

Program Specifications

Service Type: Residential setting for adolescent males with highly aggressive behaviors and concurrent psychiatric disorders

Licensure Category: Child caring facility

Program Model

DCF is seeking providers who are able to provide congregate care treatment on a fee-for-service basis. Because this is a fee-for-service program, neither start-up nor ramp-up funds will be available. Similarly, the Department will not fund capital expenses that are not part and parcel of the rate which will be determined by the Department. No guarantee of usage, either specific or implied, is made herein.

The program sought is envisioned as a fee-for-service 6-25 bed congregate care setting for males who demonstrate highly aggressive behavior with concurrent serious mental health conditions that can lead to rejection by community-based service options and risk of out-of-state placement. These youth will likely present with complex behavioral, developmental, and mental health needs and will require trauma-focused clinical intervention. There will be a specialized focus on the treatment of highly aggressive and other behavioral problems. Youth referred to this program will be with or without adjudication; however, youth will not include adjudicated sex offenders.

The program model will utilize individual treatment, group therapy, and family therapy (where appropriate) and will address trauma issues and behavior problems, including aggressive behavior and other high risk behaviors. The program will provide training for all staff in a relational and/or trauma-informed model approved by DCF, including ongoing training for all staff involved in the program. Regardless of the model used, no program may unilaterally reject or eject a child from the program. It is anticipated that use of an underlying, acceptable treatment foundation will ensure that clinical work is integrated throughout all interventions. What is done with each youth must be highly individualized. A "one size fits all" approach (i.e., one treatment plan fits all youth) is not appropriate in this construct. Individual plans and activities must be carefully selected dependent on the needs, personality, skills, and the personal desires and goals of each youth. We recognize that while the treatment portion of the program is critical (i.e., individual, family, group counseling) most of the time spent in a residential setting is not spent in a formal treatment context. Consequently, all time will be active treatment of some form. This will require that all staff have both traditional behavioral health skills as well as the willingness to utilize their avocations and unique skills actively within the program: for example, music, athletics, writing, drama, arts, computer literacy, outdoor skills, horticulture, volunteerism, etc. should be incorporated into the program model.

Target Population

The Department is seeking a specialized 6-25 bed residential setting for males (ages 12-21 years) as indicated above. It should be assumed that all referred youth will have some level of emotional and/or psychiatric disturbance, some level of behavioral disturbance (including, but not limited to, significant aggressive behavior), and some degree of trauma history. This program will provide treatment services in a setting that promotes healing and recovery through the experience of a safe, responsive, and engaging community.

Daily Programming

The provider will offer a predictable, consistent, engaging, supportive, and structured environment that promotes growth and enhances stability, and which supports the physical and emotional safety of all the residents. Each youth will attend school daily or, for those who have completed their evaluation, will be involved in a meaningful vocational activity at least 20 hours per week. Other structures inherent in the program will include time for personal care, leisure/quiet time, involvement in activities such as shopping, meals and meal planning, vocational, social skill work, activities of daily living skills training, and individualized schedules for appropriate and positive youth identified activities. The development of friendships and meaningful activities will be encouraged and facilitated.

Service Elements

The program will provide access to an array of clinical services (individual therapy, group counseling, family therapy, creative/expressive therapies, medication management, etc), medical services, educational services (e.g., special and regular education, educational assessment, Ansell Casey Life Skills Training, etc.), and supportive services (mentoring, vocational and recreational, parent education, etc.). If this program is licensed as a residential treatment center the provider will need to operate an on-grounds school. Family interventions must focus on a family's readiness to take a child home. Family participation in all aspects of treatment, as appropriate, will be expected consistent with the permanency plan. For the well being of the child, if there are clinical or legal considerations that would impact family participation, all efforts to understand and overcome these barriers will be explored.

Daily activities, services, and supports will be guided by an individualized treatment plan that will identify areas of strength to be built upon and which will highlight the youth's capacities to overcome identified challenges. The ideal program will incorporate creative and expressive therapies (e.g., art, music, writing, etc.) within each treatment plan. Treatment goals will be the result of collaboration between team members, DCF and program staff, family members, and youth. The youth served will require intensive treatment, individualized programming, structure, supervision, and crisis management. The youth identified in the target population will require comprehensive coordinated care management (e.g., related to educational, medical, clinical, vocational, and spiritual

needs). Specialized treatment for youth with aggressive behavior problems must be provided; the amelioration of these problems must be considered to be the primary goals of this treatment program.

It is anticipated that youth served in this program will return home or to a suitable home-like environment, or will transfer to a lower level of care or to another level of service in the adult systems (e.g., Department of Mental Health and Addiction Services, Department of Developmental Services). To this end, providers will be expected to develop and maintain relationships with various agencies and community providers to improve the continuity and quality of care delivered to the youth.

