



Comprehensive Review of Professional Resource Family Care

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July 2014**

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EXECUTIVE SUMMARY

In 2007, Professional Resource Family Care (PRFC) was added to the Home and Community-Based Services (HCBS) Serious Emotional Disturbance (SED) Waiver. The intention of the HCBS SED Waiver is to serve children and youth ages 4 to 18 with SED in community-based settings rather than more restrictive treatment settings. As such, PRFC is “intended to provide short-term and intensive supportive resources for the participant and his or her family” through offering “intensive family-based support...through utilization of a co-parenting approach provided...in a surrogate family setting” (Kansas Department for Aging and Disability Services, 2013, p. 15).

In SFY 2014, the Kansas Department for Aging and Disability Services (KDADS) contracted with the University of Kansas School of Social Welfare to conduct a study on Professional Resource Family Care. The purpose of this study was to conduct a comprehensive review of Professional Resource Family Care (PRFC) that addressed the following: what is PRFC, how is it being used, and does it appear to be a promising community-based alternative to more restrictive treatment settings that might be replicated by other Community Mental Health Centers (CMHCs)?

Methodology

This multi-modal study used the following data sources:

1. Review of the literature
2. Semi-structured interviews with CMHC “users” and “non-users” of PRFC
3. Review of service use data (SFY 2011-SFY 2013)

Interviews and literature were analyzed qualitatively using a constant comparative analysis methodology. Medicaid management information systems (MMIS) data was analyzed quantitatively to provide descriptive statistics. As the study was intended as an introductory, exploratory approach, caution should be taken in applying study findings beyond their intended purpose.

Key Findings

This study sought to answer a number of questions about the provision of PRFC. A thorough literature review did not identify any journal articles or reports on Professional Resource Family Care (PRFC). Our search was expanded to review a sample of states, particularly those with children’s mental health waivers, to investigate similar services. We

contacted a number of states whose mental health websites noted programs with features that resemble PRFC. None currently offers a service identical to PRFC. The most similar service identified is Professional Parenting Homes offered to Missouri children who would otherwise be served in a state hospital setting. Professional Parenting Homes must participate in over 40 hours of training and become licensed, they can only have one child placed at a time, and one parent is not allowed to work outside the home. In addition to a base payment, Professional Parents are reimbursed for two respite days a month, the time they spend in required training, and for time between placements. “Professional Parent Home” was recently added as a Medicaid-billable Community Psychiatric Rehabilitation service for children in Missouri.

Key findings presented below are organized by study question.

Study Question #1: What is PRFC?

PRFC is unique compared to other SED waiver services because it provides eligible children with a short-term, intensive stay in a licensed home setting and includes a co-parenting component between the child’s parent(s) and PRFC providers. In Kansas, all licensed foster homes are sponsored through a child placing agency (CPA). Since the PRFC home is considered a licensed foster home, a CMHC that wants to provide and bill for this service must either become a CPA or contract with a CPA who can then offer this specific type of licensed home. The majority of CMHCs in Kansas who provide PRFC do so through the contracting model.

There is no single model of co-parenting used in providing PRFC. In general, co-parenting is described as a PRFC provider supporting a parent/guardian through coaching, mentoring, modeling, and providing suggestions of strategies that they have found to work with the child in the PRFC home. Parents may also share ideas and information with the PRFC provider on daily routines as well as techniques they have used with their child previously and how those worked. Ideally, this parent-to-parent relationship provides the parent/guardian (and professionals) with a different perspective on the child’s behaviors as well as possible responses and strategies that can be attempted in their own home. The four partners involved in PRFC - the parent(s), PRFC provider, CMHC, and the CPA - have both unique and overlapping roles.

Study Question #2: How is PRFC currently being used in Kansas?

PRFC is the most restrictive level of care a CMHC can offer since it occurs outside of the child’s own home. CMHCs generally described PRFC as the last community-based service attempt for children/youth at imminent risk of out of home placement (e.g. hospital, psychiatric residential treatment facility [PRTF], or foster care). CMHCs also mentioned using PRFC as a step-down from a more restrictive level of care that allows additional time for more intense family work prior to transitioning the child/youth home.

CMHCs look to PRFC when other services are not effectively identifying or addressing the child/family need. Most interviewees relayed that, in addition to the child's clinical need, the parent's investment to the child (i.e. does the parent want the child to return home? will the parent participate in PRFC and increased services? is the parent willing to make changes?) is given weighty consideration prior to recommending PRFC. Overnight respite is a service similar to PRFC in that it occurs outside the home and offers a break to families needing some time to re-energize. PRFC differs in that it allows for a longer stay in a licensed foster home, and it includes co-parenting.

Referrals for PRFC originate at the clinical level and include assessing the "fit" between the family and PRFC. The timeline for PRFC is determined by the child's clinical need as well as child and family progress. Most CMHCs reported starting with a typical projection for length of service that ranges by CMHCs from 21 to 45 days, thus ensuring that all parties involved have a sense of the anticipated timeframe.

Both rural and urban CMHCs have billed for PRFC though the majority of CMHCs who have used PRFC more frequently are located in urban areas. During SFY 2011 to SFY 2013, a total of 11 CMHCs billed for PRFC. During that timeframe, PRFC was billed for a total of 86 children/youth. The average age of children/youth served during this time was 13 years, though 42% of those served were between the ages of 14 and 16. At least five children/youth used PRFC twice during this time period. A total of 39 children/youth (49%) who received PRFC during SFY 2011 to SFY 2013 had a history of at least one PRTF stay prior to PRFC. Furthermore, based on corresponding service dates, it appears that 11 children/youth discharged directly from the PRTF to PRFC as a step-down. There was data available for 57 of the 86 children/youth that allowed us to review whether PRTF admittance occurred during a 12 month period following PRFC. The limited data suggest there is some successful diversion and/or step-down for youth using PRFC: Only 18 (32%) of the 57 children/youth were admitted to a PRTF within the 12-months following the end of their PRFC stay. It may be important to note that the majority of the 18 children/youth (12 or 67%) entered a PRTF within 0-3 months of PRFC ending and 10 (56%) of them had at last one PRTF stay prior to PRFC. This statistic is similar to that of Blader's (2004) study where he examined readmission rates for 109 pre-adolescents (children up to age 13) who were admitted to a psychiatric hospital during a 14 month period. In his study, 34% of children were readmitted and 81% readmissions occurred within the first 90-days post discharge. While it is possible to speculate on possible reasons for PRTF admittance within 90 days of PRFC ending, answering that specific question is beyond the scope of this study.

Though the claims data suggests possible success for some children/youth who used PRFC, there are no formal, standardized outcomes currently measured for PRFC. CMHCs who use PRFC reported difficulty in establishing standardized service outcomes and indicators due to the individualized needs and nature of the service, as well as the fact that so many other services are being received during PRFC. Related to what success may be for children and families who

use PRFC, the following caution was given by multiple interviewees: success looks different and means something different for each child/family.

CMHCs with experience providing PRFC shared some lessons learned such as the importance of keeping the child's parent(s) engaged, helping parents understand the PRFC service and expectations of the service prior to initiating it, and striving to transition the child back home as soon as possible. Assessing the fit between the family and PRFC, making a good match between the family and the home, parent involvement, PRFC provider qualities, PRFC home in close geographic proximity to the child's home, and collaboration were other factors noted as contributing to the success of PRFC.

Study Question #3: Does PRFC appear to be a promising community-based alternative to more restrictive treatment settings that might be replicated by other CMHCs?

PRFC is being used as a community-based alternative both in attempting to divert children and youth from the hospital or a PRTF as well as a step-down from PRTF. This study's examination of billing data provides some evidence to suggest that many children/youth who use PRFC are not using a PRTF within 12 months following the end of PRFC. However, since other community-based services are typically intensified during PRFC, attributing successful diversion solely to PRFC is not possible. Essentially, most CMHCs who use PRFC believe it helps keep some children out of more restrictive settings. Several CMHCs noted that the service does not fit well for many children/youth but in certain situations it is useful.

The overarching benefit of PRFC, in essence, is that the child remains in the community. Staying connected to the community allows services to continue with a lesser amount of disruption to the child and family. The six CMHC "users" spoke about the benefits of PRFC occurring in a community-based, family environment with parent-to-parent interactions. Since the child is living temporarily in another home, a break for members of the family system is inherent. This temporary break allows for increased learning opportunities for child, family, and service providers and provides a different perspective on the situation for all parties involved. Children and families may benefit from experiencing a different type of family structure or learning different ways to interact with one another. Regardless of whether or not they are currently able to provide the service, almost all CMHC interviewees acknowledge the value they see in having PRFC as a service option for certain situations.

Overall, outcomes for children and families following PRFC vary, and there was not enough use of PRFC to truly evaluate its promise as a community-based alternative to residential treatment. During interviews, multiple challenges to offering and providing PRFC were given. The main challenge is that there are not enough PRFC providers available for CMHCs to use the service and/or use it consistently. PRFC must occur in a licensed family foster home (sponsored

by a licensed child placing agency) which impacts the process of recruiting, training, supporting, and retaining an adequate number of PRFC providers.

Conclusion

PRFC is unique compared to other SED waiver services because it provides for a short-term, intensive stay in a licensed home setting and includes a co-parenting component between the child's parents and PRFC providers. These unique features not only define PRFC but also are the factors that lead to its benefits for children, parents and CMHCs, as well as the challenges in providing this service. PRFC is being used as a treatment service for diversion/step-down from more restrictive levels of care in Kansas. However, only a handful of CMHCs are billing for PRFC on a regular basis (i.e. several times a year), and this level of utilization links directly to the identified challenge of having access to open beds in licensed homes where there are specially trained and skilled PRFC providers willing and able to provide PRFC. To date there is not enough use of PRFC to ascertain the extent to which PRFC can be used to keep children in community rather than in more restrictive levels of care. Additionally, due to the nature of the situations that generally prompt PRFC, individual outcomes for PRFC vary. The CMHCs interviewed indicate that PRFC is a valuable community-based service option to more restrictive levels of care but PRFC is not a suitable service for all situations. Rather, using PRFC requires a good match between the situation, child, family, and PRFC provider so that short-term, intensive work can occur. Engaging parent(s)/guardian(s) in the PRFC service reportedly impacts the child and family's success during and post-PRFC. This particular aspect, engaging parents, is difficult – particularly in situations where there is low parental investment related to the child/youth returning home following PRFC. Several CMHCs noted that they would like to increase the availability of overnight respite care providers (i.e. licensed foster homes) in their area because respite is valuable community-based alternative that meets the needs of a larger population of children/families than PRFC.

Recommendations

A consistent finding across the interviews indicated that PRFC could and would be used more frequently if it were more readily available. The lack of PRFC homes that are in close proximity to the child's community with the skill set, flexibility, and/or an open bed is the primary barrier to providing PRFC. There is an *overarching need to recruit and retain skilled PRFC providers*. It should be noted that there is an overall shortage of licensed foster homes in Kansas which adds to the challenge of increasing the number of providers of PRFC and overnight respite for children with serious emotional disturbances. Findings from this study indicate that not all foster parents are suited or willing to provide PRFC. Identifying common provider characteristics and the necessary skill sets for providing PRFC may inform targeted recruitment and training of PRFC providers. Recruitment and retention of these skilled providers will be imperative to enhancing the system capacity to deliver this service. Ideally, partnering with CPAs who currently sponsor PRFC homes and CMHCs on research and development

activities would facilitate recruitment and retention of resource homes to provide children's mental health services.

