Minimum level (N=56)		Preferred level (N=56)	
	N	%	N	%
High School Diploma or GED	5	8.9%	1	1.8%
Associate's Degree	4	7.1%	1	1.8%
Bachelor's Degree	21	37.5%	16	28.6%
Bachelor's Degree (human service field)	18	32.1%	14	25.0%
Master's Degree	5	8.9%	9	16.1%
Master's Degree (human service field)	2	3.6%	15	26.8%
Other	1	1.8%	0	0.0%

Table 682. HT (GRO) - Do case managers need any certifications? (N=58)

	N	%
No certifications needed	44	75.9%
Certifications needed	14	24.1%

HT – GRO Direct Care Staff

Table 683. HT (GRO) - Recommended level of education for direct care staff

	Minimum level (N=56)		Preferred level (N=55)	
	N	%	N	%
High School Diploma or GED	46	82.1%	16	29.1%
Associate's Degree	4	7.1%	9	16.4%
Bachelor's Degree	3	5.4%	10	18.2%
Bachelor's Degree (human services field)	3	5.4%	19	34.5%
Other	0	0.0%	1	1.8%

Table 684. HT (GRO) - Do direct care staff need any certifications? (N=56)

	N	%
No certifications needed	21	37.5%
Certifications needed	35	62.5%

Human Trafficking – GRO Ideal Caseloads and Competitive Pay

Providers were asked about the ideal caseloads and pay for therapists, case managers, and direct care staff. For those providers who indicated in-house therapists would be ideal (55%), the mean response for the typical caseload and ideal caseload was 7 youth. The maximum caseload was 10 youth. For case managers, the mean response for typical caseload was 19 youth. The ideal caseload was 9 youth and the maximum caseload was 13 youth.

For in-house therapist salaries, providers reported a mean of $73,200 for a competitive therapist salary without benefits. For case managers, the mean competitive salary without benefits was $46,893. For direct care, $15.00 was considered a competitive hourly rate for entry level staff and $17.00 was a competitive hourly rate experienced staff.

HT – GRO Therapist Caseloads

Table 685. HT (GRO) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	17	1	17	7.4	8	8	4.64
Ideal caseload	21	1	12	7.0	8	5	3.11
Max caseload	24	2	20	10.0	10	10	4.77

HT – GRO Therapist Competitive Salary

Table 686. HT (GRO) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	20	$50,000	$150,000	$73,200	$65,000	$65,000	$27,194

HT – GRO Case Manager Caseloads

Table 687. HT (GRO) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	30	1	26	10.2	10	5*	6.96
Ideal caseload	41	1	26	9.1	8	8	5.11
Max caseload	41	1	30	12.8	12	10	6.53

*Multiple modes exist. The smallest value is shown.

HT – GRO Competitive Salary for Case Managers

Table 688. HT (GRO) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	42	$30,000	$60,000	$46,893	$45,000	$45,000	$7,755

HT – GRO Direct Care Competitive Hourly Rate

Table 689. HT (GRO) - Competitive hourly rate for direct care staff

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive hourly rate - entry level	52	$9.00	$22.00	$14.95	$15.00	$12.00	$3.16
Competitive hourly rate - experienced	51	$12.00	$25.00	$17.74	$17.00	$15.00	$3.52

Human Trafficking – GRO Staffing Ratios and 1:1 Supervision

Providers were asked what the ideal awake and sleep youth to staff ratios should be for youth who have experienced human trafficking. The mean ideal awake ratio for one staff was 4 youth and the mean ideal sleep ratio for one staff was 8 youth. Providers were also asked the percentage of time they thought one to one supervision was needed, where one staff member supervised one youth. Providers reported a mean of 40% for the percentage of time that one to one supervision was needed.

HT – GRO Staffing Ratios

Table 690. HT (GRO) - Ideal number of children per staff ratios

	N	Min	Max	Mean	Median	Mode	Std dev
Ideal awake ratio	51	1	8	4.2	4	5	1.68
Ideal sleep ratio	51	2	16	8.4	8	8	3.24

HT – GRO 1:1 Supervision

Table 691. HT (GRO) - Percent of time 1:1 supervision is needed

	N	Min	Max	Mean	Median	Mode	Std dev
% of time 1:1 supervision is needed	37	0%	100%	39.5%	30%	50%	30.13%

Human Trafficking – GRO Increased Costs

Providers were asked what additional costs should be considered when working with youth who have experienced human trafficking. Providers indicated security (56%) and property damage (50%) as common categories for increased costs. Providers also mentioned the following additional costs related to youth who have experienced human trafficking: personal items for youth, maintenance and repair, therapeutic and wrap around services, housekeeping, increased staffing and staff development, training and appreciation,

increased Human Resources costs, overtime, stipends, and signing bonus costs due to turnover.

Table 692. HT (GRO) - Are there increased costs associated with any of the following? (N=50)

	N	%
Security	28	56.0%
Property damage	25	50.0%
Insurance	24	48.0%
Supplies	24	48.0%
Food/dietary needs	19	38.0%
Vehicle depreciation	16	32.0%
None of the above	12	24.0%
Licenses/permits	12	24.0%
Other	7	14.0%

Human Trafficking – GRO Services

Providers were asked about the recommended frequency of therapy for youth who have experienced human trafficking. For individual therapy, 37% of providers suggested therapy should be once per week and 35% suggested twice per week. Thirty-five percent of providers recommended family therapy should be once per week and 42% recommended group therapy to occur once per week.

Providers were also asked about services they would recommend for youth who have experienced human trafficking. The following services were noted by 75% or more of the providers: crisis services/stabilization (96%), psychological testing and evaluation (92%), Healthy Relationship Program or Classes (92%, recreational therapy (90%), education and tutoring services (88%), risk assessments (86%), Behavioral Support Specialist (82%), youth support groups (82%), assistance with acquiring a high school diploma and GED (78%) and art therapy (77%). In open-ended questions providers mentioned the following additional services needed for youth who have experienced human trafficking: mental health support (EMDR, substance use disorder services), peer support, drop-in centers, and transition services (i.e. education, job). One provider said services need to be child specific and able to combine with other services.

Providers were also asked about the recommended maximum length of services for youth who have experienced human trafficking. The most common response (33%) was that there should be no maximum services.

HT – GRO Therapy

Table 693. HT (GRO) - Recommended frequency of therapy sessions

		Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
		N	%	%	%	%	%	%	%	%	%	%	%	%
HT (GRO)	Individual Therapy													
		52	0%	0%	4%	2%	37%	35%	13%	0%	0%	0%	10%	0%
	Family Therapy													
		48	0%	0%	15%	25%	35%	17%	4%	0%	0%	0%	0%	4%
	Group Therapy													
		50	0%	2%	16%	6%	42%	20%	6%	0%	0%	0%	8%	0%

HT – GRO Needed Services

Table 694. HT (GRO) - Additional recommended services

	Total N	Service needed N	%
Crisis Services / Stabilization	51	49	96.1%
Psychological testing and evaluation	51	47	92.2%
Healthy Relationship Programs / Classes	51	47	92.2%
Recreational therapy	48	43	89.6%
Education and tutoring services	51	45	88.2%
Risk assessments	51	44	86.3%
Behavior Support Specialist	51	42	82.4%
Youth support groups	51	42	82.4%
Assistance with HS diploma or GED	51	40	78.4%
Art therapy	48	37	77.1%
Dance / Movement therapy	48	34	70.8%
Peer mentoring	51	36	70.6%
Animal therapy	48	33	68.8%
Assistance with obtaining a driver's license	51	35	68.6%
Play therapy	48	32	66.7%
Forensic assessments	51	33	64.7%
Dietician / Nutrition services	39	25	64.1%
Equine therapy	48	30	62.5%
Parent support groups	51	29	56.9%
Legal services	51	29	56.9%
Personal Care Services (PCS)	39	22	56.4%
Medical specialists	39	21	53.8%
Parenting programs / classes	51	27	52.9%
Nursing - Other	39	20	51.3%
Prenatal and Postnatal Care	39	17	43.6%
Applied Behavior Analysis (ABA)	51	19	37.3%
Physical / Rehabilitation Therapy	51	16	31.4%
Occupational Therapy	51	14	27.5%
Neurofeedback	51	14	27.5%
Speech Therapy	51	10	19.6%
Private Duty Nursing (PDN)	39	6	15.4%

Note: Services highlighted in orange were identified by at least 75% of GROs as a needed service.

HT – GRO Maximum Length of Services

Table 695. HT (GRO) - Recommended maximum length of services

	Total N	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
HT (GRO)	55	2%	0%	0%	2%	7%	13%	24%	11%	9%	33%

Human Trafficking – GRO Aftercare

Providers were asked about the recommended length of aftercare and estimated caseload for an aftercare case manager for youth who have experienced human trafficking. Thirty-three percent of providers indicated that there should be 6 months of aftercare with the mean caseload of 11 youth.

Table 696. HT (GRO) - Recommended length of aftercare

	Total N	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months %	No max %
HT (GRO)	55	7%	4%	0%	5%	0%	0%	33%	0%	2%	2%	0%	2%	22%	24%

Table 697. HT (GRO) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std dev
HT (GRO) estimated aftercare caseload	44	1	30	11	7

Primary Setting – Expectant and Parenting Youth (EPY) – GRO Tier 1 Service Package

Brief Description: This facility-based setting will offer time-limited services for youth and young adults who are pregnant and/or already parenting. The organization must have an evidence-informed program model and provide after-care services to support transition to support healthy parenting in a less restrictive setting. GRO will have specialized programming to assist and support the youth parent who is pregnant or parenting for up to two years after the birth of a baby. This section examines the needs and costs specific to the provision of this service package.

Expectant and Parenting Youth – GRO Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the expectant and parenting youth package. Half of the providers (50%) reported a treatment director is needed for expectant and parenting youth. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 81% felt a psychiatrist was important, 85% felt a physician was important and 83% felt having a nurse was important when working with expectant and parenting youth. Providers indicated they would like a psychiatrist (78%), physician (89%) and/or nurse (92%). For psychiatrists and physicians, contracted staff was the preference. However, 55% of providers noted that they would like an in-house nurse. Most reported that psychiatrists (52%), physician (52%), and nurse (82%) should be on call 24/7.

In terms of therapists, 100% providers reported that therapists were important and 100% reported wanting a therapist. The majority of providers (68%) reported that therapists would ideally be in-house and 68% felt a therapist needed to be on call after hours.

For case managers, the both the minimum and ideal level of education was a bachelor's degree in human services. Providers noted that additional certifications were not needed for case managers working with expectant and parenting youth. In open-ended questions, GRO providers said that when working with youth who are pregnant or parenting, case managers may need the following training, certifications, or qualifications: mental health, pregnant/parenting, and social work license.

For direct care staff, the minimum level of education was a high school diploma (75%). The preferred level of education was a bachelor's degree in human services (46%). Providers (58%) noted that additional certifications were needed for direct care staff working with youth with substance use disorders.

