**SCOPE OF SERVICE:**

**Qualified Residential Treatment Programs (QRTP)** are a specific category of a congregate care setting, for which agencies must meet detailed assessment, case planning, documentation, judicial determination and ongoing review and permanency hearing requirements for a child to be placed in and continue to receive title IV-E FCMP's for the placement. The facility must also meet the definition of a CCI at sections 472(c)(2)(A) and (C) of the Social Security Act, including that it must be licensed (in accordance with section 471(a)(10) of the Act and that criminal record and child abuse and neglect registry checks must be completed in accordance with section 471(a)(20)(D) of the Social Security Act.

**HISTORY OF THE AGENCY**

1. The Division of Family and Children's Services (DFCS) was designated by the Mississippi Legislature as the licensing authority for the Department of Human Services on July 1, 2000.

2. In March 2004, the Olivia Y. lawsuit was filed against Mississippi, MDHS, and DFCS. This case alleged that Mississippi's foster care system was failing to adequately protect and provide services to children in its custody. The Olivia Y. lawsuit is still ongoing, and the Mississippi Department of Child Protection Services (MDCPS) is now the defendant. As this litigation is ongoing, these licensure standards may be impacted.

3. On May 13, 2016, the legislature created MDCPS, and authorized MDCPS to carry out various duties and responsibilities of DFCS including the licensing of family foster homes, child-caring agencies, and child-placing agencies.

4. On July 1, 2023, MDCPS became a standalone agency. The Mississippi legislature has declared that MDCPS shall be the licensing authority for foster family homes, child-caring agencies, and child-placing agencies.

**MDCPS LICENSURE REQUIREMENTS:**

All Offerors offering placement services under the Traditional and/or Therapeutic Group Home Contract will require a current license(s) by MDCPS. All Offerors shall meet all requirements contained in Licensing Requirements for Residential Child Caring Agencies and Child Placing Agencies (Licensing Standards). The Licensing Standards can be accessed online at https://www.mdcps.ms.gov/mdcps-policy. Offerors must acknowledge acceptance and compliance with licensing standards by signing the Licensing Requirements for Residential Child Caring Agencies and Child Placing Agencies (Licensing Standards). If the Offeror is not yet licensed by MDCPS, proof of application may be

submitted in conjunction with the response to this Request for Qualifications. If a contract is awarded, the Offeror must be fully licensed by MDCPS within one hundred twenty (120) days of the award date, or the contract will be subject to immediate termination. No children will be placed with the Offeror under this contract until the Offeror is fully licensed. If an Offeror offers multiple placement service types, they will be expected to meet all licensing standards for each of the placement types as outlined in the Licensing Requirements.

**GENERAL QRTP REQUIREMENTS:**

*A.* Partner Provider must meet or exceed all standards prescribed within these and other applicable policies to receive and maintain licensure *(full Congregate Care and Child Placing Agencies Standards attached)*.

B. Mississippi Qualified Residential Treatment Programs must meet additional requirements above and beyond the requirements for MDCPS Therapeutic Group Home Licensure.

C. Partner Provider must be licensed by MDCPS to receive a referral of any child/ren in MDCPS custody and accept referral from all 82 Mississippi Counties.

D. The maximum bed capacity of each Group Home is: Ten (10) beds per home.

E. The required staff to youth ratio shall be: Two (2) staff members must be on site at all times.

F. Partner Provider's ability to ensure that each youth receives an Initial Safety/Risk Assessment within 24 hours of admission.

G. Partner Provider shall submit a written monthly summary for each child that describes any progress and/or lack thereof according to Individual Service Plan and Risk Assessment. The monthly summary shall also include any updates regarding medical appointments, medication, education, therapy, overall functioning within current setting and identified plans for anticipated discharge. All monthly summaries shall be submitted by the 5th day of each month to the MDCPS Therapeutic Placement Unit at TherapeuticPlacement@mdcps.ms.gov as well as to the identified MDCPS Specialist.

H. Partner Provider's ability to ensure that each youth receives a comprehensive initial assessment and individual service plan to be performed by a fully licensed mental health professional within 14 days of admission.

I. Partner Provider must describe its geographic service capacity, population age range and gender population.

J. Children and youth ages ten (10) to twenty (20) in foster care that have been assessed and deemed appropriate for this level of care.