Recommendations for increasing the use of resource homes as a community-based alternative to more restrictive treatment settings include:

- Create a systems-level advisory committee that examines barriers and possible solutions to providing PRFC as a planned community-based alternative to more restrictive treatment.
- Interview a contracting CPA to learn more about their role in utilizing PRFC as well as perceived benefits and barriers.
- Interview parents of children who have used PRFC to learn about their perspective on the benefits and challenges of using PRFC.
- Further "professionalize" the PRFC service. In order to attract skilled individuals to provide PRFC consistently, this may include compensating PRFC providers for training time and for days that there is no PRFC child/youth in the resource home (i.e. paying to hold a bed for PRFC) such as Missouri has done.
- Provide training to PRFC providers that is specific to co-parenting/parent engagement. There is currently no co-parenting model or co-parenting specific pre-service training.
- Compile a listing of specific PRFC home characteristics (including strengths/skill sets and family composition) and options for placement (i.e. home can only take children of a particular sex) that can be provided to CMHC treatment teams. Having that information available may enhance the treatment teams' ability to recognize potential "good fits" for the service in a planned fashion.
- Disseminate information to child/family service providers statewide on what PRFC is and how it is being used currently to inform expanded development of the service.
- Review evidence-informed recruitment and retention strategies that can be adapted and/or applied to recruiting skilled resource home providers.
- Create a shared funding mechanism that channels the financial resources needed to support the development of a network of providers/resource homes (i.e. incentive payments for referring potential professional parents who complete the licensure process; funds to support home repairs to meet licensing standards; support for CMHCs interested in becoming a CPA).
- Create a state or regional-level position with ongoing responsibility for assisting CMHCs in targeted community resource development.
- Develop measures to formally track when PRFC is utilized as a diversion or step-down from higher levels of care as well as longer term outcomes.
- Consider allowing CMHCs to bill for discharge services to facilitate a coordinated and planned transition from a PRTF to PRFC.

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I. INTRODUCTION/BACKGROUND

In 2007, Professional Resource Family Care (PRFC) was added to the Home and Community-Based Services (HCBS) Serious Emotional Disturbance (SED) Waiver. The intention of the HCBS SED Waiver is to serve children and youth ages 4 to 18 with SED in community-based settings rather than more restrictive treatment settings. As such, PRFC is “intended to provide short-term and intensive supportive resources for the participant and his or her family” through offering “intensive family-based support...through utilization of a co-parenting approach provided...in a surrogate family setting” (Kansas Department for Aging and Disability Services [KDADS], 2013, p. 15).

Study Purpose

This project will conduct a comprehensive review of Professional Resource Family Care (PRFC) that addresses the following: what is PRFC, how is it being used, and does it appear to be a promising community-based alternative to more restrictive treatment settings that might be replicated by other Community Mental Health Centers (CMHCs)?

II. LITERATURE REVIEW

Literature Reviewed

This study did not identify any traditional literature on Professional Resource Family Care (PRFC). Google Scholar, Psych Info, and Social Work Abstracts were searched using terms such as “professional resource family care,” “professional parenting,” “co-parenting,” and “community-based mental health treatment for children and adolescents” among others (see Table 1: Terms Searched).

Journal articles and reports that were found focused on related services such as parent support, professional mental health services, co-parenting between divorced parents, and therapeutic or treatment foster care, but did not feature a program identical to PRFC.

Table 1: Terms Searched

- professional resource family care
- professional parenting
- child mental health + surrogate parents
- family-based crisis stabilization
- community-based alternatives for children and adolescents
- co-parenting
- mentoring
- parent support
- extended respite
- community-based mental health treatment for children and adolescents
- therapeutic foster care + not in foster care

As no literature specific to PRFC was identified, our search was expanded to review a sample of states¹, particularly those with children’s mental health waivers, to investigate similar services. We contacted a number of states whose mental health websites noted programs with features that resemble PRFC. At the time of this review, we identified one state that offers a service almost identical to PRFC; however, no providers in that state had ever billed for PRFC. One state offers Professional Parenting Homes which has features similar to PRFC.

Given the absence of information specific to PRFC, this review focuses on related state programs and literature on community-based alternatives to residential treatment or hospitalization.

Professional Resource Family Care

One state was identified that includes a service in its Medicaid managed care service array specifically called “Professional Resource Family Care” (PRFC) with a purpose and definition similar to the one in Kansas (Magellan Behavioral Health of Nebraska, Inc., 2013, p. 56). A managed care representative from Magellan shared that PRFC was added to their services in July 1, 2011 to replace Therapeutic Foster Care. At the time of this correspondence, however, this state had not received any billing claims for the PRFC service (T. Danforth, personal communication, October 25, 2013).

Professional Parenting Homes

In 2009, The Missouri Department of Mental Health funded a major initiative called The Children’s Enhancement Project (CEP) to serve children with high needs who would have been served by the Western Missouri Children’s Unit (state hospital) prior to its closing in 2008. The CEP includes Professional Parenting Homes and Enhanced Behavior Specialists who work together to serve children in the community. Professional Parents receive enhanced training above and beyond requirements for a treatment foster parent because Professional Parents provide multiple services within their therapeutic home environment.

Professional Parents are allowed one CEP child in their home at a time. One parent (regardless of family composition) cannot be employed outside of the home. This person is essentially employed as a Professional Parent. For this reason, Professional Parents are paid for availability between times a child is placed in their home as well as for training/orientation though at a lesser rate. Professional Parent duties involve daily caregiving; therapeutic provision of services and documentation; access to community and in home therapeutic, recreational, and social activities; transportation to appointments and activities; monthly treatment reviews; family therapy with child and child’s parent/guardian; and in-home training and modeling of skills for the child’s parent/guardian. Professional Parenting Home parents receive two paid nights of

¹ States reviewed included Texas, Iowa, Montana, Michigan, Louisiana, Oregon, Vermont, Mississippi, New York, Nebraska, Maryland, Florida, Indiana, South Carolina, Wisconsin, Virginia, Wyoming, and Georgia.

respite per month (personal correspondence, T. Cunningham, April 11, 2014). A service labeled “Professional Parent Home” is also available through the State’s Community Psychiatric Rehabilitation Program. This Medicaid-funded service has the same requirements for providers of the service; however, it is billed at a daily rate only for days the child/youth is present in the Professional Parent Home (State of Missouri MO HealthNet Manuals, 2014).

Children’s Mental Health Waiver Services

Kansas is one of fourteen states that currently offer waiver services for children with SED (Centers for Medicare and Medicaid [CMS], n.d.). In reviewing the individual waiver applications and/or waiver manuals for the other thirteen states with waivers, none of the thirteen include a service called “Professional Resource Family Care”. At least two states have services labeled “Crisis Intervention” or “Crisis Stabilization” whose service definitions shared some similarities to the Kansas’ PRFC service (e.g. child temporarily cared for in another licensed home or facility, child’s parent remains involved in the service, child’s parent agrees before using the service that child will return home). These services are short-term—authorized for between 7-14 days according to the service definitions (Louisiana Department of Health and Hospitals, 2012; Montana Department of Public Health and Human Services, 2013). Both states were contacted for more information, and one responded. This response stated that their waiver had been available for one year, and during that calendar year (2013) no one utilized Crisis Intervention services (J. Bernard, personal communication, February 21, 2014).

Another state waiver offers Supportive Family-based Alternatives (SFA) that allows for a slightly longer stay than the previously mentioned services—up to 90 days per individual service plan year with extension requests permitted (Texas Department of State Health Services, 2013). SFA is considered to be a therapeutic service where modeling is provided to the youth’s family while he/she resides in a temporary home (Texas Department of State Health Services, 2013). A program evaluation indicated that no children had utilized SFA between March 31, 2010-July 31, 2012 (Texas Institute for Excellence in Mental Health, 2013). Stakeholders believe that SFA would be beneficial to families but “a lack of qualified providers and the complexities of cross-agency collaboration have been barriers to its development” (Texas Institute for Excellence in Mental Health, 2013, p. 10). One of the recommendations provided in the evaluation was that the state should “consider providing program development funds and technical assistance to communities to build a provider network for SFA” (p. 10).

Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program

The Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program, authorized through the Federal Deficit Reduction Act of 2005, supported nine states to conduct demonstrations to determine if (a) the overall functioning of the child was either maintained or improved through community based treatment rather than PRTF

treatment and (b) whether or not it was more cost-effective to treat children/youth in the community versus a PRTF setting. According to a report from the U.S. Department of Health and Human Services (2013) to the President and Congress, evaluation of the data from the nine states illustrated that child functioning was maintained or improved for children/youth utilizing these waivers, and the cost of utilizing the PRTF demonstration grant was approximately 32% of institutionalized care. Other than Kansas, it does not appear that any of the demonstration sites used services similar to PRFC.

Therapeutic/Treatment Foster Care

Another resource that allows children to remain in the community to receive mental health treatment is Therapeutic Foster Care (TFC) (Morrison Dore & Mullen, 2006). The terms therapeutic foster care, treatment foster care, and specialized foster care all refer to a similar type of community-based treatment that occurs in a specially trained foster home (Walter & Petr, 2005); likewise, in this review, the terms will be used interchangeably. TFC is similar to PRFC in that services occur in a family setting where treatment is community-based and individualized. In addition, both TFC and PRFC serve children/youth with SED who would otherwise require a higher level of care. In reviewing the 20 current best practices in TFC identified by Walter and Petr (2005), four of those best practices shared similarities with the service description and components of PRFC as outlined in Table 2.

Table 2: Practices shared by PRFC and TFC

PRFC	TFC
<ul style="list-style-type: none"> • specific provider qualification including state-approved training 	<ul style="list-style-type: none"> • specialized training for providers
<ul style="list-style-type: none"> • identifies the child/youth, child’s family, and PRFC provider as important members of the child’s treatment team 	<ul style="list-style-type: none"> • emphasis on biological families’ role and involvement in the service • regular feedback from biological families, TFC families, children/youth, & involved professionals
<ul style="list-style-type: none"> • frequent contact (co-parenting) between the PRFC provider and the child’s family <p>(HCBS SED waiver PRFC service definition, KDADS, 2013)</p>	<ul style="list-style-type: none"> • assisting TFC families to engage with biological parents regularly <p>(Walter & Petr, 2005)</p>

In some states, TFC is available to children both in the custody of that state (out of home placement) as well as children whose parents’ maintain full parental rights. An example of a TFC program with several characteristics similar to PRFC can be found in one mental health agency in Oregon. This program supports regular contact between the child, child’s family, family therapist, foster care case manager, and treatment foster parents to develop or enhance parenting skills and parent-child communication while the child is in a therapeutic home. However, this program differs from PRFC in that it is only available to children ages 3-13 and there is a

minimum stay between 3 and 6 months with a maximum stay of 12 months. Additionally, the providers of TFC are staff from the program (D. Ziegler, personal communication, August 23, 2013).

Though there are some similarities between PRFC and TFC, the length of stay is where PRFC seems to differ largely from TFC. The intention of PRFC is clearly stated in the Kansas HCBS SED Waiver manual as “to provide short-term and intensive supportive resources for the waiver participant and his or her family” (KDADS, 2013, p. 15). While TFC has shown some promise as a positive tool to use as a step-down from more restrictive levels of care (Farmer, Wagner, Burns, & Richards, 2003), it frequently is not a short-term transition service as evidenced in one study where 60% of youth remained in TFC 12 months after placement (Farmer, Wagner, Burns, & Richards, 2003). Walter and Petr (2005) discovered similar length of placement outcomes (i.e. often 12 months or longer) in their review of the TFC literature.