EPY – GRO Treatment Director

Table 698. EPY (GRO) - Should a treatment director be required? (N=26)

	N	%
Yes	13	50.0%
No	13	50.0%

EPY – GRO Psychiatrists

Table 699. EPY (GRO) - How important is it to have a psychiatrist? (N=27)

	N	%
Not important	5	18.5%
Somewhat important	8	29.6%
Very important	6	22.2%
Extremely important	8	29.6%

Table 700. EPY (GRO) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=27)		
Yes	21	77.8%
No	6	22.2%
If yes, would you prefer to contract with them or have them in-house? (N=21)		
Contract	18	85.7%
In-house	3	14.3%

Table 701. EPY (GRO) - Should a psychiatrist be on-call or available 24/7? (N=21)

	N	%
Yes	11	52.4%
No	10	47.6%

EPY – GRO Physicians

Table 702. EPY (GRO) - How important is it to have a physician? (N=26)

	N	%
Not important	4	15.4%
Somewhat important	6	23.1%
Very important	5	19.2%
Extremely important	11	42.3%

Table 703. EPY (GRO) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=26)		
Yes	23	88.5%
No	3	11.5%
If yes, would you prefer to contract with them or have them in-house? (N=23)		
Contract	16	69.6%
In-house	7	30.4%

Table 704. EPY (GRO) - Should a physician be on-call or available 24/7? (N=23)

	N	%
Yes	12	52.2%
No	11	47.8%

EPY – GRO Therapists

Table 705. EPY (GRO) - How important is having a therapist? (N=25)

	N	%
Not important	0	0.0%
Somewhat important	2	8.0%
Very important	11	44.0%
Extremely important	12	48.0%

Table 706. EPY (GRO) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=25)		
Yes	25	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=25)		
Contract	8	32.0%
In-house	17	68.0%

Table 707. EPY (GRO) – Should a therapist be on-call or available 24/7? (N=25)

	N	%
Yes	17	68.0%
No	8	32.0%

EPY – GRO Nurses

Table 708. EPY (GRO) - How important is having a nurse? (N=24)

	N	%
Not important	4	16.7%
Somewhat important	6	25.0%
Very important	5	20.8%
Extremely important	9	37.5%

Table 709. EPY (GRO) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=24)		
Yes	22	91.7%
No	2	8.3%
If yes, would you prefer to contract with them or have them in-house? (N=22)		
Contract	10	45.5%
In-house	12	54.5%

Table 710. EPY (GRO) - Should a nurse be on-call or available 24/7? (N=22)

	N	%
Yes	18	81.8%
No	4	18.2%

EPY – GRO Case Management Staff

Table 711. EPY (GRO) - Recommended level of education for case managers

	Minimum level (N=23)		Preferred level (N=23)	
	N	%	N	%
High School Diploma or GED	3	13.0%	1	4.3%
Associate's Degree	2	8.7%	0	0.0%
Bachelor's Degree	6	26.1%	4	17.4%
Bachelor's Degree (human services field)	10	43.5%	8	34.8%
Master's Degree	1	4.3%	3	13.0%
Master's Degree (human services field)	1	4.3%	7	30.4%
Other	0	0.0%	0	0.0%

Table 712. EPY (GRO) - Do case managers need any certifications? (N=24)

	N	%
No certifications needed	17	70.8%
Certifications needed	7	29.2%

EPY – GRO Direct Care Staff

Table 713. EPY (GRO) - Recommended level of education for direct care staff

	Minimum level (N=24)		Preferred level (N=24)	
	N	%	N	%
High School Diploma or GED	18	75.0%	5	20.8%
Associate's Degree	3	12.5%	3	12.5%
Bachelor's Degree	1	4.2%	4	16.7%
Bachelor's Degree (human services field)	2	8.3%	11	45.8%
Other	0	0.0%	1	4.2%

Table 714. EPY (GRO) - Do direct care staff need any? (N=24)

	N	%
No certifications needed	10	41.7%
Certifications needed	14	58.3%

Expectant and Parenting Youth – GRO Ideal Caseloads and Competitive Pay

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 9 youth. However, the ideal caseload was 6 and the maximum caseload was 7 youth. For case managers, the typical caseload was 12 youth. The ideal caseload was 9 youth and the maximum caseload was 12 youth.

For salaries, providers noted that a competitive therapist salary without benefits was $65,625. For case managers, the mean competitive salary without benefits was $46,658.

EPY – GRO Therapist Caseloads

Table 715. EPY (GRO) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	7	1	15	8.7	10	10	4.61
Ideal caseload	11	0	12	5.5	5	0	4.78
Max caseload	12	0	20	7.3	10	10	6.76

EPY – GRO Therapist Competitive Salary

Table 716. EPY (GRO) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	8	$60,000	$70,000	$65,625	$67,500	$70,000	$4,955

EPY – GRO Case Manager Caseloads

Table 717. EPY (GRO) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	13	5	25	11.9	12	15	5.35
Ideal caseload	16	1	15	8.7	9	8*	3.86
Max caseload	16	2	20	12.1	12	10*	4.76

*Multiple modes exist. The smallest value is shown.

EPY – GRO Case Manager Competitive Salary

Table 718. EPY (GRO) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	19	$30,000	$60,000	$46,658	$45,000	$45,000	$7,874

EPY – GRO Direct Care Competitive Hourly Rate

Table 719. EPY (GRO) - Competitive hourly rate for direct care staff

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive hourly rate - entry level	23	$9.00	$21.00	$15.13	$15.00	$12.00*	$3.25
Competitive hourly rate - experienced	23	$12.50	$25.00	$18.11	$18.00	$15.00	$3.58

*Multiple modes exist. The smallest value is shown.

Expectant and Parenting Youth – GRO Staffing Ratios and 1:1 Supervision

Providers were asked about the recommended frequency of therapy for expectant and parenting youth. The mean ideal wake ratio was 1 staff for 5 youth and the mean ideal sleep ratio was 1 staff for every 9 youth. On average, providers indicated that 1 staff to 1 youth ratios were requested 26% of the time.

EPY – GRO Staffing Ratios

Table 720. EPY (GRO) - Ideal number of children per staff ratios

	N	Min	Max	Mean	Median	Mode	Std dev
Ideal awake ratio	22	0	10	5.0	5	8	2.66
Ideal sleep ratio	22	0	20	9.1	8	8	5.08

EPY – GRO 1:1 Supervision

Table 721. EPY (GRO) - Percent of time 1:1 supervision is needed

	N	Min	Max	Mean	Median	Mode	Std dev
% of time 1:1 supervision is needed	15	0%	100%	26.4%	10%	0%*	35.28%

*Multiple modes exist. The smallest value is shown.

Expectant and Parenting Youth – GRO Increased Costs

Providers were asked what additional costs should be considered when working with youth with substance use disorders. Providers indicated supplies (60%), insurance (50%) and food/dietary needs (50%) as the most common categories for increased costs. For providers that selected other, GRO providers mentioned the following additional costs related to expectant and parenting youth: costs for infants and toddlers, increased staffing and staff development, training and appreciation, increased human resources, overtime, stipends, and signing bonus costs due to turnover.

Table 722. EPY (GRO) - *Are there increased costs associated with any of the following? (N=20)*

	N	%
Supplies	12	60.0%
Food/dietary needs	11	55.0%
Insurance	10	50.0%
Security	7	35.0%
Vehicle depreciation	7	35.0%
Property damage	7	35.0%
Licenses/permits	5	25.0%
None of the above	5	25.0%
Other	3	15.0%

Expectant and Parenting Youth – GRO Services

Providers were asked about the recommended frequency of therapy for expectant and parenting youth. For individual therapy 52% of providers suggested individual therapy should be once per week. Providers (35%) felt family therapy should be twice a month. Providers (40%) felt group therapy should be once a month. Providers were also asked about services they would recommend for expectant and parenting youth. The following services were noted by 75% or more of the providers: prenatal and postnatal care (95%); parenting programs/classes (95%); education and tutoring services (90%); healthy relationship programs/classes (90%); recreational therapy (89%); assistance with HS diploma or GED (80%); assistance with obtaining a driver's license (80%); parent support groups (80%); play therapy (78%); crisis services/stabilization (75%); and youth support groups (75%).

In open-ended responses, providers mentioned the following additional services needed for youth who are pregnant or parenting: peer support, and postpartum support (including for postpartum depression). One provider said services need to be child specific and able to combine with other services. Providers were also asked about the recommended maximum length of services for expectant and parenting youth. The most common response (38%) was that there should be no maximum service length.

EPY – GRO Therapy

Table 723. EPY (GRO) - Recommended frequency of therapy sessions

	Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
	N	%	%	%	%	%	%	%	%	%	%	%	%
EPY (GRO)	Individual Therapy												
	21	0%	0%	5%	10%	52%	14%	0%	0%	0%	0%	14%	5%
	Family Therapy												
	20	0%	10%	15%	35%	20%	15%	0%	0%	0%	0%	5%	0%
	Group Therapy												
	20	0%	5%	15%	15%	40%	20%	0%	0%	0%	0%	5%	0%

EPY – GRO Needed Services

Table 724. EPY (GRO) - Additional recommended services

	Total N	Service needed N	%
Prenatal and Postnatal Care	20	19	95.0%
Parenting programs / classes	20	19	95.0%
Education and tutoring services	20	18	90.0%
Healthy Relationship Programs / Classes	20	18	90.0%
Recreational therapy	18	16	88.9%
Assistance with HS diploma or GED	20	16	80.0%
Assistance with obtaining a driver's license	20	16	80.0%
Parent support groups	20	16	80.0%
Play therapy	18	14	77.8%
Crisis Services / Stabilization	20	15	75.0%
Youth support groups	20	15	75.0%
Art therapy	18	13	72.2%
Psychological testing and evaluation	20	14	70.0%
Behavior Support Specialist	20	14	70.0%
Dietician / Nutrition services	20	14	70.0%
Dance / Movement therapy	18	12	66.7%
Medical specialists	20	13	65.0%
Peer mentoring	20	13	65.0%
Animal therapy	18	11	61.1%
Equine therapy	18	11	61.1%
Risk assessments	20	12	60.0%
Nursing - Other	20	12	60.0%
Applied Behavior Analysis (ABA)	20	9	45.0%
Physical / Rehabilitation Therapy	20	9	45.0%
Personal Care Services (PCS)	20	9	45.0%
Legal services	20	9	45.0%
Forensic assessments	20	7	35.0%
Occupational Therapy	20	6	30.0%
Neurofeedback	20	6	30.0%
Speech Therapy	20	5	25.0%
Private Duty Nursing (PDN)	20	3	15.0%

Note: Services highlighted in orange were identified by at least 75% of GROs as a needed service.

