



**REPORT / CHILDREN'S MENTAL HEALTH**

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# **The Residential Treatment Initiative to Prevent Parental Relinquishment: 2017 Evaluation Report**

Submitted to the Texas Health and Human Services Commission

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The University of Texas at Austin

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# 2017 Evaluation Report

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## Background

Texas has documented a significant problem with mental health access, where families of children and youth with severe emotional disturbances are unable to access intensive mental health services (Child & Family Research Institute, 2014). To access these services when private health insurance is not available or mental health benefit limits have been exceeded, families turn to the child welfare system to take conservatorship of the child or youth to access a placement within a residential treatment facility. In these circumstances, caregivers are faced with the heartbreaking choice of refusing to care for their youth and relinquishing their parental rights through a judicial process or failing to get their youth needed care. In the 83rd Texas Legislative Session, the Department of State Health Services (moved to the Health and Human Services Commission, HHSC) was provided with \$2 million for the biennium to implement a program in partnership with the Department of Family and Protective Services (DFPS). Within this program, families referred to child welfare in which investigations find no evidence of abuse, but rather caregivers are solely referred due to a lack of access to intensive mental health services, are offered placement in contracted residential treatment centers (RTC) across the state. Caregivers retain their parental rights and services are focused on supporting families in reunification following treatment. The program began placing youth in need of residential treatment in January 2014 with funding for to serve up to 10 youth at a time in residential treatment. The program gained funding to serve additional children in the 84<sup>th</sup> Legislative Session and increased program capacity to 30. The 85<sup>th</sup> Legislative Session resulted in funding for 40 youth. The program has not undergone an external evaluation to date.

## Evaluation Design

**Aim of Evaluation.** The goal of the evaluation is to document the impact of the RTC initiative on children and families in Texas. The evaluation will explore lessons learned in the initial years of this initiative and identify potential opportunities for strengthening the program. Over the next few years, the evaluation will ask the following questions:

- What are the characteristics of the youth and families served in the RTC initiative? Are there characteristics of families or placements that predict successful outcomes (e.g., reunification with family)?
- Do caregivers find the treatment provided through the program acceptable? Do they report perceptions that the child has improved following treatment?
- What percentage of youth placed on the waiting list for RTC placement are successfully served without an out-of-home placement? What are the characteristics of the family and service system that may be related to successful intervention without a RTC placement?
- What strengths and barriers do caregivers report to accessing effective mental health care within the RTC initiative?
- What strengths and barriers do center administrators report related to referral processes, treatment planning, continuity with community providers, and coordination with state agencies?
- What strengths and barriers do local mental health providers report related to eligibility assessment processes, maintenance of families on the wait list, coordination of care during placement, and continuity planning?

The goal for the current year (FY2017) is to review all available program materials and data, develop the initial evaluation plan, and conduct a qualitative review of stakeholder perceptions of the program. The following methods were utilized in the evaluation.

**Document Review.** A variety of program materials were gathered and reviewed by the evaluation team in order to fully understand the program goals, policies, processes, and communication. TIEMH evaluation staff reviewed the following:

- Current HHSC contracts with the Local Mental Health Authorities (LMHAs) and Residential Treatment Centers (RTCs)
- DFPS Investigation and Referral to DSHS Residential Treatment Center Resource Guide
- DFPS Policy Handbook for CPS
- DFPS Form 2037 Referral for DSHS Funded RTC Bed (Child Not in DFPS Conservatorship)
- Current Notice of Open Enrollment for RTCs and Program Evaluation Tool
- Senate Bill 44 Needs Assessment
- DFPS and DSHS Joint Report on Senate Bill 44 (Companion to Needs Assessment)
- 2016 Hogg Foundation Mental Health Guide
- Additional program documents, such as the Program Description for LMHAs and RTCs (in draft form), the Relinquishment Avoidance Agreement with Roles, the Referral Form and Common Application, the weekly update template, and the RTC Initiative Brochure.

**Administrative Data Analysis.** Select data was available from two HHSC administrative databases. Youth referred to the RTC initiative were tracked through a programmatic database that included information on referral, eligibility, wait list status, and RTC placement. In addition, notes made by the HHSC RTC Coordinator provide updates on the status of the youth and family. Children within the programmatic database were matched to identify information from within the HHSC public mental health database. Of the 228 youth referred to the program, 201 were matched to a registration record. However, the sample size for individual analyses varies based on the data available across the different data elements. This database includes information on the youth's gender, age, ethnicity, diagnoses, community-based services received from the LMHA, and assessment using the Child and Adolescent Needs and Strengths (CANS) scale. The CANS scale is conducted as a part of the initial eligibility process, and is repeated at least every 90 days while youth is in community-based care with the LMHA. CANS scores are not available while the youth is in residential care. These administrative databases were analyzed to describe the characteristics of youth referred to date, the outcome of the referral process, the residential placements and length of stay, services provided by the LMHA during the youth's residential stay, and LMHA services following discharge from the residential program.

**Stakeholder Interviews.** In-depth interviews were conducted with relevant stakeholders to gather information on the RTC program, the roles of key staff members, and perceptions of strengths, weaknesses, and opportunities from a variety of perspectives. Initial interviews were conducted with the HHSC RTC Coordinator, the DFPS RTC Coordinator, and a former DSHS RTC Coordinator, who had recently taken a different position. Additional interviews were conducted with a sample of individuals recruited from the list of designated liaisons at the LMHAs and contracted RTCs. While all liaisons were provided an opportunity to participate in the interviews through an invitation shared by the HHSC RTC Coordinator, TIEMH evaluators identified a subset of LMHAs and RTCs to proactively recruit for participation in the interviews. The sample was chosen to achieve variety in the geographical distribution of sites, the number of referrals from the region (for LMHAs), and the number of placements (for RTCs). LMHAs were selected that received no or low, moderate, or high referrals, and RTCs were selected that received a low, moderate or high number of placements. TIEMH evaluation staff contacted liaisons at seven RTCs and twelve LMHAs requesting their participation in a confidential phone interview to provide feedback about their experiences with the program. Interviews were semi-structured with some standard questions, but allowed for additional probes and tailoring. The interview is provided in Appendix A.