Summary

This review documents that Professional Resource Family Care (PRFC) is a unique service within the array of community-based mental health treatment for children and youth at-risk of state hospitalization. At least five other states have services that share components of PRFC, though at this time the majority of these are not being utilized. An exception is Missouri where Professional Parent Homes are offered either through the Children’s Enhancement Project (CEP) or the Medicaid-supported Community Psychiatric Rehabilitation Program. Although we were unable to find any literature specific to PRFC, similarities between PRFC and other community-based services point to shared challenges and benefits and provide a foundation from which the continued development of PRFC can be informed. In addition, a lack of current literature provides Kansas with a distinctive opportunity to contribute to the evidence base on community-based mental health services for children.

III. METHODOLOGY

The purpose of this study was to conduct a comprehensive review of Professional Resource Family Care (PRFC). The intent was to learn more about PRFC including how it is used and whether it may be a promising community-based alternative to more restrictive treatment settings.

Study Questions

This project was guided by the following questions:

1. What is Professional Resource Family Care (PRFC)?
2. How is PRFC currently being used in Kansas?
3. Does PRFC appear to be a promising community-based alternative to more restrictive treatment settings that might be replicated by other Community Mental Health Centers (CMHCs)?

Data Sources

Literature review. The purpose of the literature review was to document the state of knowledge regarding PRFC. Journal articles and reports were reviewed along with a sample of states, particularly those with children’s mental health waivers, to investigate similar services. The review included personal correspondence with a small number of agency representatives.

Interviews. Staff identified six CMHCs who billed for PRFC more than once in CY 2012 (“users”) and a sample of six CMHCs who did not bill for PRFC more than once in CY 2012 (“non-users”). The study methodology included two interviews with each PRFC “user”: (1) a service system-level interview with the CBS director or an administrator and (2) a service utilization-level interview (typically staff supervising or facilitating waiver services). One administrative level interview was conducted with each “non-user.” Interview protocols were developed. The research plan was submitted to the Institutional Review Board (IRB) and Human Subjects approval was granted.

Project staff identified the specific CMHC administrators or staff to be interviewed and scheduled face-to-face meetings with as many “users” and “non-users” as possible. Some phone interviews were scheduled with “non-users.” A total of eighteen interviews were conducted using semi-structured interview guides (Appendices B and C).

Service data. Medicaid Management Information Systems (MMIS) Professional Claims was used to gather information on claims billed for PRFC. Originally, claims data from CY 2012 was the most current, full year available. Based on that data, criteria for “user” and “non-user”

participants were selected. Claims data for SFY 2011-SFY 2013 was received on 1/31/2014 and incorporated into the study analysis and report.

Study Participants

Participants were informed verbally and in writing that their participation was voluntary and consent could be revoked at any time. Participants were assured that the results would not include identifying information for themselves or their agencies. Participants reviewed and signed consent forms prior to the interviews. All 12 CMHCs that were contacted agreed to participate in this study.

PRFC Users are defined as Community Mental Health Centers who billed more than once for PRFC in calendar year 2012. Those CMHCs are listed below:

- Bert Nash Community Mental Health Center, Inc.
- COMCARE of Sedgwick County
- High Plains Mental Health Center
- Johnson County Mental Health Center
- Prairie View, Inc.
- Wyandot Center for Community Behavioral Healthcare, Inc.

PRFC Non-Users are defined as Community Mental Health Centers who did not use PRFC, or only used PRFC once in calendar year 2012. The following CMHCs used PRFC one time or less during calendar year 2012:

- COMPASS Behavioral Health
- Community Mental Health Center of Crawford County
- Family Service & Guidance Center of Topeka
- Pawnee Mental Health Services
- Southwest Guidance Center
- Iroquois Center for Human Development
- Horizons Mental Health Center
- The Center for Counseling and Consultation
- Sumner Mental Health Center
- Cowley County Mental Health and Counseling Center
- Four County Mental Health Center
- South Central Mental Health Counseling Center
- Labette Center for Mental Health Services
- Spring River Mental Health & Wellness
- Southeast Kansas Mental Health Center
- Mental Health Center of East Central Kansas
- Central Kansas Mental Health Center
- Kanza Mental Health and Guidance Center
- The Guidance Center, Inc.
- Elizabeth Layton Center, Inc.

In collaboration with KDADS, a sample of six “non-users” was chosen for this study to gain information from CMHCs serving a variety of geographic regions in Kansas.

Data Analysis

Qualitative interviews were digitally recorded. Detailed notes were also taken. Audio-recordings of all eighteen interviews were transcribed verbatim by a contracted transcriptionist. Open-coding was used rather than a pre-defined code list. Data were analyzed qualitatively using a constant comparative analysis methodology where researchers looked for broad themes among responses.

Strengths and Limitations of the Study

Through interviews and examination of service data, this study sought to understand the circumstances under which PRFC is utilized, service barriers and facilitating factors. Though the total sample included nearly half of the CMHCs in Kansas, only 50% of the sample (n=6) had experience using PRFC more than one time in CY 2012. However, 11 of the 12 participating CMHCs reported using PRFC at least one time since it was added to the SED waiver. Due to the relatively small number of CMHCs consistently using PRFC in Kansas as well as the small number of children/youth who utilized the PRFC service between SFY 2011 and SFY 2013 (n=86), it is difficult to assess the promise of this service as an alternative to more restrictive levels of treatment. Neither parents nor a contracting CPA were interviewed so there are likely additional benefits and challenges to using PRFC that have not been explored. However, based on the CMHC interviews conducted and the MMIS claims data available to study, it is possible to present a fairly comprehensive review of PRFC.

As the study was intended to provide a more in-depth, nuanced view of these issues than currently exists in the literature, a relatively small sample of providers was interviewed. Thus, results are limited in their generalizability. Caution should be taken in applying study findings beyond their intended purpose.

IV. FINDINGS

Study Question 1: What is Professional Resource Family Care (PRFC)?

Professional Resource Family Care (PRFC) is a SED Waiver service that supports a child or youth's short-term stay in a specially trained, licensed family foster home and provides "co-parenting" between the child's parent/legal guardian and the PRFC provider. PRFC is different than foster care in that the child's parent(s) retains full custody of the child during PRFC. PRFC was added to the SED waiver during its 2007 renewal.

Core Aspects of PRFC

There are two core aspects of PRFC that together differentiate it from other SED waiver services:

- Short-term, intensive support that occurs while the child resides in a licensed foster home
- Co-parenting between the child's parent(s) and the PRFC provider

Short-term, intensive support that occurs while the child resides in a licensed home.

According to the service definition (KDADS, 2013, p. 15), PRFC is intended to provide "...short-term and intensive supportive resources for the waiver participant and his or her family." Interviewees spoke about PRFC differing from other waiver services in that it allows a focused length of time to work with a child and family intensively while a child receives care in a licensed foster home. Though PRFC is longer than a service such as overnight respite care, the intent that a child return to his or her family home as soon as possible is similar. PRFC must occur in a licensed family foster home. In Kansas, all licensed family foster homes are sponsored through a licensed child placing agency (CPA) which is responsible for recruiting, training, licensing, overseeing and supporting homes as well as placing children. In order to gain access to licensed family foster homes, a CMHC must either become a CPA or contract with a CPA. The majority of CMHCs in Kansas who provide PRFC do so through the contracting model.

Co-parenting between the child's parent(s) and the PRFC provider

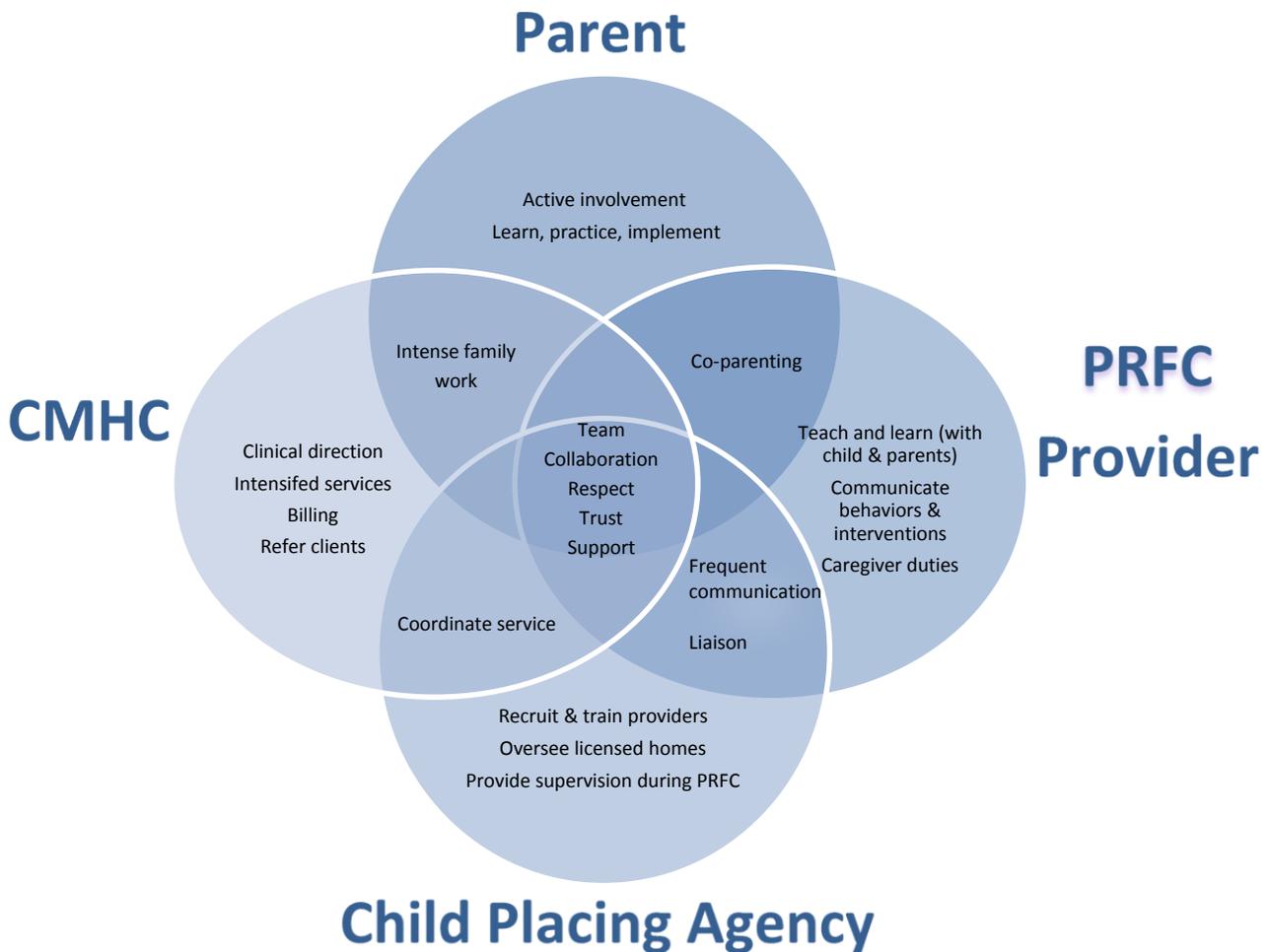
There is no single model of "co-parenting" used in providing PRFC. In general, co-parenting is described as a PRFC provider supporting a parent/guardian through coaching, mentoring, modeling, and providing suggestions of strategies that they have found to work with the child in the PRFC home. Parents may also share ideas and information with PRFC providers on daily routines as well as techniques they use or have used with their child previously and how those worked. This parent-to-parent relationship may provide the parent/guardian (and the professionals) with a different perspective on the child's behaviors as well as possible responses and strategies that can be attempted in their own home. Co-parenting may include the parent/guardian spending time at the PRFC home or the PRFC provider going to the parent's

home to collaborate. The co-parenting aspect also entails working out details about day-to-day parenting responsibilities (i.e. child’s activities and/or appointments, transportation, visits, school). Co-parenting is thought to be most successful when the parent/guardian feels respected and sees it as a partnership—which is why a good match between PRFC provider and child’s parent may be vital to the outcomes of the service.