EPY – GRO Maximum Length of Services

Table 725. EPY (GRO) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
EPY (GRO)	21	0%	0%	0%	0%	0%	24%	14%	5%	19%	38%

Expectant and Parenting Youth – GRO Aftercare

Providers were also asked about the recommended length of services for expectant and parenting youth. The most common response (36%) was that there should be 12 or more months of aftercare services. Additionally, the average caseload for an aftercare case manager would be 12 expectant and parenting youth.

Table 726. EPY (GRO) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months %	No max %
EPY (GRO)	22	9%	0%	0%	5%	0%	0%	27%	0%	0%	0%	0%	0%	36%	23%

Table 727. EPY (GRO) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std dev
EPY (GRO) estimated aftercare caseload	19	0	30	12	8

Primary Setting – Substance Use Disorders (SUD) – GRO Tier 1 Service Package

Brief Description: This facility-based treatment setting will offer time-limited intensive services for children, youth, and young adults who have a DSM-5 diagnosis for a substance use disorder that requires regular clinical intervention to support day-to-day activities. The organization must have an evidence-informed treatment model and provide after care services to support transition and recovery in a less restrictive setting. Clinical, case management, and direct delivery staff should be well-versed in treatment model and trained to provide services that support care for children, youth, and young adults with substance disorders. Regular group therapy, weekly family therapy, and individual therapy will be conducted by a Licensed Chemical Dependency Counselor (LCDC). This section examines the needs and costs specific to the provision of this service package.

Substance Use Disorders – GRO Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the youth with substance use disorders package. Most providers (84%) reported a treatment director is needed for youth with substance use disorders. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 93% felt a psychiatrist was important, 79% felt a physician was important and 79% felt having a nurse was important when working with youth with substance use disorders. Providers indicated they would like a psychiatrist (94%), physician (85%) and/or nurse (87%). For all these positions, contracted staff was the preference and most reported that psychiatrists (61%), physician (63%), and nurse (70%) should be on call 24/7.

In terms of therapists, 100% providers reported that therapists were important and 100% reported wanting a therapist. The majority of providers (57%) reported that therapists would ideally be in-house and only 82% felt a therapist needed to be on call after hours.

For case managers, the minimum and ideal level of education was a bachelor's degree in human services (29%), but the preferred level of education was a master's degree in human services (31%). Providers (73%) noted that additional certifications were not needed for case managers working with youth with substance use disorders. In open-ended questions, GRO providers said that when working with youth with substance use disorders, case managers may need the following training, certifications, or qualifications: Trust-Based Relational Intervention®, mental health, relationship building, Satori Alternatives to Managing Aggression (an EBI), substance use disorder certifications (including Licensed Chemical Dependency Counselor), social work license, and CPR certification. One provider said:

> *'Our case managers are also our therapists, so they have to have a master's degree and a license in social work or counseling." _RTC Provider*

For direct care staff, the minimum level of education was a high school diploma (73%). The preferred level of education was a bachelor's degree in human services (32%) or a high

school diploma. Providers (61%) noted that additional certifications were not needed for direct care staff working with youth with substance use disorders.

SUD – GRO Treatment Director

Table 728. SUD (GRO) - Should a treatment director be required? (N=69)

	N	%
Yes	58	84.1%
No	11	15.9%

SUD – GRO Psychiatrists

Table 729. SUD (GRO) - How important is to have a psychiatrist? (N=70)

	N	%
Not important	5	7.1%
Somewhat important	8	11.4%
Very important	22	31.4%
Extremely important	35	50.0%

Table 730. SUD (GRO) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=68)		
Yes	64	94.1%
No	4	5.9%
If yes, would you prefer to contract with them or have them in-house? (N=64)		
Contract	52	81.3%
In-house	12	18.8%

Table 731. SUD (GRO) - Should a psychiatrist be on-call or available 24/7? (N=64)

	N	%
Yes	45	70.3%
No	19	29.7%

SUD – GRO Physicians

Table 732. SUD (GRO) - How important is it to have a physician? (N=68)

	N	%
Not important	14	20.6%
Somewhat important	11	16.2%
Very important	19	27.9%
Extremely important	24	35.3%

Table 733. SUD (GRO) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=67)		
Yes	57	85.1%
No	10	14.9%
If yes, would you prefer to contract with them or have them in-house? (N=57)		
Contract	47	82.5%
In-house	10	17.5%

Table 734. SUD (GRO) - Should a physician be on-call or available 24/7? (N=57)

	N	%
Yes	36	63.2%
No	21	36.8%

SUD – GRO Therapists

Table 735. SUD (GRO) - How important is having a therapist? (N=67)

	N	%
Not important	0	0.0%
Somewhat important	3	4.5%
Very important	18	26.9%
Extremely important	46	68.7%

Table 736. SUD (GRO) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=65)		
Yes	65	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=65)		
Contract	28	43.1%
In-house	37	56.9%

Table 737. SUD (GRO) - Should a therapist be on-call or available 24/7?(N=65)

	N	%
Yes	53	81.5%
No	12	18.5%

SUD – GRO Nurses

Table 738. SUD (GRO) - How important is having a nurse? (N=63)

	N	%
Not important	13	20.6%
Somewhat important	22	34.9%
Very important	15	23.8%
Extremely important	13	20.6%

Table 739. SUD (GRO) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=62)		
Yes	54	87.1%
No	8	12.9%
If yes, would you prefer to contract with them or have them in-house? (N=54)		
Contract	33	61.1%
In-house	21	38.9%

Table 740. SUD (GRO) - Should a nurse be on-call or available 24/7? (N=54)

	N	%
Yes	38	70.4%
No	16	29.6%

SUD – GRO Case Management Staff

Table 741. SUD (GRO) - Recommended level of education for case managers

	Minimum level (N=58)		Preferred level (N=59)	
	N	%	N	%
High School Diploma or GED	6	10.3%	2	3.4%
Associate's Degree	3	5.2%	0	0.0%
Bachelor's Degree	20	34.5%	14	23.7%
Bachelor's Degree (human services field)	17	29.3%	16	27.1%
Master's Degree	5	8.6%	9	15.3%
Master's Degree (human services field)	6	10.3%	18	30.5%
Other	1	1.7%	0	0.0%

Table 742. SUD (GRO) - Do case managers need any certifications? (N=64)

	N	%
No certifications needed	47	73.4%
Certifications needed	17	26.6%

SUD – GRO Direct Care Staff

Table 743. SUD (GRO) - Recommended level of education for direct care staff

	Minimum level (N=59)		Preferred level (N=57)	
	N	%	N	%
High School Diploma or GED	43	72.9%	18	31.6%
Associate's Degree	9	15.3%	8	14.0%
Bachelor's Degree	3	5.1%	12	21.1%
Bachelor's Degree (human services field)	4	6.8%	18	31.6%
Other	0	0.0%	1	1.8%

Table 744. SUD (GRO) - Do direct care staff need any certifications? (N=61)

	N	%
No certifications needed	24	39.3%
Certifications needed	37	60.7%

Substance Use Disorders – GRO Ideal Caseloads and Competitive Pay

Providers were asked about the ideal caseloads and salaries for therapists and case managers. The mean response for the typical caseload 15 youth. However, the ideal caseload was 12 and the maximum caseload was 24 youth. For case managers, the typical caseload was 11 youth. The ideal caseload was 10 youth and the maximum caseload was 13 youth. Providers were also asked how many case managers should be supervised by one supervisor.

For salaries, providers noted that a competitive therapist salary without benefits was $74,389. For case managers, the mean competitive salary without benefits was $48,144. For direct care staff, $14.89 was considered a competitive hourly wage for entry level staff and $17.80 is a competitive hourly rate for experienced staff.

SUD – GRO Therapist Caseloads

Table 745. SUD (GRO) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	18	1	15	5.9	5	2*	4.06
Ideal caseload	21	1	12	6.8	5	5	3.52
Max caseload	24	2	24	10.8	10	10	5.42

*Multiple modes exist. The smallest value is shown.

SUD – GRO Therapist Competitive Salary

Table 746. SUD (GRO) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	18	$50,000	$150,000	$74,389	$65,000	$65,000	$28,578

SUD – GRO Case Manager Caseloads

Table 747. SUD (GRO) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	35	1	26	10.7	10	5*	6.49
Ideal caseload	49	1	26	9.5	10	10	5.48
Max caseload	47	1	26	13.4	13	10*	6.29

*Multiple modes exist. The smallest value is shown.

Table 748. SUD (GRO) - Case management supervision recommendation

	N	Min	Max	Mean	Std dev
Number of case managers that should be supervised by one case supervisor	75	2	10	5.15	1.83

SUD – GRO Case Manager Competitive Salary

Table 749. SUD (GRO) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	45	$30,000	$80,000	$48,144	$45,000	$45,000	$9,132

SUD – GRO Direct Care Competitive Hourly Rate

Table 750. SUD (GRO) - Competitive hourly rate for direct care staff

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive hourly rate - entry level	54	$9.00	$21.00	$14.89	$15.00	$12.00	$3.18
Competitive hourly rate - experienced	55	$12.00	$25.00	$17.80	$18.00	$15.00	$3.63

Substance Use Disorders – GRO Staffing Ratios and 1:1 Supervision

Providers were asked about the recommended frequency of therapy for youth who have substance use disorders. The mean ideal wake ratio was 1 staff for 5 youth and the mean ideal sleep ratio was 1 staff for every 10 youth. On average, providers indicated that 1 staff to 1 youth ratios were requested 32% of the time.

SUD – GRO Staffing Ratios

Table 751. SUD (GRO) - Ideal number of children per staff ratios

	N	Min	Max	Mean	Median	Mode	Std dev
Ideal awake ratio	59	2	8	4.9	5	5	1.68
Ideal sleep ratio	59	2	16	10.2	10	15	4.09

SUD – GRO 1:1 Supervision

Table 752. SUD (GRO) - Percent of time 1:1 supervision is needed

	N	Min	Max	Mean	Median	Mode	Std dev
% of time 1:1 supervision is needed	46	0%	100%	31.5%	25%	50%	26.41%

Substance Use Disorders – GRO Increased Costs

Providers were asked what additional costs should be considered when working with youth with substance use disorders. Providers indicated property damage (64%), supplies (50%), insurance (41%) and security (41%) as the most common categories for increased costs. For providers that selected other, GRO providers mentioned the following additional costs related to youth with substance use disorders: maintenance and repair, transportation to specialized testing or targeted therapy, therapeutic services, staff development, training and appreciation, increased human resources costs, overtime, stipends, and signing bonus costs due to turnover.