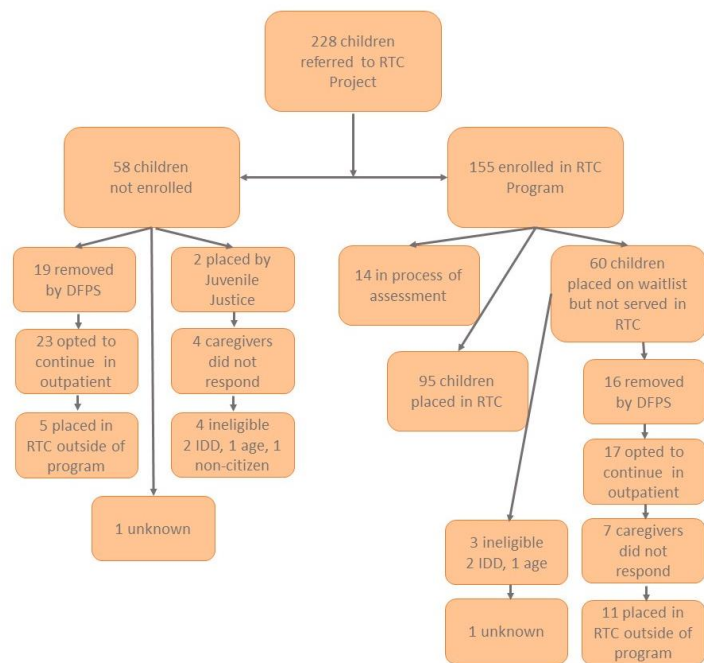
A total of 18 interviews were conducted, with all sampled RTCs ( $n=7$ ) agreeing to participate and 92% of sampled LMHAs ( $n=11$  of 12) agreeing to participating. The evaluator was unable to reach the liaison at one LMHA, after being told the identified individual was not the correct person. Another LMHA was contacted, but the LMHA liaison (Director of Children's Services) was unaware of the RTC Initiative and unfamiliar with the LMHAs role in the initiative; as a result, an interview was not conducted. Therefore, nine representatives of LMHAs and nine representatives of RTCs were interviewed, with two representatives participating at two RTCs. A request was made to also interview some relevant stakeholders within the DFPS system (e.g., case managers, intake); however, approval was not granted by the time of this report.

**Child/Youth Record Review.** The HHSC RTC Coordinator receives documentation of initial eligibility, including a recent psychological evaluation and the Common Application, treatment plans, weekly progress updates, and incident reports on youth. While using these documents to evaluate either process or outcomes was beyond the scope of the current evaluation, documents were reviewed to identify the potential use of this documentation to answer evaluation questions or to identify areas of programmatic development.

## Results: Administrative Data Analysis

**Pathway Following Referral.** Two hundred and twenty-eight children have been referred to the RTC initiative from DFPS since initiation of the program, using data captured from May 4, 2017. Youth were referred from 57 different counties, distributed throughout the state. The greatest number of referrals originated from urban areas, specifically Bexar County ( $n=31$ ), Tarrant County ( $n=23$ ), Harris County ( $n=13$ ), Dallas County ( $n=12$ ), and Travis County ( $n=10$ ). Youth referred to the program were assessed for eligibility by the LMHA and, if found eligible, initiated in community-based services while awaiting placement in the RTC. Figure 1 illustrates the flow of children following referral and the outcome at various parts of the process.

Figure 1. Pathway of Children Referred to the RTC Program



While some youth were withdrawn from the program prior to being formally enrolled and others were withdrawn while on the wait list, the distinction appeared to be more about the timing of decisions to withdraw than the eligibility of the youth; therefore, the reasons for withdrawal are aggregated across the two groups. A small number of youth were assessed following referral and found to be ineligible ( $n=7$ , 3.1%), with one family not a Texas citizen, 4 children having an IQ below 70 and necessitating services for Intellectual or Developmental Delay (IDD) services, and 2 youth nearing 18 years of age. Following referral to the RTC program, most families were engaged in intensive outpatient services, primarily within wraparound programs at the LMHAs. A proportion of families ( $n=40$ , 17.5%) reported improvement in the youth's functioning as a result of these services and opted to withdraw from the RTC program. Another proportion of youth went on to have custody removed by the DFPS ( $n=35$ , 15.4%), generally due to the caregiver's decision to move forward with relinquishment and/or immediate concern for the safety of the youth or siblings. Another subset of the youth referred to the program were placed in a residential setting outside

of the program or with another caregiver ( $n=16$ , 7.0%). In a few instances, caregivers failed to complete the required assessments or to respond to placement options ( $n=11$ , 4.8%).

At the time of this evaluation, fourteen youth referred to the program (6.1%) were in the process of enrollment and had not yet been placed on the waitlist for placement. The remainder of the youth ( $n=95$ , 41.7%) had been placed into a residential setting as a part of the RTC program. The length of stay in the RTC program for youth who have been discharged ( $n=66$ ) ranged from 5 to 495 days, with a median length of 226.5 days (7-1/2 months). In general, brief placements (<90 days) reflected disrupted episodes of care, where the youth was removed by the caregiver because of dissatisfaction or discharged by the facility for an inability to meet the youth's needs. It should be noted that the RTC Program database reflects the admission date for the latest placement, which could misrepresent the length of stay for youth who have been transferred between residential settings. The evaluation team used available notes to attempt to identify the initial placement date, but there may be some inaccuracy due to a lack of clear data.

Table 1 describes the number of children placed within each contracted residential provider. Some children were served within two residential providers over the course of care and are reflected in the chart more than once. The greatest number of youth were placed in Houston Serenity Place and Unity Children's Home, both located in Harris County. "Unknown" placements reflect very recent placements that are not fully captured in the available data; and evaluators expect the residential provider will be updated within the tracking database.