Roles of the PRFC Partners

The data collected in this study suggests that there are four key partners in PRFC: Parent(s), PRFC Provider, CMHC and the Child Placing Agency (CPA). As previously mentioned, it is possible for a CMHC to become a CPA and serve in both roles. Figure 2 shows the unique and overlapping roles of each key partner which are also described briefly below.

Figure 1. Roles of the four partners involved in PRFC



Parent(s).

As with other waiver services, a child's parents are valued members of the treatment team. PRFC requires active participation from the parent/guardian both directly in PRFC (i.e. co-parenting and collaboration) as well as in the other services (e.g. family therapy) that may intensify during PRFC as noted by this CMHC administrator:

...in professional resource family care the expectation is the family is an integral part of the service. They participate in the service, not just the child.

Many CMHC "users" mentioned that they try to explain PRFC and the parental commitment necessary up front so that parents/guardians understand to what they are agreeing when they choose to use PRFC for their child. Several CMHCs noted that parental involvement is critical to the overall outcomes of PRFC. Parental involvement in co-parenting creates opportunities for learning, practicing, and implementing new strategies so that family system change may occur and gains made during PRFC can generalize back into the family home. Despite its importance to the child's success, many CMHCs identify parent involvement as a challenge.

if the parent is unwilling to meet with that resource, then there's not a lot of active learning going on and it doesn't really change the family system and the resources that they have at home, and especially in terms of their parenting resources.

While a couple of CMHCs offered examples of parents who were over-involved (i.e. did not give child and PRFC provider enough space and time to work on child's needs), most shared that actively engaging parents in the treatment process while the child resides in another home is the more typical challenge.

PRFC provider.

The role of the PRFC provider varies depending on the needs of the child and family being served. Overall, learning, teaching, communicating, and providing daily care with a child receiving PRFC is the main role of the PRFC provider. Through learning about the child and what types of responses and strategies seem to help the child manage in the PRFC home, the PRFC provider can work with the child and the child's parent(s) (i.e. co-parenting) to help transfer techniques back into the child's own home. One CMHC interviewee spoke about trying to follow a routine in the PRFC home as similar to the daily routine in the child's own home as possible. This way gains the child makes in functioning are more likely to transfer home.

The parent gives us a list of things that they'd like the kids to work on during the stay. And so we really try to accommodate those things. We ask them what their regular chores are. You know, we ask them what their routine is at home and we try and have the

resource home follow that as best we can....This is the framework of their family functioning...we want them to be practicing being able to work within that framework when they're in that home also.

Since the child is living with the PRFC provider, the provider must clearly communicate observations and what seems to be working for the child with all members of the treatment team. This may be done individually with service providers, the CPA staff, and the child's parents/guardian or in treatment team meetings. The PRFC provider also completes daily progress notes that are submitted to the CMHC. In regard to daily caregiving, PRFC providers generally help get the child to and from appointments as they are able, which may depend on their work schedule or other commitments. Occasionally, PRFC providers may attend appointments with the child and/or child's family.

CMHC.

CMHC staff make referrals for PRFC to CPA staff. If there is a home available to provide PRFC that is a good match for the child/youth, the CMHC staff then coordinates the service. Coordination involves providing clinical direction for PRFC and working intensively with the child and family during PRFC, increasing other services as necessary. CMHCs are also responsible for billing this service. Therefore, the workload intensifies for CMHC staff when providing PRFC.

We can't just take one [member] out and not work with everybody... the one-on-one kind of stuff with the kids, we increase that and parent support is to be increased.

...it's much more than just a place for this child to land. It's got to be...the case managers who know the kids, continue to work with that child to be able to support that family...to get that kid back home.

CPA.

Whether a CMHC operates a CPA or contracts with a CPA, there is specific staff responsible for understanding the Kansas Department of Health and Environment (KDHE) regulations for licensed foster homes and for recruiting, training, and supporting PRFC providers. The CPA staff is knowledgeable about the PRFC providers' strengths and limitations as well as the types of children/youth who are a good fit for each home. Thus, when the CPA receives a referral, they determine whether there is an available PRFC home and if so, whether the provider is a good match for the child and family in need. The CPA staff is responsible for frequent, on-going communication with the PRFC provider during the service.

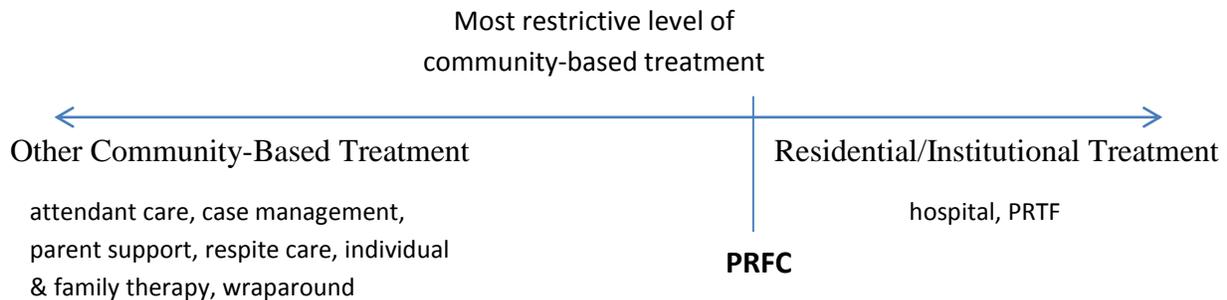
...it's a lot of coordination time. It's a lot of prep time. It's a lot of training time.

Study Question 2: How is PRFC Currently Being Used in Kansas?

Where Does PRFC Fit in the SED Waiver Service Array?

Children/youth on the SED waiver may utilize a wide array of services at various points in time, depending on the severity of clinical need. Figure 2 is a continuum constructed to help visualize where PRFC is situated amongst this array. PRFC falls at the far side of community-based mental health services for children with SED between the other community-based services and more restrictive settings. Though it is a community-based service, several CMHCs note that PRFC is the most restrictive level of care a CMHC can offer since it occurs outside of the child's own home. PRFC involves a higher intensity of services and involvement from all parties associated with treatment. While it provides a physical separation of families (i.e. a break), the intent of this separation is to stabilize and revitalize a child and family so that they can engage in treatment and change. PRFC is not one of the first services offered for a child on the waiver. Rather, an array of services such as case management, attendant care, parent support, family and individual therapy, wraparound, psychosocial groups, and respite care are typically in place prior to PRFC starting and during PRFC as well.

Figure 2. PRFC along a service continuum



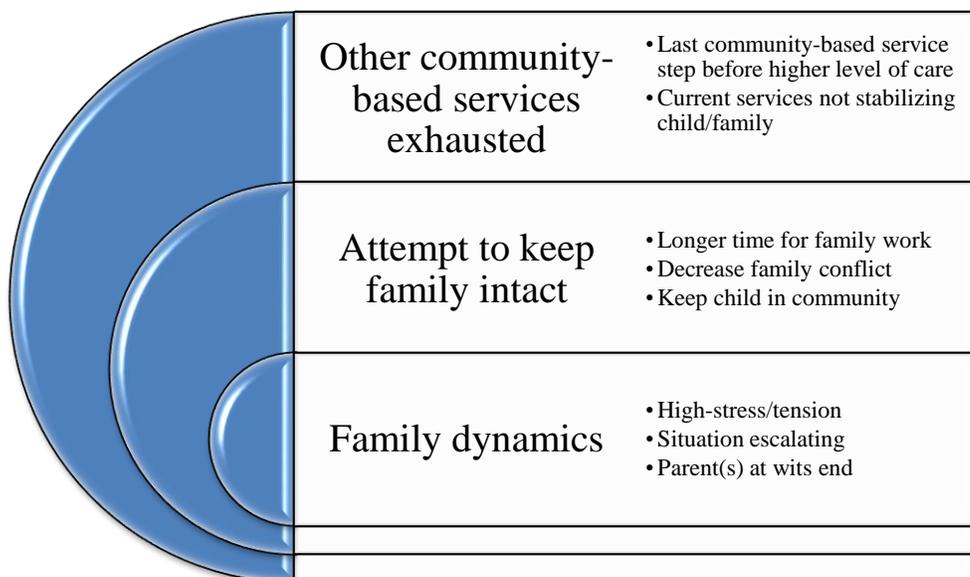
When is PRFC considered?

CMHCs look to PRFC when other services are not effectively identifying or addressing the child/family need. PRFC is reportedly used as a diversion (e.g. following a screen for PRTF or possibly due to escalating behaviors that seem likely to lead to a screen) and as a step-down to ease the transition from residential treatment back home. In addition to the child's clinical need, the parent's investment to the child (i.e. does the parent want the child to return home? will the parent participate in PRFC and increased services? is the parent willing to make changes?) is given weighty consideration prior to recommending PRFC. Negative or deteriorating family dynamics (e.g. parent-child conflict, parent worn out, stress in home or community is building) may be the crux of a majority of referrals as reflected in the following comment.

Typically the cases that we're going to refer to PRFC, the parent is a lot of times really burned out. They're really tired. They are having a difficult time appropriately handling their child. Sometimes, for whatever reason, they're not able to follow the recommendations for a million different reasons. A lot of times just because they're tired and they feel like they've tried everything.

Family dynamics affect parent investment which in turn affects parent involvement and post-PRFC outcomes. Although all CMHCs interviewed agree that PRFC is used as a diversion or a step-down from a higher level of care, there are a variety of situations that seem to initiate referrals (see Figure 3).

Figure 3. Situations that may lead to a referral to PRFC



Respite versus PRFC.

One theme that came across in several interviews was the difference between initiating overnight respite and PRFC. Overnight respite outside of the home provides a benefit similar to PRFC in that it offers a break to families needing some time apart. It may be selected for use in situations where a short break is the main goal and/or parent(s) seem unlikely to stay engaged during a longer PRFC stay, to de-escalate a situation, or to help ease the transition home following PRFC. Overnight respite may be planned on a regular basis or sought during a crisis that does not necessitate a hospital stay for safety concerns.