Table 753. SUD (GRO) - Are there increased costs associated with any of the following? (N=56)

	N	%
Property damage	36	64.3%
Supplies	28	50.0%
Insurance	23	41.1%
Security	23	41.1%
Food/dietary needs	22	39.3%
Vehicle depreciation	19	33.9%
Licenses/permits	17	30.4%
None of the above	13	23.2%
Other	7	12.5%

Substance Use Disorders – GRO Services

Providers were asked about the recommended frequency of therapy for youth who have substance use disorders. For individual therapy 40% of providers suggested individual therapy should be once per week. Providers (35%) felt family therapy should be once a month. Providers (44%) felt group therapy should be once a month or once a week. Providers were also asked about services they would recommend for youth with substance use disorders. The following services were noted by 75% or more of the providers: recreational therapy (98%); education and tutoring services (93%); psychological testing and evaluation (89%); risk assessments (89%); crisis services/stabilization (87%); healthy relationship programs/classes (83%); youth support groups (83%); assistance with HS diploma or GED (80%); peer mentoring (78%); and behavior support specialist (76%).

In open-ended responses, GRO providers mentioned the following additional services needed for youth with substance use disorders: transition services (education, job, life skills, independent living), substance use disorder services, and ongoing case management. One provider said services need to be child specific and able to combine with other services. Providers were also asked about the recommended maximum length of services for youth with substance use disorders. The most common response (37%) was that there should be no maximum services.

SUD – GRO Therapy

Table 754. SUD (GRO) - Recommended frequency of therapy sessions

		N Total	None %	1x every other month %	1x per month %	2x per month %	1x per week %	2x per week %	3x per week %	4x per week %	5x per week %	6x per week %	Daily %	Prefer not to say %
SUD (GRO)	Individual Therapy													
		58	0%	0%	5%	3%	40%	33%	7%	2%	0%	2%	9%	0%
	Family Therapy													
		54	0%	4%	20%	20%	35%	15%	4%	0%	0%	0%	0%	2%
	Group Therapy													
		55	0%	0%	15%	4%	44%	22%	5%	2%	2%	0%	7%	0%

SUD – GRO Needed Services

Table 755. SUD (GRO) - Additional recommended services

	Total N	Service needed N	%
Recreational therapy	49	48	98.0%
Education and tutoring services	54	50	92.6%
Psychological testing and evaluation	54	48	88.9%
Risk assessments	54	48	88.9%
Crisis Services / Stabilization	54	47	87.0%
Healthy Relationship Programs / Classes	54	45	83.3%
Youth support groups	54	45	83.3%
Assistance with HS diploma or GED	54	43	79.6%
Peer mentoring	54	42	77.8%
Behavior Support Specialist	54	41	75.9%
Dietician / Nutrition services	36	24	66.7%
Art therapy	49	32	65.3%
Assistance with obtaining a driver's license	54	35	64.8%
Animal therapy	49	29	59.2%
Personal Care Services (PCS)	36	21	58.3%
Equine therapy	49	27	55.1%
Parent support groups	54	27	50.0%
Legal services	54	26	48.1%
Medical specialists	36	17	47.2%
Dance / Movement therapy	49	23	46.9%
Play therapy	49	23	46.9%
Parenting programs / classes	54	23	42.6%
Nursing - Other	36	14	38.9%
Applied Behavior Analysis (ABA)	54	17	31.5%
Occupational Therapy	54	16	29.6%
Physical / Rehabilitation Therapy	54	16	29.6%
Forensic assessments	54	15	27.8%
Speech Therapy	54	13	24.1%
Neurofeedback	54	13	24.1%
Prenatal and Postnatal Care	36	8	22.2%
Private Duty Nursing (PDN)	36	4	11.1%

Note: Services highlighted in orange were identified by at least 75% of GROs as a needed service.

SUD – GRO Maximum Length of Services

Table 756. SUD (GRO) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
SUD (GRO)	60	2%	2%	2%	0%	8%	13%	23%	7%	7%	37%

Substance Use Disorders – GRO Aftercare

Providers were also asked about the recommended length of services for youth with substance use disorders. The most common response (30%) was that there should be six months of aftercare services. Additionally, the average caseload for an aftercare case manager would be 13 youth with substance use disorders.

Table 757. SUD (GRO) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months %	No max %
SUD (GRO)	60	12%	3%	2%	3%	2%	0%	30%	0%	2%	2%	2%	0%	23%	20%

Table 758. SUD (GRO) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std dev
SUD (GRO) estimated aftercare caseload	47	0	50	13	9

Primary Setting - Sexual Aggression/Sex Offender Adjudication (SA/SO) – GRO Tier 1 Service Package

Brief Description: This facility-based treatment setting will offer time-limited services for children, youth, and young adults who have been identified as sexually aggressive and/or who have been adjudicated a sex offender, and who require regular clinical intervention to support day-to-day activities. The organization must have an evidence-informed treatment model and provide after-care services to support transition to a less restrictive setting. Clinical, case management, and direct delivery staff should be well-versed in treatment model and trained to provide intensive services that support care for children and youth. Services may include psychological assessment and evaluation, targeted treatment to address deviant behavior, and relapse prevention training/programming. This section examines the needs and costs specific to the provision of this service package.

Sexual Aggression/Sex Offender Adjudication – GRO Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for the youth with histories of sexual aggression package. Most providers (92%) reported a treatment director is needed for youth with histories of sexual aggression. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 96% felt a psychiatrist was important, 82% felt a physician was important and 81% felt having a nurse was important when working with youth with histories of sexual aggression. Providers indicated they would like a psychiatrist (100%), physician (92%) and/or nurse (77%). For all these positions, contracted staff was the preference and most reported that psychiatrists (75%), physician (57%), and nurse (79%) should be on call 24/7.

In terms of therapists, 100% providers reported that therapists were important and 100% reported wanting a therapist. The majority of providers (52%) reported that therapists would ideally be in-house and only 82% felt a therapist needed to be on call after hours.

For case managers, the minimum level of education was a bachelor's degree (437%), but the preferred level of education was a master's degree in human services (32%). Providers (75%) noted that additional certifications were not needed for case managers working with youth with histories of sexual aggression. In open-ended questions, GRO providers said that when working with youth with sexual aggression / adjudicated as sex offenders, case managers may need the following training, certifications, or qualifications: Trust-Based Relational Intervention®, sexual aggression/disorder training/certification, relationship building, Satori Alternatives to Managing Aggression (an EBI), mental health and case management certification.

For direct care staff, the minimum level of education was a high school diploma (65%). The preferred level of education was a bachelor's degree in human services (31%). Providers (69%) noted that additional certifications were needed for direct care staff working with youth with substance use disorders.

SA/SO – GRO Treatment Director

Table 759. SA/SO (GRO) - Should a treatment director be required? (N=51)

	N	%
Yes	47	92.2%
No	4	7.8%

SA/SO – GRO Psychiatrists

Table 760. SA/SO (GRO) - How important is to have a psychiatrist? (N=51)

	N	%
Not important	2	3.9%
Somewhat important	4	7.8%
Very important	13	25.5%
Extremely important	32	62.7%

Table 761. SA/SO (GRO) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=52)		
Yes	52	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=52)		
Contract	43	82.7%
In-house	9	17.3%

Table 762. SA/SO (GRO) - Should a psychiatrist be on-call or available 24/7? (N=52)

	N	%
Yes	39	75.0%
No	13	25.0%

SA/SO – GRO Physicians

Table 763. SA/SO (GRO) - How important is it to have a physician? (N=51)

	N	%
Not important	9	17.6%
Somewhat important	10	19.6%
Very important	12	23.5%
Extremely important	20	39.2%

Table 764. SA/SO (GRO) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=51)		
Yes	47	92.2%
No	4	7.8%
If yes, would you prefer to contract with them or have them in-house? (N=47)		
Contract	43	91.5%
In-house	4	8.5%

Table 765. SA/SO (GRO) – Should a physician be on-call or available 24/7? (N=47)

	N	%
Yes	27	57.4%
No	20	42.6%

SA/SO – GRO Therapists

Table 766. SA/SO (GRO) - How important is having a therapist? (N=50)

	N	%
Not important	0	0.0%
Somewhat important	2	4.0%
Very important	11	22.0%
Extremely important	37	74.0%

Table 767. SA/SO (GRO) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=50)		
Yes	50	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=50)		
Contract	24	48.0%
In-house	26	52.0%

Table 768. SA/SO (GRO) - Should a therapist be on-call or available 24/7? (N=50)

	N	%
Yes	41	82.0%
No	9	18.0%

SA/SO – GRO Nurses

Table 769. SA/SO (GRO) - How important is having a nurse? (N=47)

	N	%
Not important	10	21.3%
Somewhat important	21	44.7%
Very important	6	12.8%
Extremely important	10	21.3%

Table 770. SA/SO (GRO) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=47)		
Yes	36	76.6%
No	11	23.4%
If yes, would you prefer to contract with them or have them in-house? (N=36)		
Contract	23	63.9%
In-house	13	36.1%

Table 771. SA/SO (GRO) - Should a nurse be on-call or available 24/7? (N=36)

	N	%
Yes	28	77.8%
No	8	22.2%

SA/SO – GRO Case Management Staff

Table 772. SA/SO (GRO) - Recommended level of education for case managers

	Minimum level (N=46)		Preferred level (N=44)	
	N	%	N	%
High School Diploma or GED	8	17.4%	2	4.5%
Associate's Degree	5	10.9%	1	2.3%
Bachelor's Degree	17	37.0%	11	25.0%
Bachelor's Degree (human service field)	9	19.6%	10	22.7%
Master's Degree	3	6.5%	6	13.6%
Master's Degree (human service field)	4	8.7%	14	31.8%
Other	0	0.0%	0	0.0%

Table 773. SA/SO (GRO) - Do case managers need any certifications? (N=48)

	N	%
No certifications needed	36	75.0%
Certifications needed	12	25.0%

SA/SO – GRO Direct Care Staff

Table 774. SA/SO (GRO) - Recommended level of education for direct care staff

	Minimum level (N=43)		Preferred level (N=42)	
	N	%	N	%
High School Diploma or GED	28	65.1%	9	21.4%
Associate's Degree	8	18.6%	12	28.6%
Bachelor's Degree	4	9.3%	8	19.0%
Bachelor's Degree (human services field)	2	4.7%	13	31.0%
Other	1	2.3%	0	0.0%

Table 775. SA/SO (GRO) - Do direct care staff need any certifications? (N=45)

	N	%
No certifications needed	14	31.1%
Certifications needed	31	68.9%

Sexual Aggression/Sex Offender Adjudication – Ideal Caseloads and Competitive Pay

Providers were asked about the ideal caseloads and salaries for therapists and case managers. For those providers who indicated in-house therapists would be ideal, the mean response for the typical caseload 9 youth. The ideal caseload was 8 and the maximum caseload was 11 youth. For case managers, the typical caseload was 12 youth. The ideal caseload was 10 youth and the maximum caseload was 14 youth.

For salaries, providers noted that a competitive therapist salary without benefits was $66,500. For case managers, the mean competitive salary without benefits was $48,441. For direct care staff, $15.13 was considered a competitive hourly wage for entry level staff and $18.57 is a competitive hourly rate for experienced staff.