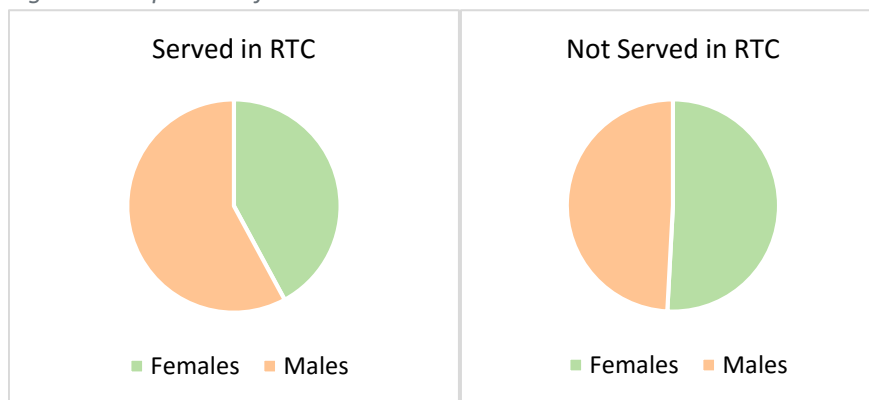
*Table 1. Placement of Youth in Residential Care*

Residential Provider	Number of Youth	Residential Provider	Number of Youth
Houston Serenity Place	23	Unity Children's Home	22
Center for Success & Independence	9	Gulf Winds RTC	8
Pegasus Schools, Inc.	6	Roy Maas Youth Alternatives	8
We Care Treatment Center	6	Krause Children's RTC	4
Everyday Life, Inc.	3	Renewed Strength, Inc.	2
Brookhaven Youth Ranch	1	Minola's Place of Texas	1
Willow Bend Center	1	Unknown	5

**Demographics of Youth.** The children referred to the RTC Program were slightly more likely to be male (52.2%) than female (46.9%). Males were more likely than females to be eventually placed in residential services. Figure 2 illustrates the gender distribution of youth receiving or not receiving residential care in the program. Children referred into the program

ranged in age from 6 to 17 years old, with a mean age of 13.1 years ( $sd=2.4$ ). The children who were served in the RTC were slightly younger than those not served in a residential center, with mean ages of 12.5 and 13.5 years, respectively. Race and ethnicity is only available on the subset of children who were represented in the state

*Figure 2. Proportion of Males and Females*



administrative data ( $n=168$ ). The youth were reported to be 19.0% Black, 8.9% Hispanic/Latino, 63.1% White, non-Hispanic, and 8.9% other. In comparison to the demographics of Texas children, Hispanic children are under-



represented in the referred group (8.9% compared to 49%) and White, non-Hispanic children are over-represented (63.1% compared to 32%).

**Diagnoses of Youth.** Information on the primary diagnoses of children referred to the RTC program were gathered from the state administrative database. Information on diagnoses is also included in the psychological assessment submitted with the referral; however this information is not currently captured in a database, therefore data from the state database was used for this summary. Data was available for 139 youth, with nine youth excluded as they have not yet completed the eligibility determination. Data is presented for those admitted to an RTC and those who were not served in an RTC.

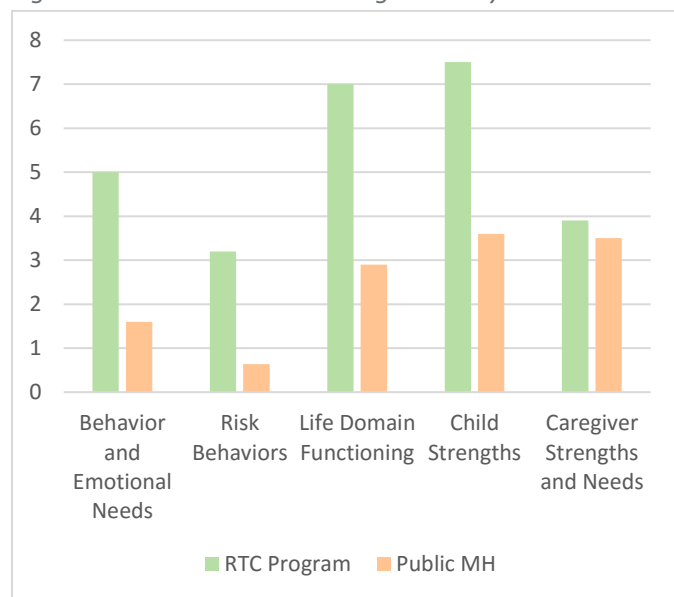
*Table 2. Category of Primary Diagnosis for Youth Referred to the RTC Program*

Diagnostic Category	Not Served in RTC	Served in RTC
Attention Deficit Disorder	6 (10.2%)	12 (16.9%)
Conduct/Oppositional Defiant Disorder	10 (16.9%)	7 (9.9%)
Bipolar Disorder	11 (18.6%)	17 (23.9%)
Major Depressive Disorder	11 (18.6%)	9 (12.7%)
Other Mood Disorder	17 (28.8%)	15 (21.1%)
PTSD/Reactive Attachment Disorder	2 (3.4%)	4 (5.6%)
Schizophrenia	0 (0%)	3 (4.2%)
Adjustment Disorder	0 (0%)	1 (1.4%)
Unknown/missing	2 (3.4%)	3 (4.2%)
Total	59	71

**Assessed Strengths and Needs of Youth and Caregivers.** Following referral from DFPS, youth are assessed for eligibility using the Child and Adolescent Strengths and Needs (CANS) assessment. As described previously, some caregivers opted to withdraw prior to the assessment process and some families have not yet completed the assessment when the administrative data was gathered. One hundred and fifty-six children

referred to the RTC program had a CANS assessment within 90 days from the referral. The average time from referral to assessment was 18.2 days, with 50% of the sample receiving an assessment within eleven days. Each CANS scale is summarized by identifying the total number of elements identified as a need to be addressed or a lack of a strength (score of 2 or 3); these are considered “actionable items” needing to be addressed within the plan of care. This summary score should be interpreted as the number of identified problem areas within each domain. The elevations of one domain should not be compared to another, as the potential number of actionable items varies across domains. The summary of elevations on each CANS scale for