PRFC, on the other hand, is generally the last community-based service attempt for children/youth at imminent risk of out-of-home placement (hospital, PRTF, or maybe foster care due to behaviors). Examples of precipitating factors include: the child/youth has a history of

multiple hospital or PRTF stays, family is calling crisis line frequently, and/or there are quite a few (if not all) waiver services in place and the child and/or family situation is not stabilizing. PRFC attempts to keep the family intact by keeping the child in (or near) his own community and allowing for intense family work and support. While families using PRFC might be in crisis, the child is not usually in an ‘acute crisis’ (one that indicates a need for hospitalization due to imminent safety risks). PRFC allows for a stay in a licensed foster home that is longer than overnight respite care. A lengthened stay can be useful in these high-risk situations to give the CMHC time to intensify services with family.

PRFC Service Process

Referral.

Referrals for PRFC originate at a clinical level. Though not all CMHCs have the same starting point, most described referrals initiating with treatment teams, clinical reviews, and/or a therapist when situations in the child’s life (often times at home) are escalating and other services being used or tried previously are not helping the situation to stabilize. Also, referrals are made for some children exiting a PRTF when a child and/or family need a slower transition that allows for increased family and individual treatment gains. In addition to the child’s clinical need, an important referral consideration is assessing the “fit” between the family and PRFC. This assessment is based on both prior and current treatment-related interactions as well as conversations with the child’s parent/guardian. If a child and family are a good fit for PRFC, the CMHC collaborates with CPA staff to discuss the availability of a home for the child. CMHCs who provide PRFC on a fairly regular basis mentioned that a good match between the PRFC provider and the child as well as the child’s family is important to the progress that can be made during PRFC. If there is an available PRFC home that is a good match for the child and family, the service can be offered and planned.

... there’s not a whole lot of these homes available in the state of Kansas. And then depending on each home’s specific skill set, kids may or may not be successful in that...it’s not a one size fits all.

We work hard to match the needs of the child to the strengths of the home.

Delivery.

Once PRFC is initiated, the CMHC has an on-going role in monitoring and assessing the service progress. Collaboration between treatment team members is described as an essential piece of PRFC. Almost all CMHCs reported there are team meetings regularly (e.g. weekly or every other week) that include the child’s parent(s)/guardian and the PRFC provider so that behaviors, interventions, and progress can be discussed as well as appointments and family visits. The child and family continue to receive other CMHC services during PRFC (such as family therapy and case management) and those occur frequently (typically at least once a

week). CMHC and/or CPA staff also speaks individually to PRFC providers, parents, and child/youth on a regular basis to hear how things are going. In addition, the PRFC provider is responsible for documenting daily progress reports.

As described previously, co-parenting is a critical component of PRFC. There is no set model or method of co-parenting. Many interviews described co-parenting as a sharing of ideas or suggestions between PRFC provider and child's parent/guardian. Co-parenting occurs through phone calls, in-person collaboration (e.g. meeting together and modeling interactions or coaching), texts, and email. A few interviewees mentioned that it is helpful to share expectations regarding communication between PRFC providers and parent(s)/guardian (e.g. daily communication or a minimum of twice a week) prior to service beginning.

the parents know that the expectation is that they speak with the resource parent to do the collaborative parenting at least every other day if not daily.

at least weekly...the recommendation is that they speak on the phone or meet just to kind of say here's what's going on. This is what has worked. Have you tried this before? I mean we encourage it a lot.

The timeline for PRFC is determined by the child's clinical need and child and family progress though one CMHC noted that there have been times when the length of services was largely determined by the availability of the PRFC provider. Most CMHCs reported starting with a typical projection for length of service to give all parties involved a sense of the timeframe. The typical projected timeframe for PRFC varies by CMHC, ranging from 21 to 45 days. At least one interviewee stated that a PRFC stay never lasts longer than 30 days. Other interviewees report an average PRFC length of stay around 30 to 60 days.

Service Use To-Date

A total of eleven CMHCs billed for PRFC between SFY 2011 and SFY 2013 (July 1, 2010-June 30, 2013). Both rural and urban centers have billed for PRFC, though the majority of CMHCs who have used PRFC more frequently are located in urban population areas. As reflected in Figure 4 below, 5 of 7 CMHCs who billed for PRFC 5 or more times during this time period are located in urban areas.

Figure 4. CMHCs billing for PRFC between SFY 2011 and SFY 2013 (n=85)*

CMHC	Number Billed
High Plains (Rural/Frontier)	27
COMCARE (Urban)	14
JCMHC (Urban)	10
Wyandot (Urban)	10
Bert Nash (Urban)	7
FSGC (Urban)	5
Prairie View (Semi-urban/Rural)	5
Compass (Rural/Frontier)	3
Kanza (Rural)	2
CMHC of Crawford County (Semi-urban)	1
Pawnee (Frontier/Rural/Semi-urban)	1

Source: PAHP claims data provided by KDADS.

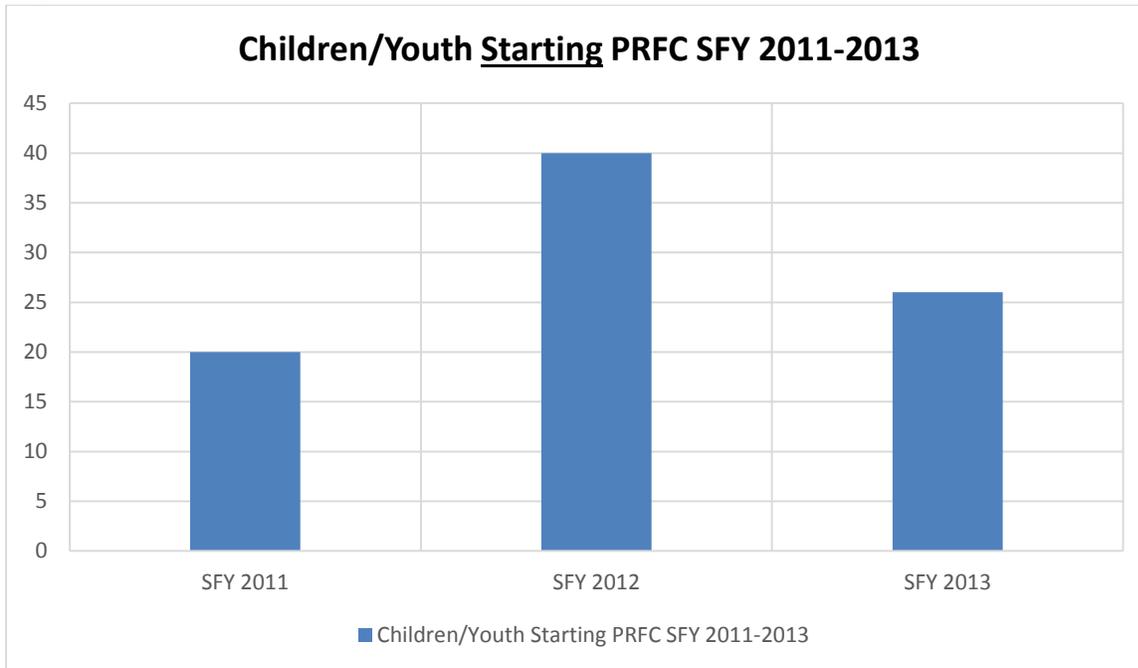
**Notes.* In addition, to the numbers listed, PRFC was billed for 1 child/youth by a non-CMHC/CPA. Classification of KDHE population density peer-groups using 2010 Population Census.

PRFC was billed for a total of 86 children/youth in SFY 2011 through SFY 2013.

The average age of children/youth served during this time was 13 years, though 42% of those served were between the ages of 14 and 16. At least five children/youth used PRFC twice during this time period. Service use data supports the CMHCs assertions of the intensity of needs among children/youth referred to PRFC. As detailed later in this report, nearly 50% of children/youth who received PRFC during this time period had a prior history of at least 1 PRTF stay. Children or youth who use PRFC have a range of diagnoses. Due to safety concerns, those with extreme aggression and sexual acting out behaviors are typically not a good fit for this service.

Service use fluctuates as illustrated in Figure 5. As will be discussed later in this report, there are a variety of factors associated with the variation in PRFC use. Lack of an open PRFC bed in close proximity to child's community or not having a PRFC provider who is a good match for the child and family are factors that may contribute to fluctuation in service use.

Figure 5. Number of Children Who Started PRFC SFY 2011, 2012, and 2013



Source: PAHP claims data provided by KDADS.

Note. This chart indicates the number of children/youth starting PRFC during each SFY, not the total number of children/youth who received PRFC during this time period. PRFC may have started during one SFY for some children/youth and ended in another SFY.

Outcomes

There are no formal, standardized outcomes currently measured for PRFC. PRFC “users” look for clinical improvements or gains on an individual basis to determine length of stay as well as whether or not PRFC has been generally successful for each child and/or family. CMHC interviewees identified a number of clinical, subjective measurements used and offered input on lessons learned from providing PRFC that seem to effect outcomes for children and families.

CMHCs who use PRFC reported difficulty in establishing standardized service outcomes and indicators due to the individualized needs and nature of the service as well as the fact that so many other services are being received during PRFC. Two interviewees noted that the nature of the situations that result in PRFC (i.e. parent is at wits end and child is on the verge of leaving the community) may distort the outcomes. In other words, children and/or families who use PRFC are at high-risk of being separated in some manner, and PRFC is generally the last effort in community-based services. Thus, poor outcomes may not be a direct reflection of PRFC, but rather, due to the dire straits that lead to the service as described by this CMHC administrator.

Outcomes have not been so great, I'm just going to say.... I don't think it's necessarily directly related with PRFC. It could be the fact that we were kind of using it as a last stitched effort to try something new that we haven't tried before...These were really high risk, difficult cases—'I don't know if I can take care of my kid anymore' kind of situations that...so that could be a poor reflection on the service because we were dealing with people that were pretty desperate.

Success is defined individually.

The caution given by interviewees when defining what a success may be for children or families who use PRFC is that success looks different and means something different for each child and family. The following comment provides an example of this sentiment: *“Well, we really like it when it helps to keep them out of the PRTF but sometimes you have to reframe what is success in the lives of these kids.”* When it comes to examples of success for children and/or their families, both “users” and “non-users” of PRFC had many similar thoughts about possible successes they have seen or would like to see. Success may be decreasing family stress or conflict, a family and/or child learning and applying skills to manage better at home, a child being able to transition home after PRFC and maintain there (hopefully with a lower level of services), reduced behaviors/symptoms, extending time between hospital admissions or crises as well as diversion from hospital or PRTF.

Service outcomes.

CMHCs reported that some of the PRFC outcomes considered (though not formally tracked at this time) include:

- Is child successfully diverted from higher level of care?
- Did child maintain in the PRFC home until a planned transition home could occur?
- Did psychiatric symptoms stabilize?
- Were hospital admissions or crisis level of care decreased?
- Is the child able to transition back to permanent home and remain stable there?