K. No child under ten (10) years of age may be placed in a congregate care setting, including group homes and intake and assessment centers/emergency shelters, unless:
    a. The child has exceptional needs that cannot be met in a relative or foster family home, or the child is a member of a sibling group; and
    b. The appropriate MDCPS Assistant Deputy Commissioner has provided written approval for the congregate care placement.
    c. Sibling groups in which one or more of the siblings are under the age of ten (10) must not be placed in a congregate care setting for more than sixty (60) days.

L. A qualified and independent individual must conduct a comprehensive assessment of a child placed in a QRTP within thirty (30) days of the placement start date (section 475A(c)(1)(A) of the Act). The qualified individual may conduct this assessment prior to the placement in the QRTP but must complete it no later than the end of the 30-day period.

M. Within sixty (60) days of a foster youth's placement in a QRTP, a court review must take place to approve or disapprove the placement. The Court will consider the 30-day assessment and determine whether the needs of the youth can be met through placement in a foster family home or whether the QRTP provides the most effective and appropriate level of care for the youth, as specified in the permanency plan for the youth.

N. A QRTP placement must be reviewed by the MDCPS Commissioner and the United States Department Health and Human Services Secretary if a foster youth fourteen (14) years of age or older has been placed in a QRTP for twelve (12) consecutive months or eighteen (18) non-consecutive months.

O. A QRTP placement must be reviewed by the MDCPS Commissioner and the United States Department Health and Human Services Secretary if a title IV-E agency places a child in a QRTP for more than twelve (12) consecutive months, or eighteen (18) non-consecutive months, or, in the case of a child who has not attained age thirteen (13), for more than six (6) consecutive or non-consecutive months, the title IV-E agency must submit to HHS:
        i. The most recent versions of the evidence and documentation submitted for the most recent status review or permanency hearing.
        ii. The signed approval of the head of the title IV-E agency for the continued placement of the child in that setting (section 475A(c)(5) of the Social Security Act).

P. A QRTP shall be licensed and nationally accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Council on Accreditation, or others approved by the Secretary.

Q. A QRTP shall have an approved trauma informed approach applicable to the population of youth being served in which all employees, volunteers, interns, and independent contractors within a QRTP must be trained in that trauma informed approach. MDCPS has identified Trust-Based Relational Intervention (TBRI) as its trauma informed approach of choice. Any other model must be deemed evidenced based according to the Family First Prevention Services Act Clearinghouse and approved by MDCPS. In addition, organizations shall have a trauma informed treatment model that addresses services of youth's and family's clinical needs.

*R*. QRTPs will be required to have nursing and clinical staff accessible in person, virtual or via telephone 24/7. These staff can be contract staff who can come on-site at any time if the child's needs warrant face-to-face interaction from these staff.

S. QRTP's should facilitate and document family participation in the child's treatment with consideration for the child/youth's safety and development needs. The treatment should be family driven with both the family and the child included in all aspects of care (when in the best interest of the child). Documentation of family involvement shall include:

T. Facilitation of regular contact between the child and family including siblings and all attempts to do so;

U. Ways in which family was actively involved and any support provided to the family of youth in residential treatment program;

V. Plans to provide outreach and six (6) months of aftercare support for the child and the family must be documented and maintained in the youth's case file; (services may be provided directly or via partnerships with providers in close proximity to youth's home);

    i. The provider will continue to document at least monthly for six (6) months verifying aftercare support services to be kept in youth's file.

W. Any outreach with any known biological family and fictive kin of the child, how this outreach is made, and maintain contact information for any known biological family and fictive kin of the child.

X. Partner Provider must agree to bi-annual performance based congregate care scorecard reviews for all congregate care settings excluding (see attached).