*Figure 3. CANS Elevations at Program Entry*



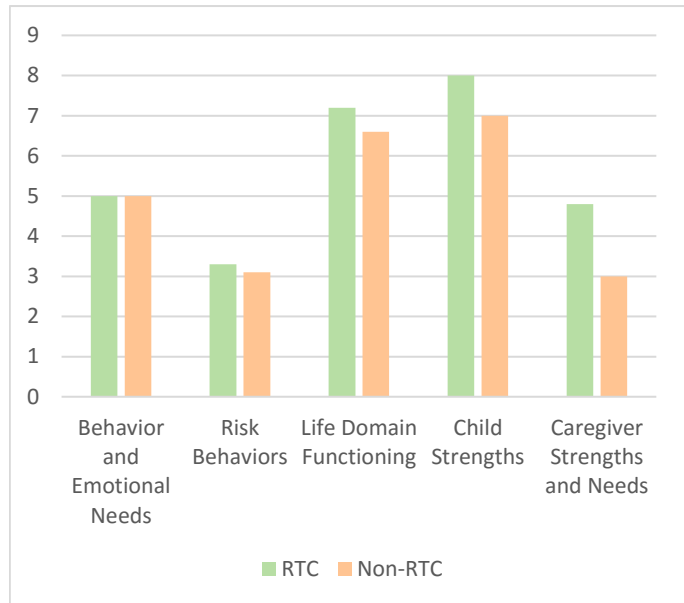
youth referred to the RTC program is shown in Figure 3, along with the comparison group of all youth served by the public mental health system in community-based services. As evidenced in the figure, the number of problematic issues is significantly higher for the youth referred to the RTC program across all of the child domains than the youth typically served in community-based mental health services. The number of actionable items for



Caregiver Strengths and Needs did not differ between the two groups ( $t=1.09$ ,  $df=133,030$ ,  $p=.28$ ), suggesting that the families of youth referred to RTC program and those seeking public mental health services were not significantly different in terms of their strengths, capacities, and needs.

The severity of needs and presence of strengths was also examined by comparing those youth who were placed in an RTC in the program and those who were discharged from the program prior to a placement. Figure 4 illustrates the CANS scale elevations for these two subgroups. Results demonstrated that the group of children eventually placed in an RTC did not differ from those who were not placed in residential care on three of the scales - Behavior and Emotional Needs, Risk Behaviors, or Life Domain Functioning. However, the children placed in an RTC had fewer identified strengths on the Child Strengths scale ( $t=2.28$ ,  $df=145$ ,  $p=.024$ ) and fewer strengths and more needs identified on the Caregiver Strengths and Needs scale ( $t=3.23$ ,  $df=145$ ,  $p=.0015$ ).

Figure 4. CANS Elevations – RTC Program Subgroups



An examination of specific items on the CANS provides additional information about the types of emotional and behavioral problems experienced by the families referred for the program. Table 3 describes the percent of youth referred to the RTC program who have experienced problematic symptoms or risk behaviors. The most common problem areas were difficulties with anger control, impulsive or hyperactive behavior, and oppositional behavior. Internalizing problems, such as depression and anxiety, were also common. The problem areas that were least likely to be reported were fire setting, substance use, and sexual aggression.

Table 3. Percent of Youth Referred to RTC Program with Problem Areas

CANS Item	% Action Needed	% Intensive Action Needed	CANS Item	% Action Needed	% Intensive Action Needed
Psychosis	18.7%	1.9%	Mania	18.2%	3.9%
Impulsive/ Hyperactivity	55.8%	24.0%	Anxiety	44.2%	4.6%
Depression	52.0%	7.1%	Adjustment to Trauma	28.6%	10.4%
Oppositional	42.9%	35.7%	Conduct	38.3%	20.1%
Anger Control	52.0%	32.5%	Substance Use	5.8%	1.3%
Eating Disturbance	9.1%	1.3%	Suicide Risk	31.4%	1.9%
Self-Mutilation	27.7%	1.3%	Other Self-Harm	36.1%	1.9%
Danger to Others	49.0%	5.2%	Social Behavior	41.6%	29.9%
Sexual Aggression	9.7%	5.2%	Running Away	14.3%	6.5%
Delinquency	14.9%	8.4%	Fire Setting	5.2%	1.3%
Bullying	21.4%	10.4%			

Note: Action Needed is CANS score of 2; Intensive Action Needed is CANS score of 3.

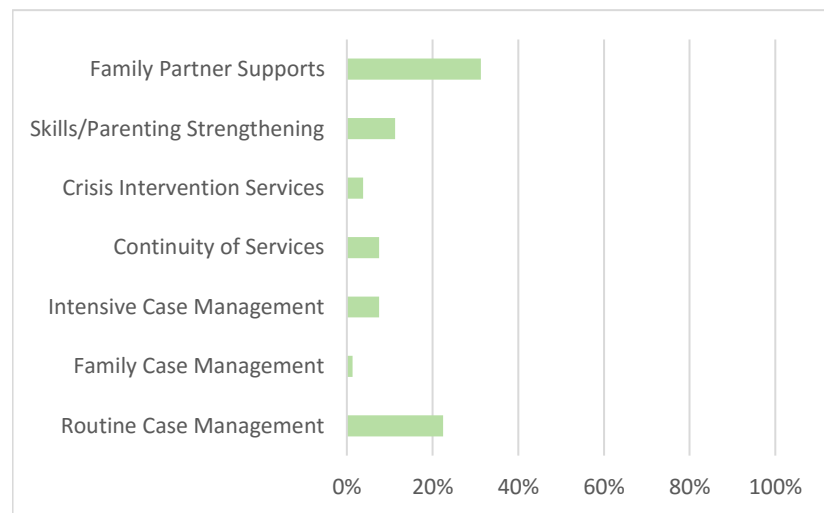
**Services Provided to Families while Youth in Residential Care.** Texas HHSC contracts with LMHAs to provide care management and family support services to build supports for the family and coordinate care while the youth is receiving residential treatment services. These services are intended to ensure that the caregivers are important partners in the care plan and are assisted in building the community supports for the youth's return to the home. Data is available on 80 of the 95 children admitted to residential care in the program; seven children did not have data because they would have been served in the NorthSTAR region and administrative data from this program was not a part of the evaluation. Analysis examined the treatment or coordination services that were provided by the LMHA during the time that they youth was admitted to the RTC. A small number of services - those focused on assessment or benefits - were excluded from the analysis. Figure 5 illustrates the percentage of families (n=80) who received at least one incidence of the service type.