SA/SO – GRO Therapist Caseloads

Table 776. SA/SO (GRO) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	13	1	24	9.3	5	1*	8.39
Ideal caseload	17	2	24	8.0	5	5	6.17
Max caseload	18	2	24	11.3	10	6*	6.45

*Multiple modes exist. The smallest value is shown.

SA/SO – GRO Therapist Competitive Salary

Table 777. SA/SO (GRO) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	10	$50,000	$85,000	$66,500	$65,000	$65,000	$9,144

SA/SO – GRO Case Manager Caseloads

Table 778. SA/SO (GRO) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	23	2	26	12.3	12	2*	8.08
Ideal caseload	37	1	26	9.9	10	5	6.34
Max caseload	34	2	30	14.2	12	10	8.05

*Multiple modes exist. The smallest value is shown.

SA/SO – GRO Case Manager Competitive Salary

Table 779. SA/SO (GRO) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	34	$30,000	$80,000	$48,441	$45,000	$45,000	$9,310

SA/SO – GRO Direct Care Competitive Hourly Rate

Table 780. SA/SO (GRO) - Competitive hourly rate for direct care staff

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive hourly rate - entry level	39	$9.00	$22.00	$15.13	$15.00	$12.00	$3.32
Competitive hourly rate - experienced	39	$12.00	$25.00	$18.57	$18.00	$15.00*	$4.09

*Multiple modes exist. The smallest value is shown.

Sexual Aggression/Sex Offender Adjudication – Staffing Ratios and 1:1 Supervision

Providers were asked about the recommended frequency of therapy for expectant and parenting youth. The mean ideal wake ratio was 1 staff for 4 youth and the mean ideal sleep ratio was 1 staff for every 9 youth. On average, providers indicated that 1 staff to 1 youth ratios were needed 50% of the time.

SA/SO – GRO Staffing Ratios

Table 781. SA/SO (GRO) - Ideal number of children per staff ratios

	N	Min	Max	Mean	Median	Mode	Std dev
Ideal awake ratio	41	1	8	3.9	3	3	1.77
Ideal sleep ratio	41	1	16	8.6	8	10	4.18

SA/SO – GRO 1:1 Supervision

Table 782. SA/SO (GRO) - Percent of time 1:1 supervision is needed

	N	Min	Max	Mean	Median	Mode	Std dev
% of time 1:1 supervision is needed	39	1%	100%	49.6%	50%	100%	34.16%

Sexual Aggression/Sex Offender Adjudication – GRO Increased Costs

Providers were asked what additional costs should be considered when working with youth with substance use disorders. Providers indicated insurance (63%), security (56%), property damage (56%) and supplies (54%) as the most common categories for increased costs. For providers that selected other, they mentioned the following additional costs: therapeutic services and activities (including Adolescent Sexual Offender and Licensed Sexual Offender Treatment Provider therapists), recreation and sports, special events, additional supervision, and private rooms.

Table 783. SA/SO (GRO) - Are there increased costs associated with any of the following? (N=41)

	N	%
Insurance	26	63.4%
Security	23	56.1%
Property damage	23	56.1%
Supplies	22	53.7%
Food/dietary needs	16	39.0%
Vehicle depreciation	16	39.0%
Licenses/permits	15	36.6%
Other	5	12.2%
None of the above	4	9.8%

Sexual Aggression/Sex Offender Adjudication – GRO Services

Providers were asked about the recommended frequency of therapy for youth who have experienced human trafficking. For individual therapy 33% of providers suggested individual therapy should be once or twice per week. Providers (25%) felt family therapy should be once a week. Providers (43%) felt group therapy should be once a week. Providers were also asked about services they would recommend for youth who have histories of sexual aggression. The following services were noted by 75% or more of the providers: psychological testing and evaluation (95%); recreational therapy (92%); risk assessments (90%); behavior support specialist (88%); healthy relationship programs/classes (88%); crisis services/stabilization (83%); education and tutoring services (83%); and youth support groups (78%).

In open-ended responses, providers mentioned the following additional services needed for youth with sexual aggression or adjudicated as sex offenders: substance use disorder treatment when appropriate, private room/bathroom, and mental health support (EMDR). One provider said that services need to be child specific and able to combine with other services.

Providers were also asked about the recommended maximum length of services for youth with histories of sexual aggression. The most common response (35%) was that there should be no maximum services.

SA/SO – GRO Therapy

Table 784. SA/SO (GRO) - Recommended frequency of therapy sessions

	Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
	N	%	%	%	%	%	%	%	%	%	%	%	%
SA/SO (GRO)	Individual Therapy												
	43	0%	0%	5%	2%	33%	33%	19%	5%	0%	0%	5%	0%
	Family Therapy												
	40	0%	5%	15%	23%	25%	23%	8%	0%	0%	0%	0%	3%
	Group Therapy												
	40	0%	5%	3%	8%	43%	25%	8%	3%	0%	0%	8%	0%

SA/SO – GRO Needed Services

Table 785. SA/SO (GRO) - Additional recommended services

	Total N	Service needed N	%
Psychological testing and evaluation	41	39	95.1%
Recreational therapy	37	34	91.9%
Risk assessments	41	37	90.2%
Behavior Support Specialist	41	36	87.8%
Healthy Relationship Programs / Classes	41	36	87.8%
Crisis Services / Stabilization	41	34	82.9%
Education and tutoring services	41	34	82.9%
Youth support groups	41	32	78.0%
Personal Care Services (PCS)	26	19	73.1%
Assistance with HS diploma or GED	41	28	68.3%
Peer mentoring	41	28	68.3%
Art therapy	37	24	64.9%
Play therapy	37	22	59.5%
Forensic assessments	41	24	58.5%
Assistance with obtaining a driver's license	41	24	58.5%
Applied Behavior Analysis (ABA)	41	22	53.7%
Legal services	41	22	53.7%
Parent support groups	41	21	51.2%
Medical specialists	26	13	50.0%
Parenting programs / classes	41	19	46.3%
Dietician / Nutrition services	26	12	46.2%
Animal therapy	37	17	45.9%
Dance / Movement therapy	37	17	45.9%
Nursing - Other	26	11	42.3%
Equine therapy	37	14	37.8%
Neurofeedback	41	15	36.6%
Physical / Rehabilitation Therapy	41	13	31.7%
Prenatal and Postnatal Care	26	7	26.9%
Private Duty Nursing (PDN)	26	7	26.9%
Speech Therapy	41	10	24.4%
Occupational Therapy	41	8	19.5%

Note: Services highlighted in orange were identified by at least 75% of GROs as a needed service.

SA/SO – GRO Maximum Length of Services

Table 786. SA/SO (GRO) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
SA/SO (GRO)	43	0%	0%	2%	2%	0%	7%	33%	7%	14%	35%

Sexual Aggression/Sex Offender Adjudication – Aftercare

Providers were also asked about the recommended length of services for youth with histories of sexual aggression. The most common response (30%) was that aftercare service should 12 or more months. Additionally, the average caseload for an aftercare case manager would be 10 youth with histories of sexual aggression.

Table 787. SA/SO (GRO) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months %	No max %
SA/SO (GRO)	44	16%	0%	5%	5%	0%	0%	20%	0%	0%	0%	2%	0%	30%	23%

Table 788. SA/SO (GRO) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std dev
SA/SO (GRO) estimated aftercare caseload	32	0	30	10	7

Primary Setting - Complex Mental Health (CMH) – GRO Tier 1 Service Package

Brief Description: This facility-based treatment setting will offer services to children, youth, and young adults who have a DSM-5 diagnosis and for whom routine clinical intervention is needed to support day-to-day activities. GRO and direct care staff must be trained in and incorporate an evidence-informed treatment model into the intervention used with the child. This section examines the needs and costs specific to the provision of this service package.

Complex Mental Health – GRO Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for youth with complex mental health needs. Most providers indicated that specialized staff were needed. Ninety-two percent of providers indicated that a treatment director should be required. In terms of other staff, providers thought it was very important or extremely important to have a therapist (98%), psychiatrist (89%), or physician (61%) for youth with complex mental health needs. Providers indicated they would ideally like a therapist (100%), psychiatrist (99%), physician (87%), and nurse (82%). Providers indicated that contract staff was preferred for psychiatrists (76%) and physicians (86%) and nurses (61%). For therapists, 61% of providers preferred in-house therapists.

For case managers, 34% of providers preferred for case managers to have a master's degree in a human services field, 23% preferred a bachelor's degree in a human services field, and 23% preferred a bachelor's degree. Most providers (76%) noted that no additional certifications were needed for case managers. Twenty-four percent of providers indicated that case managers may need the following training, certifications, or qualifications: Trust-Based Relational Intervention®, relationship building, Satori Alternatives to Managing Aggression (an EBI), mental health (including Mental Health First Aid), Licensed Master Social Worker, and CPR certification.

For direct care staff, 32% of providers preferred for direct care staff to have a bachelor's degree in a human services field, 25% preferred staff to have a high school diploma or GED, and 22% preferred staff to have a bachelor's degree. Providers (59%) noted that certifications were needed for direct care staff.

CMH – GRO Treatment Director

Table 789. CMH (GRO) - Should a treatment director be required? (N=84)

	N	%
Yes	77	91.7%
No	7	8.3%

CMH – GRO Psychiatrists

Table 790. CMH (GRO) - How important is it to have a psychiatrist? (N=85)

	N	%
Not important	3	3.5%
Somewhat important	4	4.7%
Very important	23	27.1%
Extremely important	55	64.7%

Table 791. CMH (GRO) - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=84)		
Yes	83	98.8%
No	1	1.2%
If yes, would you prefer to contract with them or have them in-house? (N=83)		
Contract	63	75.9%
In-house	20	24.1%

Table 792. CMH (GRO) - Should a psychiatrist be on-call or available 24/7? (N=83)

	N	%
Yes	60	72.3%
No	23	27.7%

CMH – GRO Physicians

Table 793. CMH (GRO) - How important is it to have a physician? (N=84)

	N	%
Not important	20	23.8%
Somewhat important	13	15.5%
Very important	23	27.4%
Extremely important	28	33.3%

Table 794. CMH (GRO) - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=83)		
Yes	72	86.7%
No	11	13.3%
If yes, would you prefer to contract with them or have them in-house? (N=72)		
Contract	62	86.1%
In-house	10	13.9%

Table 795. CMH (GRO) - Should a physician be on-call or available 24/7? (N=72)

	N	%
Yes	46	63.9%
No	26	36.1%

CMH – GRO Therapists

Table 796. CMH (GRO) - How important is having a therapist? (N=83)

	N	%
Not important	0	0.0%
Somewhat important	2	2.4%
Very important	18	21.7%
Extremely important	63	75.9%