**MDCPS CONTINUUM OF CARE:**

A. Partner Provider must agree to be an active participant in the MDCPS Continuum of Care:
    - The MDCPS Continuum of Care (CoC) serves as a network of partnering agencies that work collectively to ensure that children are protected and are provided with a wide range of family centered services that meet their needs at any level of involvement with the child protection system. Ultimately, the CoC network of partner providers spans the entire spectrum of child protection services to include prevention services, medical and legal supports, licensed foster homes and residential treatment settings.
    - When out of home placements have been deemed in the best interest of the child, the CoC ensures that children and youth are provided with quality therapeutic foster homes that are safe, licensed, child and family centered and trauma informed. Moreover, the CoC-purpose is to establish and maintain a robust statewide partnership consisting of organizations that serve children and youth in foster care that are committed to significantly decreasing overall placement disruptions, reducing congregate care placements and achieving permanency.
    - As a part of the Continuum of Care, each partnering agency commits to its designated service role (according to contract) within the CoC and is required to engage in evidenced based practices that promote physical and psychological safety, shared parenting, a culture of trauma awareness, and actively collaborate with MDCPS regarding youth admissions and discharge transitions. In addition, CoC members agree to work diligently to ensure that youth are not denied admission and/or discharge based upon agreed contract criteria. Ultimately, CoC members actively coordinate with MDCPS and other members of the CoC regarding referrals, admissions, discharges, placement transitions and aftercare recommendations/services.
    - The Continuum of Care statewide partnership is comprised of dedicated organizations that serve children and youth in the following settings:
        - Intake and Assessment Center
        - Traditional Group Home
        - Therapeutic Group Home
        - Qualified Residential Treatment Program (QRTP)

- Supervised Independent Living
- Teen Maternity Home
- Specialized Group Care for Minor Victims of Human (Sex) Trafficking (SGC)
- **Traditional Foster Care*
- **Therapeutic Foster Care*
- **Adoption*
    - **Serves as the least restrictive environment and a priority goal for permanency.*

**TRAINING REQUIREMENTS:**

A. Partner Provider must agree to implement MDCPS approved treatment modality trainings employees:

1. **Trust-Based Relational Intervention (TBRI) -**
    - Trust Based Relational Intervention® (TBRI®) is an evidence-based parenting and intervention model designed for children who have experienced relationship-based traumas developed by Dr. Karyn Purvis and Dr. David Cross at the Karyn Purvis Institute of Child Development (KPICD) at Texas Christian University (TCU). TBRI has been built on a solid foundation of neuropsychological theory and research, tempered by humanitarian principles.

2. **Crisis Prevention and Intervention (CPI) –**
    - CPI training utilizes an evidence-based mode non-violent crisis intervention/verbal de-escalation model that prepares your staff to prevent and de-escalate medium to high-risk behavior using both a trauma-informed approach to restrictive and non-restrictive methods.

B. Partner Provider must describe its ability to establish and maintain a trauma-informed care environment to include trauma specific training for employees, youth and volunteers.

**ADMISSION REQUIREMENTS:**

A. The Partner Provider must have a written admission policy or procedures outlining the admissions process to include capacity to provide support to MDCPS in locating appropriate homes for youth placement twenty-four (24) hours – seven days per week to include holidays and weekends; to include provider's 24 hour on-call process for emergency admissions.

B. The Partner Provider must describe its history and current capacity to serve youth in foster care that have experienced complex trauma often manifested by high-risk behaviors such as elopements, verbal outbursts, physical intimidation and/or aggression, self-harm histories, poor school attendance/grades, etc. This description must also include any outcomes of current utilization of evidenced-based intervention models.

C. Denials for admission based upon past behaviors not involving acts of physical violence and/or acts of sexual aggression shall be considered a violation of contract agreement.

D. The Partner Provider must outline its referral process and ability to accept referrals for admission twenty-four (24) hours a day and seven (7) days a week.

E. The Partner Provider must provide written justification for the denial of admission within 24 hours, and it will be reviewed to determine if the reasons meet the terms of MDCPS's policy and agreed upon contract. Written justification may be provided by the provider's licensed clinician and/or licensed medical professional (psychiatrist/psychiatric nurse practitioner).

**DISCHARGE REQUIREMENTS:**

A. The Partner Provider must have and follow written policies and procedures for discharge that include coordinating child and family team meetings targeting the preservation of placement in advance of discharge. Providers shall also submit a discharge summary to MDCPS at least 14 days in advance of discharge (within 7 days in the event of emergency discharge). All discharges must be based upon the clinical justifications of a fully licensed mental health professional (LCSW, LPC, LMFT, Psychiatric Nurse Practitioner, Psychologist, Psychiatrist).

B. The Partner Provider must have a clearly defined written policy and procedure regarding denial of admission from a facility. All denials for admission must be based upon the clinical justifications of a fully licensed mental health professional (LCSW, LPC, LMFT, Psychiatric Nurse Practitioner, Psychologist, Psychiatrist).