The most commonly provided services were Family Partner supports and Routine Case Management. These services were provided to less than one-third and one-fourth of the families, respectively. Overall, fifty-five percent of the families whose child was served in residential care received no treatment or care management services through the LMHA.

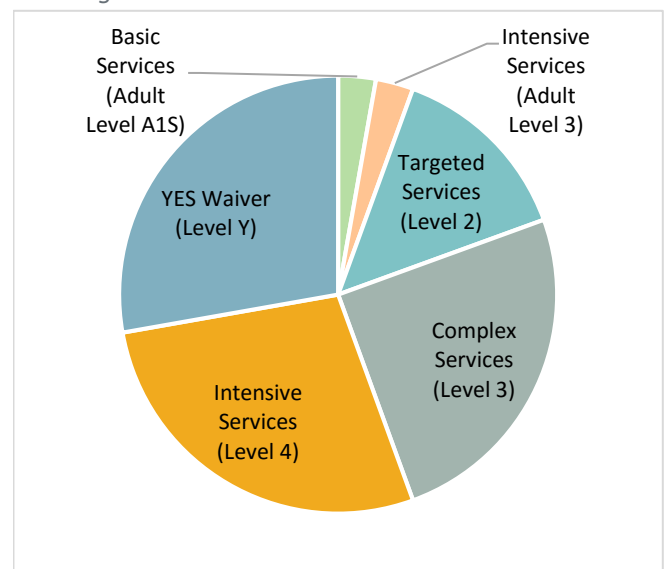
An examination of the intensity of the most common services provided shows that families receiving Routine Case Management ( $n=18$ ) received an average of 5.1 encounters ( $sd=7.1$ ) for an average total of 3.67 hours during the time their child was in RTC care. This equaled 0.48 encounters per month. For families receiving Skills Training/Family Strengthening ( $n=9$ ), families received an average of 4.9 encounters ( $sd=4.3$ ), for an average total of 4.21 hours. This represented 0.40 encounters per month. Lastly, for families receiving Family Partner services ( $n=25$ ), families received an average of 6.3 encounters ( $sd=6.6$ ) and 4.4 hours, resulting in an average of 0.88 encounters per month. Overall, the data suggests that a significant proportion of families are either not receiving or not engaging in services through the LMHA. The services that are being provided are those expected to strengthen the family's ability to transition the child home following residential care and align with the contractual expectations of HHSC.

**Outpatient Care Following Residential Services.** Data was available to examine the number of children who were served in residential care through the RTC program who received outpatient care through the

*Figure 5. Percent of Families Receiving LMHA Services during Residential Care*



*Figure 6. Level of Care Authorized for Youth following Discharge*



LMHA following discharge. Of the 87 youth with available data, 46 youth (52.9%) had not received any services within the public mental health system following their RTC discharge. The other 41 youth went on to receive care. Five youth received care more than 90 days after the discharge, two through a crisis intervention, one in Level of Care 1 (Medication Management), one in Level of Care 3 (Complex Services), and one in the adult mental health system (Basic Services). The other 36 youth (41.4%) received a service authorization within 90 days of discharge and are considered to have stepped down to outpatient care. Figure 6 illustrates the service level that was initially authorized when the youth was authorized for outpatient services. The majority of youth were discharged into wraparound programs, either within Intensive Services or the YES Waiver.

## Results: Stakeholder Interviews

**Description of Participants.** The LMHA liaisons held various roles within their organization, including two Director/Manager of Children's Services, three Team Leads/Supervisors of Wraparound, one Team Lead for Intake, one Adult Crisis Triage Specialist, one Manager of Utilization/Quality Management, one Director of Specialized Programs, and one Child/Adolescent Special Projects Coordinator (one person represented in two roles). Six liaisons described being involved with the program since it began, with the remaining three reporting less experience (i.e., 3 months, 6 months, and 1.5 years). The RTC liaisons consisted primarily of individuals in leadership or administrative roles, with four Clinic Directors, one Treatment Director, one Director of Case Management & Education, one Chief Program Officer, one Director of Daily Operations, and one therapist. The majority of respondents had three or more years of experience working directly with the program, with two individuals reporting less experience (i.e., 6 months and 1.5 years).

Additionally, state-level RTC Initiative Coordinators (past and present) from DSHS/HHSC and DFPS participated by providing historical and background information, feedback on what they'd like to learn from the evaluation, and general context to information gathered in other stakeholder interviews. Information gathered was combined across all liaison interviews and reported in a way that does not identify the individuals or organizations that participated. Results are summarized based on content area and the source of the feedback is identified as "liaison" when the information is applicable to both LMHAs and RTCs and as "LMHA liaison" and "RTC liaison" when specific to that system.

**Community Program Administration.** It is not uncommon for LMHA staff to work across many programs and have multiple roles within their agency, often referred to as "wearing many hats". For example, five of the nine LMHA liaisons also described working closely with the Youth Empowerment Services (YES) Waiver program. In two instances, the liaison duties followed staff when they moved into new roles within the LMHA (*Adult crisis specialist was formerly in child crisis unit and the UM/QM Manager was formerly the YES Waiver & RTC Initiative Manager*). In both cases, the retention of RTC Initiative responsibilities was described as a result of having knowledge and experience with the program and the small number of referrals received. Participant feedback supports the finding that LMHAs have designed local procedures and staff responsibilities for the RTC Initiative based on their local needs and resources, with limited guidance from the state and minimal consistence across LMHAs. In some cases, liaisons describe their role as being the point person for receiving referrals, coordinating assessments, engaging families into LMHA services, and providing ongoing continuity of care, aftercare coordination and support. Other liaisons had a more focused role, described receiving and coordinating referrals, with the subsequent continuity of care responsibilities transitioning to service providers, such as a case manager or supervisor. Furthermore, some LMHAs structure the RTC Initiative as a standalone program, whereas others described coordinating across all intensive service programs, including Wraparound, YES Waiver, and the RTC Initiative.