Interviewees were asked to consider specific post-PRFC outcomes for clients who received PRFC during the calendar year 2012 or more recent users if they preferred. Examples represented a wide range of outcomes including the following:

- Services decreased for children/youth, several graduated from the SED waiver
- Older youth applied to/entered college and maintained a job
- Children/youth entered DCF custody
- Children/youth gained some skills or a new perspective
- Children/youth screened for the hospital or PRTF within the same calendar year
- Parent/guardian learned and applied a new approach to working with their child
- Decrease in target behaviors for children/youth

- Children/youth chose to or ended up living with a different relative

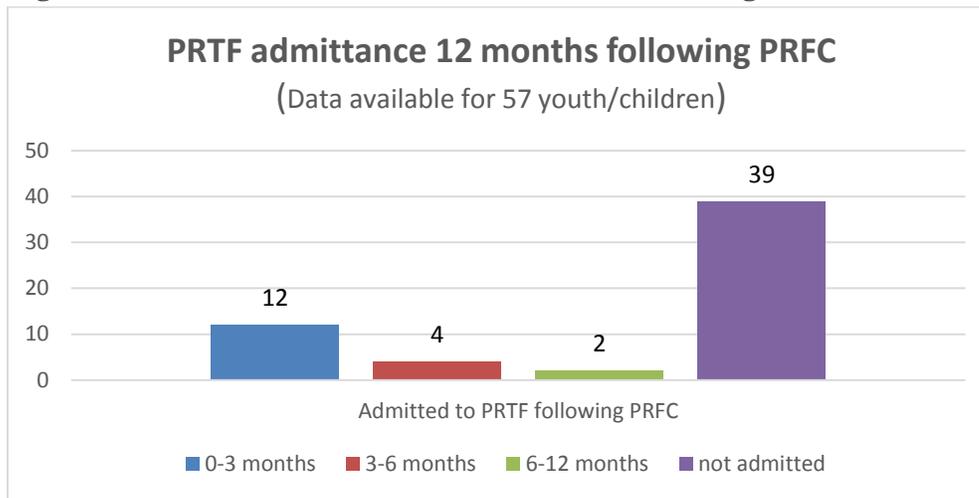
Diversion/Step-down.

As noted, CMHCs generally do not formally track how often PRFC is used to successfully divert a child/youth from PRTF, or how often PRFC is used as a planned transition from a PRTF to the community. Given the interest in PRFC as a potential diversion or step-down from a PRTF, we examined the use of PRTF among children/youth who received PRFC during SFY 2011-2013. While the data alone cannot tell us how often PRFC was used purposely as diversion or step-down, it can give us some ideas about how the service is used in this way. For example, it would seem that any child whose PRTF discharge date coincided with the same start date for PRFC was utilizing the service as a planned step-down.

PRFC was billed for a total of 86 children/youth in SFY 2011 to SFY 2013. A total of 39 children/youth (49%) who received PRFC during SFY 2011 to SFY 2013 had a history of at least one PRTF stay prior to PRFC. Furthermore, based on corresponding service dates, it appears that 11 children/youth discharged directly from the PRTF to PRFC as a step-down.

There was data available for 57 of these 86 children/youth for whom we could review whether PRTF admittance occurred during a 12 month period following PRFC. The limited data suggest there is some successful diversion and/or step-down for youth using PRFC: Only 18 (32%) of these 57 children/youth were admitted to a PRTF within the 12-months following the end of their PRFC stay. It may be important to note that the majority of those 18 children/youth (12 or 67%) entered a PRTF within 0-3 months of PRFC ending, and 10 (56%) of them had at least one PRTF stay prior to PRFC. This statistic is similar to that of Blader's (2004) study where he examined readmission rates for 109 pre-adolescents (children up to age 13) who were admitted to a psychiatric hospital during a 14 month period. In his study, 34% of children were readmitted and 81% readmissions occurred within the first 90-days post discharge. While it is possible to speculate on possible reasons for PRTF admittance within 90 days of PRFC ending, answering that specific question is beyond the scope of this study. Figure 6 provides details regarding PRTF use following PRFC for 57 of the children/youth who received PRFC during SFY 2011 to SFY 2013.

Figure 6. PRTF admittance within 12 months following PRFC



Source: PAHP claims data provided by KDADS.

Cost/Benefit.

Finally, cost/benefit is difficult to ascertain and attribute specifically to PRFC. CMHCs interviewed that contract with a licensed CPA mentioned that they do not incur additional monetary expenditures to provide PRFC through a contract. The information shared by the CMHC that operates its own CPA provides contrary information, suggesting that providing PRFC is quite costly –particularly due to recruiting, training, and supporting homes. The difference between these two viewpoints on cost indicates that the agency serving in the CPA role *may* encounter a majority of additional financial costs associated with providing PRFC. A contracting CPA may be able to provide additional information on the resources required to provide PRFC for a CMHC. It is clear from CMHC interviews that start-up costs for the CMHC pursuing the licensed CPA service model are particularly higher, if not prohibitive, for some CMHCs. Information from the interviews suggests that, at the current rates of service use and reimbursement, the provision of PRFC alone would not be enough to sustain the CMHC as a licensed CPA model.

Lessons Learned in Using PRFC

CMHCs interviewed who have utilized PRFC on a more frequent basis shared some lessons they have learned over time that contribute to PRFC success. Those lessons include the importance of keeping the child’s parent(s) engaged, helping parents understand PRFC and expectations of the service prior to initiating the service, and striving to transition the child back home as soon as possible. In addition, the following six factors were noted as contributing to the success of PRFC:

- Assessing the “fit” between the family and PRFC
- Making a good match between the family and the home
- PRFC provider qualities
- Parent involvement
- PRFC home in close geographic proximity to the child’s home
- Collaboration

Assessing the “Fit” between the Family and PRFC.

Prior to initiating PRFC, a CMHC must determine if the service “fits” for the family. Assessing the fit includes gauging the level of parent investment. Many CMHCs agreed that parents who are open to hearing suggestions and trying new things, have a connection to their child and a desire to have them at home, and are willing and able to engage in services are a good fit for PRFC. A few CMHCs spoke about the issue of teasing out what it means when a parent says he or she is “done” (i.e. if the parent/guardian(s) are unable or unwilling to engage and participate in the work of PRFC or want their child in foster care or detention). In these cases, PRFC is not a good fit.

We really have to weigh heavily like, is the family going to welcome this kid back even if they do really poorly at PRFC? And that’s the biggest consideration because we do see a lot of families like just take him...I don’t even want him. Just take and put him somewhere...And you know those parents aren’t going to co-parent at all.

Like if the family was ‘I’m done’ and what I mean is I’m really done and I’m not going to talk to them and I’m not going to call them and I’m not going to participate in anything, then we’re like yeah we need to be calling family pres or DCF or something.

A fundamental issue with pursuing PRFC when there isn’t a good fit between the situation and service is the concern about how a child will be able to transition out of PRFC and to where the child will be transitioning if home is not likely.

I’ve also had some situations where I think the parents were at a point where I wasn’t sure if they would engage and...at their high stress level, they were ready to kind of throw in the towel. And using PRFC, then it really wouldn’t be therapeutic because I don’t know what the transition would look like out of it.

Making a Good Match between the Family and the Home.

Making a good match includes determining whether there is an available PRFC provider that is a good match for the child/family. As described by one interviewee, “...they’re matching the kid, the parent to the resource family to the home.” Another CMHC staff noted why matching is imperative:

...if we know the personality of the resource home and we know the personality of the bio parent and we know that clash is going to be there, we're not even going to bring it up.

One interviewee with experience using PRFC spoke about how a good match can affect progress made during PRFC.

I do think there has been times where it wasn't a good match and it was a little more difficult to see progress...there was definitely more of an investment when they felt like they were making progress with them and there was a connection either with the kid or the family and that sort of thing.

PRFC Provider Qualities.

Interviewees provided some sense of the characteristics or abilities that a PRFC provider needs to deliver PRFC well. Some of the commonalities were that PRFC providers must have some experience with children and a basic understanding of mental health needs. They must be skilled in working with children who exhibit difficult to manage behaviors as well as collaborating respectfully with parents (some who may be distrustful, worn out, defensive, and/or be struggling with additional personal stressors).

The family providing the service needs to be well trained, understand children with SED, and also understand how to work collaboratively with...the rest of the treatment team and to connect with the family.

I guess from my perspective it's about having good quality homes that are able to provide that. One of the things that I liked about what [CPA name] did in trying to recruit more families was starting with respite first and kind of seeing, are they really good matches for these kids. Are they sound, solid families not just in terms of are they good homes but are they skilled in working with these kids...Because I'm not sure every family good or adequate at providing respite would be good in this longer-term.

Flexibility in how the service is provided (i.e. each situation may need something slightly different; being open to suggestions), as well as being willing to leave a bed open (rather than filling beds with child welfare foster placements) so that PRFC can be offered were also key characteristics mentioned.

Parent Involvement.

CMHCs spoke of the importance of a child/youth's parent(s) being involved in the PRFC service. Parental involvement increases the likelihood of generalizing changes made by both the child and family back into the home environment. One CMHC interviewee commented: *"...we learned during this year about how important the role of a parent was to stay engaged with families...and then took a more active role in making sure those connections were being maintained..."* Another states, *"...that is definitely a huge thing that is important...to have those*

parents involved and calling...” “we’ve seen better results when parents have daily contact with the resource home...I believe that’s a huge component to success, however we determine success.” At least three CMHC interviewees spoke about how they have learned to set clearer expectations for parent involvement at the beginning of the PRFC process.

I think that having gone through it, I know a little bit better how to explain it to parents... It’s not just we’re going to send your kid to a magical house far away and they come back fixed... It doesn’t work like that. So I would really emphasize how much of a big deal it is for the parents to do because they’re going to have to do most of the work to be honest.

PRFC Home within Close Geographic Proximity To Child’s Home.

Most interviewees mentioned that having access to a licensed home in close proximity to a child’s own community is central to utilizing PRFC. Several noted that the intent of PRFC is to keep a child in his or her community or minimize disruption to the child’s life. Having homes nearby helps achieve this goal whereas trying to utilize PRFC in a home that is farther away creates complications from a service delivery standpoint - including how to facilitate family work and visits, as well as school attendance. Close geographic location of PRFC homes was mentioned as important by CMHCs from both densely populated and sparsely populated areas of Kansas. Interviewees in more densely populated areas spoke more to the difficulty of getting the child to and from school whereas for interviewees from more sparsely populated areas, access to treatment services and school were both factors that made it difficult to use licensed homes that were some distance away.

...we’ve looked at others that are a little more distance, what the pros and cons of that, and sometimes that’s not a bad thing if the family is really worn out. But then when it’s time to start more of that interaction and more visits and holding the parents responsible for more of the transportation and visits and all that, then that gets a little tricky...it’s not because of a lack of willingness, but sometimes it just gets expensive for them, for transportation and coordination.

...there are sometimes barriers because the family, the biological family for that child, whether it be transportation or the distance they have to travel—they don’t have the gas money or what have you—sometimes that hinders them participating in those sessions that they should have with that PRFC family and they are meaningful times. So, you can have a really good placement but the family is not able to get there to really benefit, like I said, from actually watching it in person.

Collaboration.

PRFC involves short-term and intensive work. Therefore, parents/guardians need to be informed up-front about the level of intensity and the work that they will need to put in during

PRFC. Whether between individual team members or amongst the entire treatment team, collaboration was described as being vital to PRFC.

The collaborative nature of it is really key because it's not a service that's designed for what we lovingly refer to as foster care light. It's not a placement. It's a Medicaid service.

...they're not just going away and coming back cured. It's [PRFC] we're going away and we're all working together and then we gradually transition back home.

Those who utilize PRFC on a fairly regular basis projected that the length may average anywhere from a couple of weeks up to two months depending upon the needs and progress of the child and family. The interviewees honed in on the importance of working with both the child and the child's family intensively during PRFC, which includes increasing other services as necessary.

I would say when a kiddo is in a Professional Family Resource home, our services and the expectations on us are intensified and multiplied because it's not just a place for the kids to go for a break

We'll call them [child's parent(s)] too and go over the expectations for them because they need to know that they have to put in a lot of effort as well with family therapy and parent support. So we have to make sure they're agreeing to that.