C. The Partner Provider are encouraged to interview any child via in person/remote within a reasonable timeframe to assist youth with a comfortable transition and pre-welcome.

D. If a youth is sent to a higher level of care such as acute care and is ready to be released, the provider must re-admit the youth provided:

   1. The youth continues to meet the provider criteria;

   2. The acute care facility recommends return to the provider and returning to the provider is in the best interest of the youth; and

   3. While the youth is in a higher level of care, the provider shall continue to receive board payments for up to fourteen (14) days as a placement holder. If the provider does not allow the youth to return, such board payments shall be forfeited.

E. The youth may not be released from the provider's care until suitable placement is obtained unless the youth presents as an immediate danger to self or others or other safety issues are present. If the youth does not present as an immediate danger, the provider must establish a written safety plan and safety contract with the youth. Examples of immediate danger may include:

   1. Refusal to relinquish access to a weapon.
   2. Repeated acts of physical violence toward others.
   3. Active suicidal and/or homicidal attempts that cannot be managed safely.

F. The Partner Provider's therapeutic program is expected to establish a safety plan to address the needs of the youth while awaiting discharge. Reasons for all denials and discharges must be sent to the MDCPS Coordinated Care Department's email address at Therapeutic.Placement@mdcps.ms.gov.

G. The Partner Provider must provide written justification for the denial of discharge, and it will be reviewed to determine if the reasons meet the terms of MDCPS's policy. Written justification may be provided by the provider's licensed clinician and/or licensed medical professional

(psychiatrist/psychiatric nurse practitioner). When the discharge request is approved, the Provider will receive a Discharge Memo from the Coordinated Care Department within five (5) business days of the date of discharge indicated.

H. The Partner Provider may not discharge youth prematurely without providing MDCPS with 14 calendar days' notice, in writing by a fully licensed mental health professional (LCSW, LPC, LMFT, Psychiatric Nurse Practitioner, Psychologist, Psychiatrist). The provider shall assist with ensuring appropriate assessments and/or evaluations are completed to determine the level of care needed for the youth.

I. The Partner Provider shall provide MDCPS with a comprehensive discharge plan to include clinical recommendations. The Partner Provider shall also work, collaboratively, with MDCPS in securing appropriate aftercare services and/or placement.

J. The Partner Provider must maintain the youth under close supervision according to the mutually developed and agreed upon safety plan until an appropriate placement is found and the transfer is complete - unless the safety and well-being of the youth are compromised.

K. A youth who is sent to a detention center may be dismissed from the Partner Provider if there are charges that result in the youth being sent to the training school, there is incarceration, a need for acute care, or the youth continues to be a danger to self or others.

- This dismissal must be justified by court order or via a written recommendation of a psychiatrist, psychiatric nurse practitioner, licensed psychologist or other licensed clinical staff.

- The provider must assist MDCPS with placing the youth in an acute care facility, a congregate care treatment center, or other appropriate placement by making placement recommendations when appropriate.

L. Youth may not be discharged due to challenging behaviors. Challenging behaviors are defined as, but not limited to, fighting, non-compliant or defiant behavior, verbal altercations and/or minor property destruction.

M. In instances of suicidal ideations/threats, the Partner Provider shall conduct a suicide assessment/screening to determine their level of risks and develop a safety plan if risk is not imminent.

**MDCPS CHILD WELFARE INFORMATION SYSTEM REQUIREMENTS:**

In 2025, MDCPS will implement its new child welfare information system ("Pathways") and will have several options for sharing data once the system is live. This document should help Partner Providers determine what is the appropriate and best way to exchange data between our agencies.

One of the driving factors for interfacing with Contributing Child Welfare Agencies (CWCA) is our obligation for CCWIS compliance with our Federal Partners. To be compliant, Providers that utilize their own management system must interface with Pathways through a 2-way integrated data exchange. CCWIS compliance prohibits double entry of data between systems. Providers that fall into this category would need to interface with an Integrated Data Exchange.

**Integrated Data Exchange Interface:**

- Provider uses their own Management System
- Provides a significant about of services for MDCPS.
- Provides MDCPS with substantial data across multiple Cases.
- MDCPS will provide onboarding services at no cost.
- Providers are responsible for interface costs from the Vendor's Management System.

Providers that do not have their own Management Systems can be provided with User Access to the Pathways system to input their relevant data directly into the system. This is possible due to single entry of data and keeps MDCPS CCWIS compliant.