Table 797. CMH (GRO) - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=81)		
Yes	81	100.0%
No	0	0.0%
If yes, would you prefer to contract with them or have them in-house? (N=81)		
Contract	32	39.5%
In-house	49	60.5%

Table 798. CMH (GRO) - Should a therapist be on-call or available 24/7? (N=81)

	N	%
Yes	68	84.0%
No	13	16.0%

CMH – GRO Nurses

Table 799. CMH (GRO) - How important is having a nurse? (N=79)

	N	%
Not important	18	22.8%
Somewhat important	25	31.6%
Very important	21	26.6%
Extremely important	15	19.0%

Table 800. CMH (GRO) - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=78)		
Yes	64	82.1%
No	14	17.9%
If yes, would you prefer to contract with them or have them in-house? (N=64)		
Contract	39	60.9%
In-house	25	39.1%

Table 801. CMH (GRO) - Should a nurse be on-call or available 24/7? (N=64)

	N	%
Yes	46	71.9%
No	18	28.1%

CMH – GRO Case Management Staff

Table 802. CMH (GRO) - Recommended level of education for case managers

	Minimum level (N=75)		Preferred level (N=74)	
	N	%	N	%
High School Diploma or GED	9	12.0%	2	2.7%
Associate's Degree	6	8.0%	3	4.1%
Bachelor's Degree	27	36.0%	17	23.0%
Bachelor's Degree (human services field)	20	26.7%	17	23.0%
Master's Degree	4	5.3%	10	13.5%
Master's Degree (human services field)	8	10.7%	25	33.8%
Other	1	1.3%	0	0.0%

Table 803. CMH (GRO) - Do case managers need any certifications? (N=79)

	N	%
No certifications needed	60	75.9%
Certifications needed	19	24.1%

CMH – GRO Direct Care Staff

Table 804. CMH (GRO) - Recommended level of education

	Minimum level (N=75)		Preferred level (N=72)	
	N	%	N	%
High School Diploma or GED	56	74.7%	18	25.0%
Associate's Degree	7	9.3%	14	19.4%
Bachelor's Degree	6	8.0%	16	22.2%
Bachelor's Degree (human services field)	5	6.7%	23	31.9%
Other	1	1.3%	1	1.4%

Table 805. CMH (GRO) - Do direct care staff need any certifications? (N=75)

	N	%
No certifications needed	31	41.3%
Certifications needed	44	58.7%

Complex Mental Health – GRO Ideal Caseloads and Competitive Pay

Providers were asked about the ideal caseloads and pay for therapists, case managers, and direct care staff. For those providers who indicated in-house therapists would be ideal (61%), the mean response for the typical caseload was 13 youth. The ideal caseload was 10 youth and maximum caseload was 13 youth. For case managers, the mean response for typical caseload was 12 youth. The ideal caseload was 10 youth and the maximum caseload was 15 youth.

For in-house therapist salaries, providers reported a mean of $65,409 for a competitive therapist salary without benefits. For case managers, the mean competitive salary without benefits was $48,551. For direct care, $15.13 was considered a competitive hourly rate for entry level staff and $18.05 was a competitive hourly rate experienced staff.

CMH – GRO Therapist Caseloads

Table 806. CMH (GRO) - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	28	4	35	12.5	10	8	7.95
Ideal caseload	33	4	24	9.8	8	5*	5.43
Max caseload	36	4	28	12.9	10	8	6.13

*Multiple modes exist. The smallest value is shown.

CMH – GRO Therapist Competitive Salary

Table 807. CMH (GRO) - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	22	$50,000	$85,000	$65,409	$65,000	$65,000	$8,359

CMH – GRO Case Manager Caseloads

Table 808. CMH (GRO) - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	47	1	26	12.4	12	10*	6.25
Ideal caseload	66	1	26	10.4	10	8*	5.61
Max caseload	64	1	30	14.5	14	10	6.63

*Multiple modes exist. The smallest value is shown.

CMH – GRO Competitive Salary

Table 809. CMH (GRO) - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	59	$30,000	$80,000	$48,551	$46,000	$45,000	$9,126

CMH – GRO Direct Care Competitive Hourly Rate

Table 810. CMH (GRO) - Competitive hourly rate for direct care staff

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive hourly rate - entry level	68	$9.00	$22.00	$15.13	$15.00	$15.00	$3.24
Competitive hourly rate - experienced	69	$11.00	$25.00	$18.05	$18.00	$15.00	$3.66

Complex Mental Health – GRO Staffing Ratios and 1:1 Supervision

Providers were asked what the ideal awake and sleep youth to staff ratios should be for youth with complex mental health needs. The mean ideal awake ratio for one staff was 5 youth and the mean ideal sleep ratio for one staff was 10 youth. Providers were also asked the percentage of time they thought one to one supervision was needed, where one staff member supervised one youth. Providers reported a mean of 48% for the percentage of time that one to one supervision was needed.

CMH – GRO Staffing Ratios

Table 811. CMH (GRO) - Ideal number of children per staff ratios

	N	Min	Max	Mean	Median	Mode	Std dev
Ideal awake ratio	72	1	8	4.5	5	5	1.78
Ideal sleep ratio	72	1	24	10.0	10	8	4.57

CMH – GRO 1:1 Supervision

Table 812. CMH (GRO) - Percent of time 1:1 supervision is needed

	N	Min	Max	Mean	Median	Mode	Std dev
% of time 1:1 supervision is needed	67	0%	100%	48.1%	50%	25%	32.1%

Complex Mental Health – GRO Increased Costs

Providers were asked what additional costs should be considered when working with youth with complex mental health needs. Providers indicated property damage (82%), supplies (70%) and food/dietary needs (51%) and as common categories for increased costs. Providers also mentioned the following additional costs related to youth with complex mental health needs: One provider mentioned maintenance/repairs from property damage runs around $15,000 per year and worker's compensation runs around $30,000 per year. Two other providers mentioned maintenance, two mentioned therapeutic services and

activities. Other things mentioned included repairs, recreation and sports, special events, overtime or reduced ratios for staff related to crisis response, clothing, medication, increased staff development, training and appreciation, increased Human Resources costs, overtime, stipends, and signing bonus costs due to turnover.

Table 813. CMH (GRO) - Are there increased costs associated with any of the following? (N=71)

	N	%
Property damage	58	81.7%
Supplies	50	70.4%
Food/dietary needs	36	50.7%
Insurance	32	45.1%
Vehicle depreciation	31	43.7%
Licenses/permits	20	28.2%
Security	25	35.2%
Other	9	12.7%
None of the above	7	9.9%

Complex Mental Health – GRO Services

Providers were asked about the recommended frequency of therapy for youth with complex mental health needs. Providers recommended that individual therapy (44%), family therapy (36%) and group therapy (43%) should be provided once per week. Providers were also asked about services they would recommend for youth with complex mental health needs. The following services were noted by 75% or more of the providers: psychological testing and evaluation (99%), education and tutoring services (94%), recreational therapy (90%), Behavioral Support Specialist (84%), youth support groups (84%), crisis services/stabilization (83%), Healthy Relationship Program or Classes (79%), risk assessments (77%), assistance with acquiring a high school diploma and GED (77%) and art therapy (75%).

In open-ended questions providers mentioned the following additional services needed for youth with complex mental health needs: transition support (job, education, life skills/independent living support), mental health support (including EMDR), ongoing case management, resources such as books and workbooks, and risk reduction groups. One provider said that services need to be child specific and able to combine with other services.

Providers were also asked about the recommended maximum length of services for youth with complex mental health needs. The most common response (34%) was that there should be no maximum services.

CMH – GRO Therapy

Table 814. CMH (GRO) - Recommended frequency of therapy sessions

	Total	None	1x every other month	1x per month	2x per month	1x per week	2x per week	3x per week	4x per week	5x per week	6x per week	Daily	Prefer not to say
	N	%	%	%	%	%	%	%	%	%	%	%	%
CMH (GRO)	Individual Therapy												
	72	0%	1%	3%	3%	44%	29%	10%	1%	0%	0%	8%	0%
	Family Therapy												
	67	0%	3%	19%	25%	36%	12%	3%	0%	0%	0%	0%	1%
	Group Therapy												
	68	0%	4%	9%	12%	43%	16%	6%	1%	0%	0%	9%	0%

CMH – GRO Needed Services

Table 815. CMH (GRO) - Additional recommended services

	Total N	Service needed N	%
Psychological testing and evaluation	70	69	98.6%
Education and tutoring services	68	64	94.1%
Recreational therapy	68	61	89.7%
Behavior Support Specialist	70	59	84.3%
Youth support groups	68	57	83.8%
Crisis Services / Stabilization	70	58	82.9%
Healthy Relationship Programs / Classes	68	54	79.4%
Risk assessments	70	54	77.1%
Assistance with HS diploma or GED	68	52	76.5%
Art therapy	68	51	75.0%
Play therapy	68	50	73.5%
Animal therapy	68	48	70.6%
Peer mentoring	68	47	69.1%
Assistance with obtaining a driver's license	68	44	64.7%
Personal Care Services (PCS)	53	33	62.3%
Dance / Movement therapy	68	42	61.8%
Equine therapy	68	41	60.3%
Dietician / Nutrition services	53	31	58.5%
Medical specialists	53	29	54.7%
Parent support groups	68	36	52.9%
Applied Behavior Analysis (ABA)	70	35	50.0%
Parenting programs / classes	68	33	48.5%
Legal services	68	30	44.1%
Nursing - Other	53	22	41.5%
Speech Therapy	70	25	35.7%
Occupational Therapy	70	24	34.3%
Neurofeedback	70	24	34.3%
Forensic assessments	70	23	32.9%
Physical / Rehabilitation Therapy	70	17	24.3%
Prenatal and Postnatal Care	53	6	11.3%
Private Duty Nursing (PDN)	53	5	9.4%

Note: Services highlighted in orange were identified by at least 75% of GROs as a needed service.

CMH – GRO Maximum Length of Services

Table 816. CMH (GRO) - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
CMH (GRO)	73	1%	0%	0%	1%	7%	12%	22%	18%	4%	34%

Complex Mental Health – GRO Aftercare

Providers were asked about the recommended length of aftercare and estimated caseload for an aftercare case manager for youth with complex mental health needs. Thirty-three percent of providers indicated that there should be 6 months of aftercare with the mean caseload of 12 youth.

Table 817. CMH (GRO) - Recommended length of aftercare

	N Total	No aftercare %	1 month %	2 months %	3 months %	4 months %	5 months %	6 months %	7 months %	8 months %	9 months %	10 months %	11 months %	12+ months %	No max %
CMH (GRO)	73	8%	1%	3%	11%	1%	0%	33%	0%	0%	0%	0%	0%	25%	18%

Table 818. CMH (GRO) - Estimated caseload for aftercare case manager

	N	Min	Max	Mean	Std dev
CMH (GRO) estimated aftercare caseload	59	0	50	12	8

Primary Setting - Emergency Stabilization/Assessment Center (ESAC) – GRO Tier 1 Service Package

Basic Description: Time-limited services for children, youth, and young adults offered in a GRO that is licensed to provide emergency care services. The organization must have the ability to admit children with varying needs 24/7. The staff must have enhanced skills and training in de-escalation techniques, assessment, and coordination to respond to needs previously unknown. This service add-on supports the need for siblings to remain together, as well as for additional assessment and evaluation to ensure quality matching of children, youth, and young adults to subsequent placements. This section examines services and costs specific to this setting.