When asked questions about their level of understanding of the program, the majority of LMHA liaisons commented on the state's effort to prevent child relinquishment into state custody as the primary reason for the program. Goals of the program were described as keeping children and families connected, providing aid and support to families, and promoting family reconciliation and reunification. The majority of LMHA liaisons expressed having a good understanding of their role in the program, but were less confident in their overall understanding of other aspects of the program, such as the history, overall design, and the policies and procedures followed by other systems. In particular, the majority of LMHA liaisons expressed frustration with knowing very little about how to refer families, what the family needs in order to qualify for a referral, and the eligibility criteria beyond the clinical assessments conducted by the LMHA. Only six of the LMHA liaisons reported being aware of and familiar with the contract between the LMHA and HHSC that details responsibilities and requirements. One liaison reported that they were completely unaware of the program until the first time a referral was received, which prompted the individual to seek out the contract in order to understand the LMHA's role.

***[The RTC Program] caters to families that would otherwise have given up custody or not have been introduced to the LMHA services to begin with.***

LMHA liaisons were asked about any resource limitations related to program implementation and coordination and a minority of respondents ( $n=3$ ) indicated that the demands aren't great, and that the main effort is related to monitoring and coordinating the case management level. Other LMHA liaisons identified capacity within wraparound programs is limited, making it challenging to add families waiting for RTC placement or being discharged from the RTC to the caseloads of existing wraparound facilitators. The challenge of providing coordination and continuity of care services across a significant distance was noted, along with the need to provide these services primarily by phone. Some LMHAs also indicated that their capacity to conduct intake assessments is limited (4-6 week wait), making it a challenge to assist families with completing the clinical assessment and enrollment forms within the required time frame.

**Residential Program Administration.** The majority of the RTC liaisons reported feeling like they understood the program, however a few expressed less confidence in their knowledge. When asked to describe the program, the majority of RTC liaisons commented on the state's effort to keep families together by preventing child relinquishment into state custody and promoting reunification. Liaisons provided the following descriptions of what sets the program apart from other services:

- It exceeds what the YES Waiver can do and provides funding for those families that really need the support of an RTC;
- It serves families with an open CPS case where the caregivers are willing to work on family issues and caregivers are invested in their child's treatment;
- It requires more family involvement, whereas other DFPS referrals under conservatorship don't have much family involvement; and
- It keeps families connected to the LMHA the entire duration of treatment.

When RTC liaisons were asked about potential resource limitations related to program administration and coordination, multiple respondents described the time commitment involved in coordinating and communicating with families and the LMHAs at the frequency specified by the HHSC contract. In one instance, the liaison described the challenge of maintaining sufficient staff who are trained to work with youth at the level of intensity of those served under the program. RTC liaisons also identified the lack of available program information as a resource limitation, and the following specific needs were identified:

- Handouts or flyers with the program overview and referral information to give to families that may be in need of the program;

- Information about how the RTC Initiative referrals and families differ from referrals that come from other state agencies and programs that are also supported by the RTC; and
- Any additional training or resources specific to the program.

When asked about what was going well with the program, one RTC liaison stated that the contract with HHSC was helpful for the organization because it outlined the state's goals for the future and has helped in understanding the state's perspective on how residential care is going to look. The liaison expressed a personal shift in how she approaches residential care and reported significant progress on behalf of the agency in making changes to align with the state's vision. One liaison discussed the challenges of coaching young staff to provide care for the youth and families without judgment. She noted that the way staff interact with youth can escalate or de-escalate a situation, and the agency is striving to help staff recognize their own behaviors and their ability to positively impact the interaction.

Each RTC liaison described their process to determine whether a referred youth meets admission requirements and is a good fit for the facility. The number of staff involved in the review process varies with reports of single-person reviews, two-person reviews, three-person reviews, and reviews done by multidisciplinary teams. One liaison described including program level staff (managers and senior direct care staff) on the multidisciplinary team review process and another liaison stressed the importance of doing a pre-placement interview with families. The purpose of the pre-placement interview was to ensure that families are informed and understand that they have to agree to participate in services and be engaged in the treatment process. The liaison reported that they don't have direct access to the families and have to go through the HHSC RTC Initiative Coordinator to get permission to contact the family, so there have been times when the referrals come to a halt. The majority of RTC liaisons described the importance of thoroughly screening youth and families as a part of the admission process. It was suggested that the HHSC RTC Coordinator provide families the contact information for the facility and to inform the facility of the family's contact information directly so contact can be made and the family can have the opportunity to ask questions about the facility.

The following examples were provided as reasons to delay or deny admission:

- Incomplete forms or necessary documentation such as the Common Application, psychological assessments, academic records, medical records, and immunizations;
- IQ (most RTCs require 70 or above);
- Some RTCs require a 30-day supply of medication because the doctor only comes once a month;
- The need for a locked facility for safety reasons (not all facilities are locked);
- Facility specific admission criteria such as no current suicidal ideation or arson within the last 30 days or only accepting boys or girls of specific age ranges; and
- Determining a good fit based on current admissions. One liaison described receiving referrals for young children, ages 10-12 (licensed for ages 10-17), who they have not been able to accept due to the older youth currently residing in the center.

Once a youth is admitted to the facility, the majority of liaisons reported assistance from the case manager at the RTC to conduct weekly calls with the families and coordinate with the LMHA. Similarly, the assigned family therapist would provide the family and the case manager with weekly updates. There were a few instances where liaisons described communication between the family therapist and the LMHA liaison.

**Program Training and Support.** Liaisons identified a gap in training about the program and consistently stated that no formal training from state-level program administration has been provided on the RTC Initiative. One LMHA liaison described it as a “learn as you go” experience, while others described shadowing a supervisor or co-worker that had worked through a case already, a few reported that they were simply given the contract and tasked with “making it work.” In one case, the liaison was told that the HHSC RTC Initiative Coordinator would email them if

***What happens when the only people that know about the program leave the agency?***

something needed to be done. When asked if there were areas where training or resources would be helpful, LMHA liaisons provided several specific ideas for training, support, and programmatic clarification. Overall, RTC liaisons expressed fewer needs related to training and support. Feedback from RTC liaisons centered more around areas where programmatic clarification is desired. One RTC liaison indicated that they had struggled with a lack of clarity among staff about program requirements and responsibilities. An in-person meeting with the HHSC RTC Coordinator was described as helpful in gaining a better understanding of what was expected and providing clarity on processes. A variety of training and clarification needs were mentioned by one or more liaisons and are presented in Appendix B. In addition to identifying needs, there was a consensus among liaisons that resulted in the following recommendations for the development of online training and initiation of conference calls.