The model program will employ staff who guide, mentor, support, and teach young residents by setting positive examples in all domains of the therapeutic environment. It is expected that the staff who spend the most time with the youth will have the greatest opportunity to effect healthy growth opportunities and development and that consequently these staff should be hired, trained, and supervised with the expectation that they will play critical roles in the program. It is anticipated that some of the referred youth may have mild cognitive limitations and challenges. Individualized clinical approaches should be developed for those youth for whom insight-oriented and cognitive behavioral approaches are contraindicated.

In addition to clinical services, the program will be expected to provide or routinely access a range of services that include: vocational/career guidance and linkages, health (medical, dental, vision) nutrition, and wellness promotion, independent living skills development, social support and skill development/enhancement, opportunities for friendships, personal enrichment, recreation, and mentoring.

Clinical services must be comprehensive, gender, age and developmentally appropriate. Clinical services should address area such as trauma, psychiatric issues, aggressive behavior, complex behavior problems, independent living (as viable and if age-appropriate), family readiness and reunification (as viable and appropriate), family psychoeducation, social development, and relational development. Each child entering the program must undergo an assessment within 30 days of admission. This assessment will cover the psychological, medical, education, socio-emotional, spiritual, specialized clinical and legal needs of the child and will build upon those assessments previously completed. It will be a strength and resiliency-based assessment and will include a review of previous placement and treatment histories, and pre-dispositional materials, including any clinically focused assessments that are available. In addition, ongoing assessment of the youth will occur. These assessments shall assist with the development of an individualized treatment plan. Minimal clinical service expectations, as informed by a comprehensive global assessment of the youth, include: intensive, structured, individualized programming, 7 days a week; therapeutic supports and approaches to enhance normalized activity; coordinated care management; behavioral planning; assistance with daily living skills; psychiatric services; medication management; trauma informed treatment; family readiness work; comprehensive transition planning;

psychological evaluations; and specialized client specific interventions that address the needs of youth with aggressive behavior problems.

Anticipated Length of Stay

Length of service will be individualized and variable. The target length of stay is expected to be between 6 and 8 months (based on clinical progress and family readiness). The Department recognizes that a flexible approach to length of stay may be necessary to accommodate individualized treatment goals and to facilitate planful transitions to a less restrictive level of care. It is expected, however, that discharge planning will begin on admission and progress toward discharge will be reviewed at least monthly and in conjunction with the Connecticut Behavioral Health Partnership as appropriate. The provider will utilize the Treatment Outcome Package (T.O.P.) to monitor and inform clinical progress in treatment. Additional specialized psychometric and risk assessment instruments may be used as clinically indicated.

Staffing Model

Staffing for a 6-25 bed congregate care setting should include the following positions: Program Director, Clinical Director, Licensed Clinician(s), Registered Nurses and LPNs, Milieu Supervisor, and Recovery Counselors/Youth Advocates. The applicant must detail the staffing ratios and number of positions needed to provide the required services. Within this program specialized clinical services may be provided either within the program or through collaborative agreements with outside fee-for-service specialists. Psychiatry time can be provided on a limited basis within the staffing model or with an outside psychiatrist on a fee-for-service basis.

Applicants must detail the supervisory model for the program and include a plan for supervision of all program staff. All staff must possess the education, experience, competencies, and training necessary to meet the needs of the target population. Assessment, crisis intervention, and treatment services must be available daily for youth. Providers must consider how they will assess the competencies of all potential employees in the requisite areas as opposed to simply focusing on paper requirements. That is, providers will need to give thoughtful consideration of the knowledge set, skill set, and personality style(s) best suited to work with traumatized youth, especially youth with behavior problems.

The respondent will provide to DCF plans to recruit and retain professional and para-professional staff that are culturally and linguistically competent and diverse. Staff must have the ability to provide services to all eligible participants, regardless of English language limitations. While the successful respondent must provide for the most common languages, it may be necessary to make special arrangements for interpretive services to communicate with those speaking less frequently encountered languages.

Supervision Model

Providers must outline a plan of how they will utilize the staff in a collaborative, community model to create and maintain a therapeutic milieu. All staff are expected to be clinical in their approach and to be an integral part of the implementation of the individualized treatment plans. No staff member's role should be viewed as any more important than another's and no member's role should be regarded as custodial. Clinicians and Milieu Supervisors must have flexible schedules and work shifts that make them optimally available to serve youth and families (i.e., as opposed to traditional first shift schedules).

Siting policy

Providers must conform to the Department's promulgated guidelines and policy on siting congregate care programs. Providers will need to notify towns/cities of the program. A program with a licensed bed capacity greater than 6 will require zoning approval. If a provider's existing site is used for this program, the provider will need to comply with the requirements of C.G.S 17a-145. (i.e., "If the population served at any facility, institution or home operated by any person or entity licensed under this section changes after such license is issued, such person or entity shall file a new license application with the commissioner, and the commissioner shall notify the chief executive officer of the municipality in which the facility is located of such new license application, except that no confidential client information may be disclosed.")