Emergency Stabilization/Assessment Center – Ideal Staffing

Providers were asked about ideal staffing for clinical and medical staff for emergency stabilization/assessment. Most providers (78%) reported a treatment director is not needed in emergency stabilization/assessment. In terms of other staff, providers reported it was important to have clinical and medical staff. Roughly 75% felt a psychiatrist was important, 56% felt a physician was important and 52% felt having a nurse was important for emergency stabilization/assessment. Providers indicated they would like a psychiatrist (88%), physician (78%) and/or nurse (60%). For all these positions, contracted staff was the preference and most reported that psychiatrists (54%), physician (42%), and nurse (82%) should be on call 24/7.

In terms of therapists, 95% providers reported that therapists were important and 98% reported wanting a therapist. The majority of providers (51%) reported that therapists would ideally be contracted and 63% felt a therapist needed to be on call after hours.

For case managers, the minimum and ideal level of education was a bachelor's degree in human services. Providers (83%) noted that additional certifications were not needed for case managers working in emergency stabilization/assessment. In open-ended questions, emergency shelter providers said that when working with youth, case managers may need the following training, certifications, or qualifications: Licensed Bachelor Social Worker, Licensed Master Social Worker, child care administrative license, first aid/CPR certification, mental health, EBI, and case management certification.

For direct care staff, the minimum and preferred level of education was a high school diploma. Providers (59%) noted that additional certifications were not needed for direct care staff working in emergency stabilization/assessment.

ESAC – Treatment Director

Table 819. ESAC - Should a treatment director be required? (N=41)

	N	%
Yes	9	22.0%
No	32	78.0%

ESAC – Psychiatrists

Table 820. ESAC - How important is to have a psychiatrist? (N=44)

	N	%
Not important	11	25.0%
Somewhat important	8	18.2%
Very important	13	29.5%
Extremely important	12	27.3%

Table 821. ESAC - Ideal psychiatrist

	N	%
Would you ideally have a psychiatrist when working with this population? (N=42)		
Yes	37	88.1%
No	5	11.9%
If yes, would you prefer to contract with them or have them in-house? (N=37)		
Contract	32	86.5%
In-house	5	13.5%

Table 822. ESAC - Should a psychiatrist be on-call or available 24/7? (N=37)

	N	%
Yes	20	54.1%
No	17	45.9%

ESAC – Physicians

Table 823. ESAC - How important is it to have a physician? (N=43)

	N	%
Not important	19	44.2%
Somewhat important	10	23.3%
Very important	9	20.9%
Extremely important	5	11.6%

Table 824. ESAC - Ideal physician

	N	%
Would you ideally have a physician when working with this population? (N=40)		
Yes	31	77.5%
No	9	22.5%
If yes, would you prefer to contract with them or have them in-house? (N=31)		
Contract	30	96.8%
In-house	1	3.2%

Table 825. ESAC - Would you ideally want a physician on-call or available 24/? (N=31)

	N	%
Yes	13	41.9%
No	18	58.1%

ESAC – Therapists

Table 826. ESAC - How important is having a therapist? (N=41)

	N	%
Not important	2	4.9%
Somewhat important	1	2.4%
Very important	14	34.1%
Extremely important	24	58.5%

Table 827. ESAC - Ideal therapist

	N	%
Would you ideally have a therapist when working with this population? (N=42)		
Yes	41	97.6%
No	1	2.4%
If yes, would you prefer to contract with them or have them in-house? (N=41)		
Contract	21	51.2%
In-house	20	48.8%

Table 828. ESAC - Should a therapist be on-call or available 24/7?(N=41)

	N	%
Yes	26	63.4%
No	15	36.6%

ESAC – Nurses

Table 829. ESAC - How important is having a nurse? (N=42)

	N	%
Not important	20	47.6%
Somewhat important	14	33.3%
Very important	4	9.5%
Extremely important	4	9.5%

Table 830. ESAC - Ideal nurse

	N	%
Would you ideally have a nurse when working with this population? (N=37)		
Yes	22	59.5%
No	15	40.5%
If yes, would you prefer to contract with them or have them in-house? (N=22)		
Contract	14	63.6%
In-house	8	36.4%

Table 831. ESAC - Should a nurse be on-call or available 24/7?(N=22)

	N	%
Yes	18	81.8%
No	4	18.2%

ESAC – Case Management Staff

Table 832. ESAC - Recommended level of education

	Minimum level (N=42)		Preferred level (N=41)	
	N	%	N	%
High School Diploma or GED	9	21.4%	5	12.2%
Associate's Degree	1	2.4%	1	2.4%
Bachelor's Degree	13	31.0%	8	19.5%
Bachelor's Degree (human services field)	17	40.5%	17	41.5%
Master's Degree	1	2.4%	2	4.9%
Master's Degree (human services field)	1	2.4%	8	19.5%
Other	0	0.0%	0	0.0%

Table 833. ESAC - Do case managers need any certifications? (N=36)

	N	%
No certifications needed	30	83.3%
Certifications needed	6	16.7%

ESAC - Direct Care Staff

Table 834. ESAC - Recommended level of education

	Minimum level (N=42)		Preferred level (N=42)	
	N	%	N	%
High School Diploma or GED	36	85.7%	22	52.4%
Associate's Degree	3	7.1%	5	11.9%
Bachelor's Degree	0	0.0%	4	9.5%
Bachelor's Degree (human services field)	1	2.4%	10	23.8%
Other	2	4.8%	1	2.4%

Table 835. ESAC - Do direct care staff need any certifications? (N=39)

	N	%
No certifications needed	23	59.0%
Certifications needed	16	41.0%

Emergency Stabilization/Assessment Center – Ideal Caseloads and Competitive Pay

Providers were asked about the ideal caseloads and salaries for therapists and case managers. The mean response for the typical caseload 16 youth. However, the ideal caseload was 13 and the maximum caseload was 20 youth. For case managers, the typical caseload was 12 youth. The ideal caseload was 11 youth and the maximum caseload was 15 youth.

For salaries, providers noted that a competitive therapist salary without benefits was $63,308. For case managers, the mean competitive salary without benefits was $7,812. For direct care staff, $14.64 was considered a competitive hourly wage for entry level staff and $17.22 is a competitive hourly rate for experienced staff.

ESAC– Therapist Caseloads

Table 836. ESAC - Typical, ideal and max caseloads for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	14	6	25	16.4	16	15	5.87
Ideal caseload	14	6	25	13.5	14	15	5.42
Max caseload	14	8	30	20.2	20	20	6.99

ESAC – Therapist Competitive Salary

Table 837. ESAC - Competitive salary without benefits for in-house therapists

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	13	$50,000	$80,000	$63,308	$60,000	$60,000	$8,148

ESAC – Case Manager Caseloads

Table 838. ESAC - Typical, ideal and max caseloads for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Typical caseload	40	4	30	12.3	12	15	6.23
Ideal caseload	38	4	30	10.9	10	8*	5.29
Max caseload	39	6	36	15.4	13	10*	7.72

*Multiple modes exist. The smallest value is shown.

Table 839. ESAC - Case management supervision recommendation

	N	Min	Max	Mean	Std dev
Number of case managers that should be supervised by one case supervisor	75	2	10	5.15	1.83

ESAC – Case Manager Competitive Salary

Table 840. ESAC - Competitive salary without benefits for case managers

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive salary without benefits	39	$32,000	$75,000	$47,812	$45,000	$45,000	$9,566

ESAC – Direct Care Competitive Hourly Rate

Table 841. ESAC - Competitive hourly rate for direct care staff

	N	Min	Max	Mean	Median	Mode	Std dev
Competitive hourly rate - entry level	40	$10.00	$20.00	$14.64	$14.50	$15.00	$2.22
Competitive hourly rate - experienced	38	$12.00	$28.00	$17.22	$17.00	$15.00*	$3.36

*Multiple modes exist. The smallest value is shown.

Emergency Stabilization/Assessment Center – Staffing Ratios and 1:1 Supervision

Providers were asked about the recommended staffing ratios for emergency stabilization/assessment. The mean ideal wake ratio was 1 staff for 7 youth and the mean ideal sleep ratio was 1 staff for every 15 youth. On average, providers indicated that 1 staff to 1 youth ratios were requested 27% of the time.

ESAC – Staffing Ratios

Table 842. ESAC - Ideal number of children per staff ratios

	N	Min	Max	Mean	Median	Mode	Std dev
Ideal awake ratio	42	2	61	7.4	5	4	9.10
Ideal sleep ratio	42	2	181	15.0	10	8	26.62

ESAC – 1:1 Supervision

Table 843. ESAC - Percent of time 1:1 supervision is needed

	N	Min	Max	Mean	Median	Mode	Std dev
% of time 1:1 supervision is needed	42	0%	100%	27.2%	20%	10%	24.12%

Emergency Stabilization/Assessment Center – Increased Costs

Providers were asked what additional costs should be considered when working in emergency stabilization/assessment. Providers indicated property damage (81%), food/dietary needs, supplies (68%), and vehicle depreciation (54%) as the most common categories for increased costs. For providers that selected other, emergency shelter providers mentioned the following additional costs related to youth in emergency shelters: volunteer services, on-site school, health services coordination, kitchen staff and food, activities, clothing and other basic needs, lice treatments, and property damage.

Emergency shelter providers mentioned the following additional costs related to youth in emergency shelters: volunteer services, on-site school, health services coordination, kitchen staff and food, activities, clothing and other basic needs, lice treatments, and property damage.

Table 844. ESAC - Are there increased costs associated with any of the following? (N=41)

	N	%
Property damage	33	80.5%
Food/dietary needs	29	70.7%
Supplies	28	68.3%
Vehicle depreciation	22	53.7%
Insurance	19	46.3%
Licenses/permits	11	26.8%
Security	11	26.8%
Other	4	9.8%
None of the above	3	7.3%

Emergency Stabilization/Assessment Center – Services

Providers were asked about the recommended frequency of in emergency stabilization/assessment. For individual therapy 77% of providers suggested individual therapy should be once per week. Providers (46%) felt family therapy should be once a month. Providers (46%) felt group therapy should be once a month or once a week. Providers were also asked about services they would recommend for emergency stabilization/assessment. The following services were noted by 75% or more of the providers: education and tutoring services (100%); recreational therapy (95%); youth support groups (95%); psychological testing and evaluation (90%); art therapy (88%); healthy relationship programs/classes (85%); assistance with HS diploma or GED (82%); dietician/nutrition services (81%); behavior support specialist (81%); peer mentoring (80%); animal therapy (79%); play therapy (79%); risk assessments (76%); and crisis services/stabilization (76%).