**Liaison Recommendation:** LMHA liaisons described the need for an online training opportunity that provides a general overview and introduction to the program. It was suggested that an online webinar or module be developed to include information on program history and background; rationale and goals, programmatic design, and roles and responsibilities of all involved agencies.

***I think people can do a better job when they can buy in and know why they are doing what they are doing.***

***I’d be interested in learning what other centers are working with the state on the RTC Initiative and how we could improve the connection between LMHAs and RTCs.***

**Liaison Recommendation:** Both RTC and LMHA liaisons expressed the desire to have collaborative conference calls, facilitated by the HHSC RTC Coordinator, on a quarterly or semi-annual basis. This would provide an opportunity for discussions on problem-solving and improving upon coordination efforts between the LMHAs and RTCs.

**Strengths of the RTC Program.** Liaisons were asked to identify program strengths and to describe qualities that set it apart from other programs. The responses could be categorized into three primary themes – state-level program administration, caregiver participation in treatment, and collaboration between the LMHAs and RTCs.

Liaisons had generally positive feedback about the state-level operation of the program. Liaisons emphasized how helpful it was to have a designated state contact and similar contacts as the LMHA and RTC. All liaisons indicated that the HHSC RTC Coordinator has been responsive to communications and addresses concerns and questions in a timely manner. A small proportion of liaisons mentioned that there were some challenges during the time period when the HHSC RTC Coordinator position was vacant and stressed the importance of having a consistent person in that role. A few liaisons also praised the HHSC RTC Coordinator for ensuring that families understand the intensity of services and that the goal is for the child to return to the home. The liaisons also mentioned the length of time that the youth can be treated within the RTC is a strength. RTC liaisons described the ability to collaborate with HHSC RTC Coordinator to extend stays beyond six months when the youth is making progress and the family needs more time to prepare for a successful reunification. RTC liaisons also indicated that the administrative paperwork burden is less than that required by DFPS, resulting in more time focused on the youth’s care.

***There are no other services or programs in the community that would manage a [a child with a] level of need like this.***



RTC liaisons pointed out that the most unique aspect of this program is the level of family involvement, despite the youth in the program having similar issues and challenges as other youth at the RTC. RTC liaisons described the use of Skype technology to connect with families for weekly updates, treatment planning, and family therapy. One LMHA liaison indicated “the RTC has gotten better about involving families, even though at the beginning it was kind of foreign to them”. Although the requirement of family participation is an identified strength of the program’s design, many LMHA liaisons described issues with families being unaware of the expectations for participation. These examples are discussed further under the identified challenge of engaging families.

Liaisons identified continuity of care as a characteristic that sets this program apart from other programs as well. Respondents reported that the ongoing involvement of the LMHA and coordination with the RTCs was helpful in knowing what the family’s needs were in order for the youth to return home. One RTC liaison described it as critical to have everyone on the same page working on the same goals. A LMHA liaison indicated that it was very helpful to be able to maintain a relationship with the caregiver and youth while the youth was in residential care, rather than closing the family out of services. This allows the LMHA and the caregivers the opportunity to work toward reunification and be better prepared for supporting the youth upon discharge.

**Outcomes and Factors Impacting Family Outcomes.** Liaisons reported a mix of both successes and failures in family outcomes after involvement in the RTC initiative. RTC liaisons described outcomes to be much better for this program, in comparison to other DFPS programs. The liaisons shared their insights on factors that may influence the outcomes of families, which are summarized in Table 4. RTC liaisons frequently reported that length of time in care and specific family circumstances were key factors in overall outcomes. The most frequently mentioned factor was the amount of caregiver engagement and participation at both the LMHA and RTC throughout each phase of treatment. Many RTC liaisons reported that they had little follow-up information on long-term outcomes of youth once they leave the RTC. However, a few RTC liaisons were pleased to describe instances where families continue to call to report how well they are doing and express their appreciation.

*Table 4. Liaison Perceptions of Factors Impacting Family Outcomes*

What leads to a successful reunification?	What things are most helpful to families in preparing for reunification?
<ul style="list-style-type: none"> <li>• Good communication between the LMHA &amp; RTC;</li> <li>• Caregiver involvement and engagement;</li> <li>• Caregivers that want help with the child’s behaviors versus caregiver’s that just want somebody else to “fix” their child;</li> <li>• Caregivers that have flexibility, willingness to change, and are open to working on their own issues as well versus caregiver’s that are defensive and unwilling to make changes;</li> <li>• “When the process is viewed as a family systems issue versus only the child’s issue, then the outcomes are better.”</li> <li>• Caregiver working with the family partner; and</li> <li>• Families that continue in LMHA services, such as wraparound or YES Waiver, do better for longer periods of time.</li> </ul>	<ul style="list-style-type: none"> <li>• Caregivers having enough information from the beginning to understand the goal of the program is reunification;</li> <li>• Participation in family therapy sessions and weekly meetings in order to have a constant reminder of treatment progress, goals, and helpful strategies;</li> <li>• Participation in the Nurturing Parenting course;</li> <li>• Engaging the caregivers into services while the kids are in placement;</li> <li>• Caregiver visits to the RTC, and</li> <li>• Off-site passes to allow for the youth and family to practice skills, followed by time with the therapist to process the interactions.</li> </ul>

**Liaison Recommendation:** RTC liaisons suggested that slowly transitioning the youth home through home visits with the support of in-home services would allow families to practice skills in the natural environment. RTC



liaisons also reported that the transition could be improved with some funding to support aftercare services, such as in-home family therapy, from the RTC after they youth has returned home.

**Challenges and Barriers to Success.** When liaisons were asked to identify program challenges, barriers, or recurring issues, responses could be categorized into three themes - accessing the program through CPS, engaging families in services, and collaboration between agencies.