It is not magic. It's hard work.

A couple of interviewees specifically mentioned that PRFC gives the child's parents/guardians extra support, and one commented that support for everyone involved in the service is necessary to increase teamwork. Good communication between team members is important to the success of PRFC.

Study Question 3: Does PRFC appear to be a promising community-based alternative to more restrictive treatment settings that might be replicated by other CMHCs?

This question cannot be answered fully from the current study. PRFC is being used as a community-based alternative to divert children/youth from the hospital or PRTF as well as to step some children/youth down into the community from PRTF. This study's examination of billing data provides some evidence to suggest that many children/youth who use PRFC are not using a PRTF within 12 months following the end of PRFC. However, since other community-based services are typically intensified during PRFC, attributing successful diversion solely to PRFC is not possible. Nonetheless, this correlation warrants further examination to determine how PRFC may help minimize the use of more restrictive treatment settings.

Essentially, most CMHCs who use PRFC believe it helps keep some children out of more restrictive settings. Several CMHCs noted that the service does not fit well for many children/youth but in certain situations it is useful. A number of CMHCs also referred to overnight respite care as being valuable in keeping children in the community. Overall, the PRFC outcomes mentioned by CMHCs vary, and at this time there is not enough use of PRFC to evaluate its promise as a community-based alternative to residential treatment. Multiple benefits and barriers to offering and providing PRFC exist. These are listed below along with suggestions from study participants regarding strategies that may increase the use of PRFC.

Overarching Benefit of Using PRFC

Based on interviewees' comments surrounding the intent of PRFC, it seems there is a consensus of anticipated benefits to using the service. The overarching benefit, in essence, is that the child remains in the community. This allows services to continue with a lesser amount of disruption to the child and family. PRFC is seen as beneficial for diverting from a hospital, PRTF, or some other type of removal from the home due to a child's behaviors, as well as a planned step-down from PRTF to ease the transition home. One interviewee specifically stated that "*...in the end, it keeps families together...I mean that's the huge, huge benefit is that it keeps families together.*"

...it's supposed to be like a short-term diversion. So, if kids are getting ready to either go to the hospital or for a screening for PRTF it could be used as an alternative to keep the kid in the community, give the family a break, and you know perhaps divert the child from either the PRTF or hospitalization if possible.

If we had the dream of homes in every community, we certainly would be then providing a needed service where the kiddo was not having to leave their community, was not having to leave their school, was not being disrupted from all of those things.

Additional Benefits of Using PRFC

The CMHCs "users" in this study spoke repeatedly about benefits related to delivering PRFC in a community-based, family environment with parent-to-parent interactions. Due to the fact that the child is living temporarily in another home, a break for members of the family system is inherent with PRFC. This temporary break allows for increased learning opportunities for child, family, and service providers.

...we've used it for honestly separation from the family system because it's so stressed. Changes can't be made in that environment. So splitting them up and then letting them have a breather plus learning new skills to put into play was helpful.

Different situations resulted in different benefits. While in the PRFC home, interviewees believed that many children learn and make progress. It was reported that the skills may or may not generalize back into the home environment.

We can say that yes, most of these kids make improvements in their self-regulation, their managing of themselves, improving their responsibility while they're in the placement...But we can't say really that it generalizes.

Whether or not the child's learning translated back into their own home was sometimes connected in part to whether or not the parent was involved and willing to make any changes.

...the ones that are invested are the ones that see the change. The ones...that struggle with it, I'm not sure that any change comes from it...I think for any of them it probably gives them perspective – just having your child in a different situation.

Eye-Opener.

For several interviewees, the idea that PRFC can be an “eye-opener” or give parties involved a different perspective on the situation was seen as a valuable benefit of using PRFC. Through living temporarily in another family home, the child is exposed to new experiences and new opportunities to learn about themselves (including their role in the struggles they are currently having, and what they are capable of doing or being), how other families operate, and new skills. Parents are able to hear about or observe their child's behaviors and responses in a different setting. Additionally, service providers are able to see how a child adjusts and behaves in a new environment, which can help guide their work with the child and the family. A new perspective can assist with the process of making changes for all involved.

For parents/guardians.

...it's hard to say with the grandma. She at least learned that number one, she was asking too much of the kids. She would give them a list—like ridiculous amount of chores... so she learned that number one, she was being unreasonable in that aspect. And when she was able to then have more realistic expectations, all of the sudden she saw oh, well she's not doing these chores because she's a bad kid. She was just overwhelmed and had too much on her plate. So in that way, she was able to put things into...better perspective.

We've seen the parents are better able to follow through on the recommendation, setting up structure, maybe holding the child accountable. They have more realistic expectations which is huge. A lot of times going into it they have these really high expectations that due to the kids' mental health issues they just can't...that's just not where they're at and that's probably not where they're ever going to be at.

For the CMHC.

...if we do the 21 days, 28 day placement we start to see true colors...most kids can keep it together for a week, but by that two week time...you're going to usually see the difficult behaviors come out. And that's beneficial because then you can start to address those. But a lot of times the other services you don't get that always. And so that's a difference that kind of our team has noticed is that come about the second week that they're at the PRFC placement you see more of the challenging behaviors that everybody has described.

...it gives us, as treatment providers, opportunity to see how children will...perform or behave or what their needs look like in another family setting is really different and that's been very helpful to see how they do. We've learned things.

For the child/youth.

...it was so cool because she sort of got the opportunity to see what other possibilities there are...she went to this other home she saw there are so many opportunities. You know, she's a very bright, pretty girl. She could go to college and do whatever she wants. I think for the first time she realized that. So she really took the skills to heart and she set her own goals. She's got herself involved in all kinds of different activities.

I think if anything it gives them a little perspective...when you get out of your home situation, you can appreciate it a little bit more and realize that well hey this other family is going to make me do chores and they're going to make me speak respectfully. I guess, my parents aren't quite so out there when they demand these things of me. So I think it gives a lot of perspective to say okay, it is me. It's maybe not all my parent's fault.

Relationships.

The parent-to-parent relationship provides the potential to offer suggestions in a way that may feel less judgmental than ideas given by other service providers.

...that's one of the real big benefits...because it's parent to parent. So, the parent is able to listen to another parent a lot of times, whereas you know we're...I don't know, professionals sometimes...it just feels judging. No matter how hard you try not to, it feels a little judging.

One area that improved for some families was the relationship and interactions between the child and parent(s).

I mean the benefit is that kid is successful and that dad literally learned a lot about how to not react and how to parent her in a different way. That was a very successful thing.

Another one that went really well that happened—the girl that’s graduating from the waiver now...Dad finally figured out a different way to interact with his daughter. And the dad and the mom finally figured out a different way to interact with each other.

...also, instead of always telling him ‘why don’t you ever... help me fix my truck? All normal boys would want to do that.’ Instead just saying ‘hey man, do you want to help me fix my truck or can you go hand me that wrench off the thing?’ You know, just kind of changing how they approach the kid.

Additionally, both children and parents sometimes create positive adult relationships with the PRFC provider.

I think also, we’ve had some parents who have developed relationships with the PRFC parents and there’s been some contact after everything is closed and it’s more of a natural support. I don’t think that happens a ton, but I think it’s happened. I think sometimes the kids develop a positive relationship with the PRFC parents. I think whenever that happens...That’s just one of those really positive adult relationships that what the kid learns...kind of intangibles that they learn that’s going to stay with them...

Structure.

Structure was also mentioned as an important learning tool for children and families. A few interviewees mentioned that learning to follow a consistent routine each day was helpful for some children who may not have been used to that previously.

I can remember one situation just eating dinner together as a family was huge...they hadn’t done that before. So just things that I...never even would have thought of that, but that made it completely different. And they were exposed to that...we worked on that with the family that they were transitioning back to – their own family. A lot of positive things happen with this resource.

Valuable Option

Almost all CMHCs interviewed, regardless of whether or not they are currently able to provide the service, acknowledged the value they see in having PRFC as an option for certain situations. CMHCs’ perception of the need for an increase in PRFC varied. Two “non-users” reported a definite need to increase PRFC. At least four CMHCs “users” commented on a need to increase availability of PRFC in their catchment area whereas two mentioned that PRFC is a valuable service to have as an option, but they do not necessarily see a need to increase the use in their area. This sentiment is echoed by two CMHC “non-users” who state that having PRFC available would be valuable, but they do not know the extent of the need for this service. A

couple of interviewees commented that due to the recent system changes accompanying KanCare, including reduced length of PRTF stays, being able to have increased access to PRFC may be helpful. Two CMHCs (one user and one non-user) mention that instead of a need for PRFC they see a need for increased access to overnight respite care due to the potential they believe it has to help children remain in the community.

Barriers

Barriers reported did not vary much between “users” and “non-users” or amongst rural or urban CMHCs. Interviews revealed that the major barrier to providing PRFC is having PRFC homes with open beds in close proximity to the child/family needing the service, and specifically within the CMHC catchment area. A majority of CMHC “users” reported that a PRFC bed is not generally available when needed. A couple noted that often times the availability of a PRFC bed matches the need for PRFC but not always. A few CMHCs mentioned that it is not possible to pay to hold a bed for PRFC so PRFC homes may fill possible PRFC beds with foster children. CMHC “non-users” all noted that PRFC homes are not available in their area which is why they do not use PRFC. Inability to provide PRFC close to the child’s community results in barriers such as school enrollment, the CMHC’s ability to provide continuity of services, and the family’s ability to work with a PRFC provider and/or participate actively in the service. Even urban CMHCs spoke about transportation to and from school being a challenge depending on where the PRFC home is located.

Additional barriers were mentioned such as difficulty using PRFC as a step-down due to the inability for the CMHC to bill for discharge planning and pay PRFC providers for their involvement in planning. Also, most CMHCs noted that recruiting families who are willing to provide a short-term, intensive service that involves work with the child and parent(s)/guardian is difficult. One challenge noted specifically by CMHCs “users” is finding homes that can safely care for a child with challenging behaviors such as sexual inappropriateness, aggression, and cruelty to animals. Another challenge CMHCs mentioned, as previously described in this report, is getting and keeping a child’s parent(s)/guardian engaged in PRFC. Finally, at least two CMHCs mentioned KDHE licensing regulations as a barrier to recruiting homes for PRFC.

Building Capacity to Offer/Provide PRFC

There are two CMHCs in Kansas that currently have licensed CPA programs (Cowley County and High Plains). However, only High Plains has billed for PRFC during SFY 2011-2013. The majority of CMHCs who offer PRFC do so through contracts with a licensed CPA, namely DCCCA. Though contract development involves some initial investment of time, the majority of CMHCs we interviewed regarded contracting as a more feasible means of offering PRFC compared to becoming a licensed CPA. It should be noted that High Plains received a

three-year grant that supported the policy, procedure, and resource development required to become a licensed CPA.

Creating a licensed CPA program within the CMHC requires start-up costs, mainly administrative staff time, to learn about the licensing requirements, develop policies and procedures, complete training necessary for operating a CPA, and hire new staff as needed. Once a CPA is licensed, developing and overseeing licensed family foster homes requires ongoing recruitment, training, and support. For a CMHC to contract with a licensed CPA, start-up requires administrative staff time to seek out and establish a collaborative working partnership with an existing CPA.