In open-ended responses, emergency shelter providers mentioned the following additional services needed for youth in emergency shelters: mentorship, interpreter, transition support (finances, hygiene, independent living prep), supportive caseworkers. Additionally, one provider said:

> *'Many of the above services create a wonderful addition to a service delivery package for a youth in care, but we also do not want to make them all mandatory, we believe in youth choice and agency." _ Emergency Shelter Provider*

Providers were also asked about the recommended maximum length of services for emergency stabilization/assessment. Providers were split on their responses: 24%

indicated there should be no maximum service length; 24% said three months should be the maximum length of services; and 22% indicated there should be six months of services.

ESAC – Therapy

Table 845. ESAC - Recommended frequency of therapy sessions

		Total N	None %	1x every other month %	1x per month %	2x per month %	1x per week %	2x per week %	3x per week %	4x per week %	5x per week %	6x per week %	Daily %	Prefer not to say %
ESAC	Individual Therapy													
		39	0%	0%	3%	0%	77%	18%	0%	0%	0%	0%	3%	0%
	Family Therapy													
		37	5%	0%	46%	16%	24%	5%	0%	0%	0%	0%	0%	3%
	Group Therapy													
		37	14%	3%	14%	16%	46%	3%	3%	0%	0%	0%	0%	3%

ESAC – Needed Services

Table 846. ESAC - Additional recommended services

	Total N	Service needed N	%
Education and tutoring services	39	39	100.0%
Recreational therapy	42	40	95.2%
Youth support groups	39	37	94.9%
Psychological testing and evaluation	41	37	90.2%
Art therapy	42	37	88.1%
Healthy Relationship Programs / Classes	39	33	84.6%
Assistance with HS diploma or GED	39	32	82.1%
Dietician / Nutrition services	32	26	81.3%
Behavior Support Specialist	41	33	80.5%
Peer mentoring	39	31	79.5%
Animal therapy	42	33	78.6%
Play therapy	42	33	78.6%
Risk assessments	41	31	75.6%
Crisis Services / Stabilization	41	31	75.6%
Assistance with obtaining a driver's license	39	29	74.4%
Dance / Movement therapy	42	28	66.7%
Speech Therapy	41	26	63.4%
Medical specialists	32	19	59.4%
Personal Care Services (PCS)	32	18	56.3%
Occupational Therapy	41	23	56.1%
Parenting programs / classes	39	20	51.3%
Legal services	39	19	48.7%
Physical / Rehabilitation Therapy	41	19	46.3%
Prenatal and Postnatal Care	32	14	43.8%
Parent support groups	39	17	43.6%
Applied Behavior Analysis (ABA)	41	17	41.5%
Equine therapy	42	16	38.1%
Forensic assessments	41	15	36.6%
Nursing - Other	32	11	34.4%
Neurofeedback	41	13	31.7%
Private Duty Nursing (PDN)	32	3	9.4%

Note: Services highlighted in orange were identified by at least 75% of GROs as a needed service.

ESAC – Maximum Length of Services

Table 847. ESAC - Recommended maximum length of services

	N Total	30 days %	45 days %	60 days %	3 months %	6 months %	9 months %	12 months %	18 months %	24+ months %	No max %
ESAC	41	7%	0%	10%	24%	22%	0%	10%	0%	2%	24%

General Recommendations for GRO Tier 1 Providers

Recommended Certifications for Direct Care by Facility Type

GRO Direct Care Certifications

For those GRO providers that indicated additional certifications were needed for direct care staff, the following training, certifications and qualifications were mentioned: Six GRO providers mentioned trauma informed care or Trust-Based Relational Intervention®, two mentioned a specific youth care worker certification, two mentioned EBI, one said pre-service training, one said child development and one said no additional training/certifications.

RTC Direct Care Certifications

For those RTC providers that indicated additional certifications were needed for direct care staff, the following training, certifications, and qualifications were mentioned: Three RTC providers mentioned annual trainings, one mentioned initial training, one mentioned trauma informed care and one mentioned training specific to child development. Two said additional trainings/certifications are not needed.

Emergency Shelter Direct Care Certifications

For those emergency shelter providers that indicated additional certifications were needed for direct care staff, the following training, certifications, and qualifications were mentioned: 11 emergency shelter providers mentioned CPR/First Aid, eight mentioned EBI techniques, four mentioned trauma informed care, two mentioned medication training. Other types of training or certifications included initial and ongoing training, normalcy, reporting abuse, transportation, etc.

> *'CPR/First Aid, Restraint Training, Trauma Informed Care, Recognizing/Reporting Sexual Abuse, Psychotropic medication, Normalcy, Sexual Harassment Prevention, Disaster and Emergency Response and Active Shooter Training, Healthy Relationships and Attachment training, Transportation training" _Emergency Shelter Provider*

Ideal Number of Case Managers Under One Supervisor

All residential providers were asked about the number of case managers that should be supervised by one supervisor. The mean response was 4 case managers.

Table 848. Case management supervision recommendation

	N	Min	Max	Mean	Median	Std dev
Number of case managers that should be supervised by one case supervisor	121	1	20	3.8	4.0	2.51

Increased Costs with Youth Ages 14 and Older

Providers were asked what additional costs should be considered when working with youth ages 14 and older. Property damage (73%), food/dietary needs (70%) and supplies (65%) were most commonly mentioned. For those that indicated other, they specified the following: staffing costs increased due to COVID-19 pandemic (stressors and exposure), extracurricular activities, outings, clothing, grooming, transportation expenses (related to work and activities), maintenance and repair, therapeutic activities, special events, preparation for adult living, state ID cards, medications, increased staff development, training and appreciation, increased Human Resources costs, overtime, stipends, and signing bonus costs due to turnover

Increased costs when serving youth ages 14 and older (N=121)

	N	%
Property damage	89	73.6%
Food/dietary needs	85	70.2%
Supplies	79	65.3%
Vehicle depreciation	59	48.8%
Insurance	44	36.4%
Security	42	34.7%
Licenses/permits	30	24.8%
None of the above	16	13.2%
Other	12	9.9%

Aftercare Services

Providers were asked which type of aftercare services they imagined providing. Over 75% of providers indicated they imagined providing the following services: identifying and providing referrals for community providers (84%); setting up initial appointments with providers in community where child is transitioning to (75%); scheduling regular check-ins / providing case management for child/family to see how things are going, follow up on after care plan, identify and assist families in setting up appointments with new providers if needed (78%); and providing temporary therapeutic services until child has established providers in the community or when there is a gap in services for up to six months after child leaves (75%). For those that specified other, one provider specified the scholarships and support groups (no limits) they currently provide for past residents, including giveaways, opportunities, and services. Others mentioned supports they would like to provide, such as targeted case management, support groups (including peer support), mental health resources, financial help, transportation, housing, basic.

> *'We have scholarships available to past residents regardless of how long or how long ago they were residents. We also have a Facebook group established for past residents where information is made available about access to giveaways, opportunities, or services." _GRO Provider*

Additionally, 89% of providers ideally wanted an aftercare case manager and 62% ideally wanted an aftercare director or coordinator.

Table 849. What types of aftercare services would you imagine providing?

	N	%
Identifying and providing referrals for community providers	65	84.4%
Setting up initial appointments with providers in community where child is transitioning to	58	75.3%
Scheduling regular check-ins / providing case management for child/family to see how things are going, follow up on after care plan, identify and assist families in setting up appointments with new providers if needed	60	77.9%
Providing temporary therapeutic services until child has established providers in the community or when there is a gap in services for up to six months after child leaves	58	75.3%
Providing therapeutic services for six months after child leaves	48	62.3%
Supporting families in meeting basic needs for up to six months after child leaves	51	66.2%
Access to on-call staff for six months	48	62.3%
Other	10	13.0%

Table 850. Aftercare staffing needs

	N	%
Aftercare director / coordinator	44	62.0%
Aftercare case manager	63	88.7%
Aftercare therapist	38	53.5%
Additional therapists so that the therapist can keep child on caseload for up to six months after leaving	25	35.2%
Other	6	8.5%

Conclusions

Given the breadth of information presented, broad conclusions are difficult to make. However, there were themes that resonated across workshops and surveys. These themes are summarized below.

1. *Payments for the care of children do not cover costs.* Across all workgroups and surveys, providers noted that payments from the state cover on average, more than half their costs. However, a significant portion of agency budgets must be raised through fundraising, donations or grants.
2. *Medicaid/STAR health does not sufficiently contribute to sustaining mental health professionals in agencies*. Even though it is possible for agencies to bill for time spent by therapists and medical staff, few are able to recoup any funds due to credentialing issues, lack of billable activities and restrictions on number of sessions. In order to help with the lack of mental health services, state agencies should work with providers to streamline processes.
3. *External factors strain providers*. The child welfare system does not operate in isolation from other systems. For foster parents, lack of ability to access services, particularly in rural areas, increases stress and impacts retention. For all agencies, COVID related issues such as quarantines and the great resignation are impacting recruitment and retention of staff.
4. *Transportation is a large cost that is not sufficiently reimbursed*. Transporting children to activities and appointments is time-consuming. For foster parents, time off from work is often needed to meet the requirements when a new child enters a placement. For GROs, transportation often means adjustment in staffing so that ratios can be maintained.
5. *Agencies need access to training for treatment practices.* While many agencies reported using at least one evidence-informed model, the open-ended responses suggest that there is a substantial amount of work needed to understand practice models. Additionally, agencies noted the desire for trainings but also noted it was cost-prohibitive.
6. *Recruiting and retaining foster parents remains an issue*. Agencies spend funds on recruiting and retaining foster parents and only a portion of those funds are recaptured. To increase capacity, these efforts have to be supported. The main issue with retention is the ability of the agency to provide paid respite care for families and assist families with meeting state requirements.
7. *Documentation is costly.* Documentation requirements have increased over the last few years with higher needs youth requiring more documentation. With CPAs, increased documentation is burdensome for staff and foster parents. At GROs, adjustments have to be made in staffing ratios which means additional staff are needed to allow time for documentation. Some agencies have had to hire additional administrative staff to manage documentation requirements.
8. *Transition to New Service Models will require support, coordination and funding.* The capacity and cost challenges associated with mental and behavioral health services indicate that significant planning in coordination with STAR Health will need to occur to ensure the new service models can be implemented as envisioned. Time, technical support and funding will also be needed to support the use of evidence informed models and program evaluation.

It is important to interpret all findings of this report with the understanding that this information is only a piece of the puzzle for understanding how to restructure foster care rates. Additional reports from this survey will provide information about each package and subsequent market research will be conducted.