Collaborative Agreements

If the provider plans to offer access to any specialized service through a collaborative agreement with another agency, the respondent must provide the details of these agreements with the Department. The provider must submit copies of any Memoranda of Agreement or subcontracts they intend to utilize.

Budget

Budget submission is required to be made on Department prescribed forms. Forms are obtainable by contacting Margaret Glinn, Fiscal Administrative Manager I, at telephone number (860) 550-6544, or by email address: m.glinn@ct.gov. Selected program(s) will be categorized as a residential treatment center. Future calculations will be determined under the Single Cost Accounting process in accordance with Department regulations.

The budget document needs to display all of the elements that are requested under this proposal's model.

The Department prefers to a support funding distribution that apportions along the following percentage lines: Salary and Fringe representing sixty-five percent (65%) of total budget cost, Fixed expenses* reflecting approximately an eight percent (8%) level,

and Other expenses around the twenty-seven percent (27%) level. This is a recommendation of appropriate budget line cost allocation, not a hard and fast rule.

(* Fixed expenses are recognized as: rent, heat, light & water, depreciation, telephone, and insurance)

All full-time positions are recognized on a forty hour work week. To assist in the establishment of price points for position wage submission, the Department recommends the following position title wage ranges:

Annual Wage Range-	Low	High
• Program Director	\$60,840.00	\$70,720.00
Hourly wage	\$29.25	\$34.00
• Clinical Director	\$57,720.00	\$68,120.00
Hourly wage	\$27.75	\$32.75
• Consulting Psychiatrist	\$271,380.00	\$326,895.00
Hourly wage	\$130.47	\$157.16
• Licensed Clinician	\$41,080.00	\$55,120.00
Hourly wage	\$19.75	\$26.50
• Registered Nurse (RN)	\$40,040.00	\$60,320.00
Hourly wage	\$19.25	\$29.00
• Licensed Practical Nurse (LPN)	\$33,800.00	\$39,520.00
Hourly wage	\$16.25	\$19.00
• Milieu Supervisor	\$32,760.00	\$44,720.00
Hourly wage	\$15.75	\$21.50
• Recovery Counselors/ Youth Advocates	\$28,080.00	\$37,440.00
Hourly wage	\$13.50	\$18.00

Compensation levels, by position title, should be commensurate with the position's need, education and credentialing requirements, and years of experience.

Please consider the following guidelines in preparing a budget submission:

Fringe benefit package should not exceed twenty-five percent of the aggregate salary cost. Should the fringe benefit level exceed twenty-five percent, the budget narrative should provide justification for the components of the fringe package.

Rent cost, should it be included, will require that the provider organization demonstrate to the Department that the cited rent expense is both arms length and at market level.

Depreciation cost must be on a straight-line basis. All depreciable items must be aged in accordance with the American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets" guide.

Residential treatment providers are expected to provide adequate replacement clothing for residents. The Department's maximum allowance for this cost is \$642.00 annually per bed.

Indirect expense should range in the vicinity of ten to fourteen percent. Indirect expense exceeding fourteen percent of the aggregate budget must be justified in the budget narrative, which must provide an itemized list of the items included.

All remaining non-salary budget line items require the submission of a supportive narrative explaining the basis of the budgeted amount. It is imperative that the amounts identified in the budget narrative tie back to the amounts identified in the budget document.

In addition, the proposed budget should identify any anticipated third party, non-Department, income sources or in-kind contribution. Such income sources should clearly be identified by respective payer and projected amount. Income that is restricted to items included in the budget must be applied to offset the requested budget amount.

The Department will not negotiate any rates outside of the proposal process.

Outcomes

The Contractor will provide quality improvement data to the Department in a format approved by DCF as requested. These data will include but will not be limited to the following:

- a. Data on notable events while in placement including restraints, seclusions, AWOLS, arrests, suicide attempts, emergency services, incidents, and hospitalizations);
- b. Data on school attendance
- c. Data on youth's satisfaction with his/her experience in the program
- d. Data on programmatic information (e.g., number of approved/evidenced based groups per week, number of regularly scheduled individual sessions per week, average number of hours per week of family treatment, percentage of children and families receiving services in their primary language, etc.).
- e. Demographic Information (e.g., name, date of birth, gender, ethnicity/national origin, town of origin, DCF status, prior placement setting, admission date);
- f. Clinical and Diagnostic Information (e.g., DSM-IV TR, anticipated length of stay, targeted behaviors);
- g. Treatment Progress Data (e.g., participation in Administrative Case Reviews, critical incidents, participation in positive youth development activities), and will require monthly treatment update reports; and
- h. Discharge Information (e.g. reason for discharge, discharge placement setting, reason for any discharge delays, level of improvement for targeted behaviors)

Proposals

Proposals should be submitted in triplicate to the Bureau Chief of Behavioral Health and Medicine.