CMHCs interviewed in this study describe their experience with both models. Several mention that they had previously explored becoming a licensed CPA and determined that this method of delivery was not a good fit for their CMHC. A few mentioned specifically that the financial cost associated with developing a CPA program makes the venture unfeasible for them. CMHCs who decided contracting was a better fit for their CMHC spoke about the process they undertook in contracting with an existing licensed CPA. Several interviewees who currently contract with a CPA to provide PRFC shared that, following the addition of PRFC to the SED waiver, they attempted to contract with at least one CPA (some more than one) and were unsuccessful. Two CMHCs mentioned experiences contracting with CPAs to develop PRFC providers and then having those licensed homes filled with foster children so that the homes were no longer available for PRFC.

We have contracted both with [CPA name] and with [CPA name]. The one and only home that we were successful in using was a [CPA name] home. That really had been a more promising contract. We had, in the beginning we had a group of families from [CPA name] that were licensed foster homes who came and completed some in person training with us. I think we had five or six homes who went and went through a day long training with us. Then, of that group of five or six, this one home is the only one that ever followed through and went through the online training and the couple other hoops that they had to jump through.

We identified a staff member actually that was interested in becoming a provider. This is a staff member that didn't have a caseload. So we really worked around conflict of interest there...She and her family went through all of the training and all of the requirements to become a foster home. We used the service one time and the contracting agency then quickly filled up her beds with their children.

A few CMHCs with previous attempts or experiences contracting prior to their current contract noted “trust,” “respect,” and “partnership” as being important to their current contracting relationship.

...we're very much I think on the same page in terms of what is helpful for kids, what's not helpful for kids. Things like...how kids should be treated in a respite home or PRFC home, the expectations around that...not just philosophically but in a practical...What do we expect from each other? What should we expect from each other? Because it was very much in sync and it made the partnership work and it continues to be a great partnership because there is a mutual respect.

One of the key differences in the methods of delivery is that a CMHC who operates a licensed CPA recruits, trains, and supports their own sponsored homes. This gives them an opportunity to develop a relationship with the PRFC providers. In a contracting relationship, the licensed CPA recruits, trains, and supports the licensed homes; therefore, the CMHC does not necessarily have a relationship or in-depth knowledge about the PRFC providers. Some interviewees suggested that, over time they have become familiar with some of the providers and have a better understanding of those resources.

Additional Resources.

There are additional resources necessary to providing PRFC in addition to the aforementioned foundational components. CMHC staff time is required to manage the added level of collaboration and planning involved with accessing licensed homes through a CPA. Though expended monetary resources may look different for a CMHC who contracts with a CPA, some party assumes financial costs associated with recruiting, training and supporting licensed family foster homes. One example of these costs is the need to employ clinical-level staff to support PRFC homes. A contracting CPA may be able to provide valuable information on the resources required to provide PRFC for a CMHC.

Study Participants' Suggestions for Increasing and Improving PRFC Use

A variety of suggestions were given by study participants for how the State can assist with increasing use of PRFC. Those suggestions include the following:

- Allow billing for discharge planning so that the need and fit for PRFC can be assessed by CMHCs prior to PRFC discharge and PRFC providers can be paid for their time in the planning process.
- Consider increasing the daily rate of reimbursement. This may increase the availability of PRFC by allowing PRFC providers to stay at home rather than work another job outside of the home.
- Explore different KDHE licensing regulations for PRFC providers since the service is short-term and the child's parent retains custody; expedite the licensing process for PRFC providers.
- Develop state contracts with existing child placing agencies (CPAs) that pay to reserve beds specifically for PRFC.
- Provide adequate start-up funds to cover the costs of CMHCs creating own CPA.

- Open the family therapy code to include parent management training. This would allow for increased ability to work on sustainable family system changes.
- Create a how-to guide for CMHCs who have not provided PRFC.

V. CONCLUSION & RECOMMENDATIONS

PRFC is unique compared to other SED waiver services because it provides for a short-term, intensive stay in a licensed home setting and includes a co-parenting component between the child’s parents and PRFC providers. These unique features not only define PRFC but also are the factors that lead to its benefits for children, parents and CMHCs, as well as the challenges in providing this service. PRFC is being used as a treatment service for diversion/step-down from more restrictive levels of care in Kansas. However, only a handful of CMHCs are billing for PRFC on a regular basis (i.e. several times a year), and this level of utilization links directly to the identified challenge of having access to open beds in licensed homes where there are specially trained and skilled PRFC providers willing and able to provide PRFC. To date there is not enough use of PRFC to ascertain the extent to which PRFC can be used to keep children in community rather than in more restrictive levels of care. Additionally, due to the nature of the situations that generally prompt PRFC, individual outcomes for PRFC vary. The CMHCs interviewed indicate that PRFC is a valuable community-based service option to more restrictive levels of care but PRFC is not a suitable service for all situations. Rather, using PRFC requires a good match between the situation, child, family, and PRFC provider so that short-term, intensive work can occur. Engaging parent(s)/guardian(s) in the PRFC service reportedly impacts the child and family’s success during and post-PRFC. This particular aspect, engaging parents, is difficult – particularly in situations where there is low parental investment related to the child/youth returning home following PRFC. Several CMHCs noted that they would like to increase the availability of overnight respite care providers (i.e. licensed foster homes) in their area because respite is valuable community-based alternative that meets the needs of a larger population of children/families than PRFC.

Recommendations

A consistent finding across the interviews indicated that PRFC could and would be used more frequently if it were more readily available. The lack of PRFC homes that are in close proximity to the child’s community with the skill set, flexibility, and/or an open bed is the primary barrier to providing PRFC. There is an *overarching need to recruit and retain skilled PRFC providers*. It should be noted that there is an overall shortage of licensed foster homes in Kansas which adds to the challenge of increasing the number of providers of PRFC and overnight respite for children with serious emotional disturbances. Findings from this study indicate that not all foster parents are suited or willing to provide PRFC. Identifying common provider characteristics and the necessary skill sets for providing PRFC may inform targeted recruitment and training of PRFC providers. Recruitment and retention of these skilled providers

will be imperative to enhancing the system capacity to deliver this service. Ideally, partnering with CPAs who currently sponsor PRFC homes and CMHCs on research and development activities would facilitate recruitment and retention of resource homes to provide children's mental health services.

Recommendations for increasing the use of resource homes as a community-based alternative to more restrictive treatment settings include:

- Create a systems-level advisory committee that examines barriers and possible solutions to providing PRFC as a planned community-based alternative to more restrictive treatment.
- Interview a contracting CPA to learn more about their role in utilizing PRFC as well as perceived benefits and barriers.
- Interview parents of children who have used PRFC to learn about their perspective on the benefits and challenges of using PRFC.
- Further "professionalize" the PRFC service. In order to attract skilled individuals to provide PRFC consistently, this may include compensating PRFC providers for training time and for days that there is no PRFC child/youth in the resource home (i.e. paying to hold a bed for PRFC) such as Missouri has done.
- Provide training to PRFC providers that is specific to co-parenting/parent engagement. There is currently no co-parenting model or co-parenting specific pre-service training.
- Compile a listing of specific PRFC home characteristics (including strengths/skill sets and family composition) and options for placement (i.e. home can only take children of a particular sex) that can be provided to CMHC treatment teams. Having that information available may enhance the treatment teams' ability to recognize potential "good fits" for the service in a planned fashion.
- Disseminate information to child/family service providers statewide on what PRFC is and how it is being used currently to inform expanded development of the service.
- Review evidence-informed recruitment and retention strategies that can be adapted and/or applied to recruiting skilled resource home providers.
- Create a shared funding mechanism that channels the financial resources needed to support the development of a network of providers/resource homes (i.e. incentive payments for referring potential professional parents who complete the licensure process; funds to support home repairs to meet licensing standards; support for CMHCs interested in becoming a CPA).
- Create a state or regional-level position with ongoing responsibility for assisting CMHCs in targeted community resource development.
- Develop measures to formally track when PRFC is utilized as a diversion or step-down from higher levels of care as well as longer term outcomes.
- Consider allowing CMHCs to bill for discharge services to facilitate a coordinated and planned transition from a PRTF to PRFC.

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APPENDIX B: INTERVIEW PROTOCOLS FOR PRFC “USERS”

Service System Interview Protocol [Community-Based Service (CBS) Directors]

1. What is Professional Resource Family Care (PRFC)?
 - a. What are the core components of PRFC (esp. expectations for “professional” parents)?
 - b. What makes it different from other waiver services offered in Kansas?
2. When is PRFC used?
 - a. What types of situations may prompt a PRFC referral?
 - b. What factors and/or client characteristics seem to fit well with this service?
3. How long has your CMHC been offering PRFC, and how is it delivered?
 - a. Has the service and its use at your CMHC evolved over time?
 - b. Do you provide the service through contracting or as a CPA?
 - c. Where are the PRFC providers you use located?
4. What is typical service use and outcomes?
 - a. Is there a typical length of service?
 - b. Are outcomes measured for this service?
 - c. How do you define success?
 - d. Do the clients and families who have used this service provide feedback? What do they say?
6. What are the benefits and challenges to using PRFC?
 - a. Have you found barriers to service delivery and if so, what are those barriers?
7. What resources does it take to provide this service (monetary and other)?
8. How could PRFC be used by your CMHC?
 - a. What is the need for PRFC in your area?
 - b. What would it take to increase the use of this service?
9. Is this service the most effective for crisis stabilization or are other waiver services viewed as effective when it comes to crisis stabilization (or diversion from higher levels of care)?

Service Utilization Interview Protocol [CBS Directors and/or Service-level Staff]

1. Why did the PRFC referral originate and how? (e.g. CMHC staff, parent, MCO, PRTF staff)
2. Describe the child’s family participation/engagement in the service?
 - a. Was participation monitored in some way? (how?)
 - b. Was progress of the child or family monitored in some way? (how?)
3. Describe the PRFC provider’s participation/engagement in the service?

4. Did the child learn new skills during PRFC? Were those applied at visits or following discharge?
5. Did the child's parent learn new skills during PRFC? Were those applied at visits or following discharge?
6. Talk about the timeframe of the service
 - a. Duration, any extensions or early termination
 - b. Did it seem to fit the needs of the child/family?
7. Was there PRTF usage in 12 month period prior to PRFC or 12 month period following PRFC?
8. What was the child's custody status (parent/guardian, DCF, JJA, IL, other) 12 months prior to PRFC and 12 month following PRFC?
9. What other services were utilized by the child/family during PRFC?
10. What happened to this child/family post-PRFC? (child or parent improvements/gains, same, worse)?

APPENDIX C: INTERVIEW PROTOCOL FOR PRFC “NON-USERS”

Service System Interview Protocol [Community-Based Service (CBS) Directors]

1. What is Professional Resource Family Care (PRFC)?
 - a. What are the core components of PRFC?
 - b. What makes PRFC different from other waiver services offered in Kansas?
2. Has your CMHC ever offered PRFC?
 - a. If so, did you contract or are you a licensed CPA?
 - b. If not, why?
3. What are the reasons that PRFC is not currently provided in your area?
 - a. Is there a need for PRFC in your area (for whom? extent of need)?
 - b. Have you found barriers to service delivery and if so, what are those barriers?
4. What would it take to offer/increase the use of this service?
5. If you were able to offer PRFC, what how would success be defined?
6. Do you currently use other waiver services for crisis stabilization (or diversion from higher levels of care)? Which service(s) do you find most effective?