**Pathways User:**

- Provides little or moderate data across multiple cases.
- MDCPS will provide onboarding services at no cost.
- Providers have no cost for this option.

Whether a Provider has their own Management System or not, all Providers will have access to the Provider Portal. This web portal will allow access to relevant case data from Pathways, give Providers the ability to manage their accounts, and submit invoices directly to the Pathways system. The Portal is designed as a support tool for Providers but is not conducive to managing significant support services or substantial data across multiple Cases. Providers with their own Management System will not want to double entry of data through the portal.

**Provider Portal – Web-Portal:**

- All Providers will have access to the browser-based Provider Portal
- Related Case data can be accessed through the Provider Portal
- Upload relevant Case documents.
- Receive notifications.
- Submit Invoices

## FY 2025 PARTNER PROVIDER BI-ANNUAL SCORECARD

## CONGREGATE CARE/CHILD PLACING AGENCIES

The MDCPS Congregate Care Partner Provider Scorecard is based on nineteen (19) performance measures. A Partner Provider's performance is ranked by quartiles that include Safety, Permanency and Well-Being. Each metric within the quartiles is expected to be at 100%. Any metric determined to be below 80% will require a corrective action plan. A total score will be established by adding all quartile metrics (Safety, Permanency, Well-Being) together and dividing them by 19.

Two (2) or more scores below 70% within the SAFETY quartile will result in a meeting between the Partner Provider's Chief Executive Officer and MDCPS to develop a feasible plan for improvement. Repeated deficiencies within a six-month timeframe may result in further plans for improvement to include loss of contract.

Ultimately, congregate care Partner Providers' scorecard performance has implications for contract renewal.

| | FY 2025 PARTNER PROVIDER BI-ANNUAL SCORECARD CONGREGATE CARE/CHILD PLACING AGENCIES | |
|---|---|---|
| | **Facility Name:** | |
| | **Date:** | |
| | **MDCPS Reviewer Name/Title** | |
| | **Overall Assessment Period Data** | |
| 1 | Total # of youth placed in setting | |
| 2 | Placement utilization rate (based upon beds used within assessment period) | |
| 3 | Total # of child records reviewed | |
| 4 | Total # of staff records reviewed | |
| 5 | Total # of correction action plans implemented | |
| 6 | Total # of corrective action plan responses submitted within the required timeframe (10 days) | |
| 7 | Total # of substantiated maltreatment incidents | |
| | **Performance Indicator by Incidence** | |
| 1 | Total # of serious incident reports | |
| 2 | Total # of unplanned discharges | |
| 3 | Total # of youth elopements | |
| 4 | Total # of medication mismanagement episodes by staff | |
| | **SAFETY** | |
| 1 | % of staff/foster parents with compliant background checks (100%) | |
| 2 | % of days when staffing ratio was maintained (100%) | |
| 3 | % of staff/foster parents meeting training requirements (100%) | |
| 4 | % of youth who did NOT experience maltreatment by staff/foster parent (100%) | |
| 5 | % of Serious Incident Reports submitted within required timeframe (100%) | |
| 6 | % of youth receiving an initial risk assessment within required timeframe (100%) | |
| | **PERMANENCY** | |
| 7 | % of youth with an initial Individual Service Plan – to include readmissions – completed within required timeframe (100%) | |
| 8 | % of youth discharged with required discharge notice (100%) | |
| 9 | % of youth engaged in sibling/family visitations (100%) | |

| | | |
|---|---|---|
| 10 | % of ISP's containing services provided to youth - including progress/lack thereof (100%) | |
| 11 | % of Family Team Meeting that included youth and MDCPS Specialist (100%) | |
| 12 | % of required visitations by Partner Provider with foster child/ren and foster parents (100%) | |
| 13 | % of foster homes licensed within 120 days (100%) | |
| **WELL-BEING** | | |
| 14 | % of youth receiving independent living skills opportunities (100% | |
| 15 | % of youth that received a comprehensive medical exam (100%) | |
| 16 | % of youth with current dental exams (100%) | |
| 17 | % of youth with current vision exam (100%) | |
| 18 | % of youth that received a comprehensive initial mental health assessment within 14 days of placement – to include readmissions (100%) | |
| 19 | % of youth that received weekly individual therapy (100%) | |
| | | |
| | **TOTAL OVERALL SCORE:** | |