One of the most significant challenges discussed by respondents was the process for caregivers and community agencies to inquire about the program and initiate a referral through CPS. One liaison described it as the “inability to get CPS to make the report”. Liaisons felt that the primary barriers were a general lack of awareness about the program’s existence and local CPS workers’ and supervisors’ lack of knowledge about their role. It should be noted that some liaisons expressed a similar experience with local CPS workers’ lack of awareness of other specialized mental health programs, such as the YES Waiver.

- Several liaisons reported that they had to inform the CPS workers about the program by emailing them the program brochure developed by HHSC that references the DFPS referral form.
- One LMHA liaison reported, “Even when the state hospital has made a call to CPS or when parents or the agency has tried to make an inquiry about the program, CPS is saying that they don’t know anything about it.”
- One LMHA liaison highlighted how hard it is for families to have to make the report to CPS in the first place. There have been instances where the LMHA liaison is with the family when making the call and CPS will say “we have no idea what you are talking about, there is no such program.”
- RTC liaisons report trying to make a referral for a youth currently in the RTC whose insurance/funding has run out before being ready for discharge, the CPS workers aren't aware the program exists. In these cases, liaisons feel the referral would be appropriate because caregivers are stating that they will relinquish because returning home is not safe (dangerous, suicidal, aggressive, sexual contact), but they still want to work towards reunification.

**Liaison Recommendation:** Liaisons suggested that state program administration needs to address the gap in knowledge and awareness with local CPS workers by providing training and guidelines for the referral process. In addition, liaisons would like state-level program administrators to provide clear guidelines for families so they can be better prepared when making these calls.

While several liaisons reported families were well-informed and engagement in services and supports was not problematic, the majority of RTC and LMHA liaisons noted some challenges around caregiver engagement in the program. Some LMHA liaisons noted challenges in getting families to return phone calls and attend the initial assessment appointments. Liaisons expressed uncertainty whether this might be due to the referral being based more on what CPS wants the family to try than the family’s interest in participation. In addition, LMHA liaisons noted that families are not always aware that LMHA staff will be contacting them and may not understand the importance of a timely response.

**Liaison Recommendation:** The CPS case worker should coordinate the initial eligibility appointment with the LMHA to serve as a warm transfer for family.

Several liaisons also noted that the caregivers that they struggle to engage tend to view the situation as one where only the child needs services, and fail to see the issue in terms of the larger family system. Liaisons noted that some families feel overwhelmed by caring for their child and report needing a break, and do not want to engage in treatment services after the child is out of the home. One liaison also noted that some caregivers need intensive

therapeutic services themselves, and may not be ready to participate in their child's services at the beginning of the placement. RTC liaisons also noted that geographic distance can be a significant issue, limiting participation to the telephone or Skype. One liaison noted that there is not process to ensure accountability when a caregiver fails to engage in family therapy or LMHA services or fails to attend planned visits.

While overall both LMHA and RTC liaisons expressed appreciation for the coordination expected under the RTC program, some barriers were reported. LMHA liaisons reported that it seemed that some RTCs are unaccustomed to on-going coordination with community-based providers and that this resulted in LMHAs not being included in treatment planning or not having phone calls returned. Other liaisons noted that RTCs were inconsistent in keeping regularly scheduled phone meetings or providing regular weekly updates to the LMHAs. They also reported inconsistencies in the type of information shared during weekly updates. Some liaisons noted that the weekly updates frequently lacked clinical information and would focus instead on medical, nutritional, and educational information, with information on mental health limited to "attended therapy twice a week" or "it is going well".

**Liaison Recommendation:** The HHSC RTC Initiative Coordinator should ensure that the RTC liaison receives the contact information for the LMHA liaison and that the expectation is set that RTCs have a responsibility for ensuring LMHAs remain informed. In addition, LMHA liaisons recommended that they receive a regular clinical update from the therapist.

RTC liaisons reported fewer barriers in collaborating with the LMHA, however two primary issues were raised across the sites. Some RTC liaisons reported that LMHAs relied upon the RTC to initiate communication and provide updates and indicated wishing that both organizations would be proactive in their collaboration. Additionally, some RTC liaisons reported that they do not receive reciprocal feedback from the LMHA on family involvement and progress in local services and supports. This leaves them lacking information about the family's progress toward reunification, other than the family work in the RTC.

**Liaison Recommendation:** The recommendation was made that LMHA/RTC coordination should occur every other week during the initial three months, followed by weekly contact for the remainder of the stay, to discuss how the youth is progressing, services needed at home, and supports needed for the transition back home. It was noted that weekend visits begin around three months and weekly communication would allow for problem-solving the transition to home.

A few additional barriers or challenges were reported by the liaisons. RTC liaisons noted some challenges related to requirements within the contract, caregiver requests for RTC transfers, and challenges with Medicaid. These additional challenges are summarized in Appendix C. LMHA liaisons also noted some additional challenges to meeting the required time tables for the enrollment process. They indicated some families are not ready or able to attend immediately. They also indicated that contracted professionals may not be able to conduct psychological assessments within the timeframe, as many of them are also contracted by DFPS and must meet strict time requirements.

**Liaison Recommendation:** It was recommended that the HHSC contract with the LMHA allow more time for completing assessments and the common application due to large service areas and travel involved.

**LMHA Services and Supports.** The majority of liaisons indicated that youth are typically authorized into Wraparound programs and assigned a case manager following referral to the RTC program. Two liaisons specifically mentioned linking the family to a Family Partner, with service generally provided twice a month. In about half of the interviews, LMHA liaisons indicated that it is routine to inform families and offer enrollment into the YES Waiver program if they meet eligibility criteria. Youth that are already enrolled in services generally continue with those services while awaiting an RTC placement. Feedback indicates that there have been instances where participating in YES Waiver or wraparound has prevented RTC placements; however, more often the family

***Ideally It would be nice to try to get to the kids earlier. We had one case that was given up to DFPS custody - if we would've gotten the youth into services at the LMHA the outcome may have been different.***

will still take the RTC placement when it becomes available. There were some instances described in which families were currently enrolled in the YES Waiver and referred to the RTC Initiative for additional support. LMHA liaisons noted that when there is a waitlist, some families have opted to wait for RTC availability and not receive services at the LMHA in the interim and/or are receiving services elsewhere. In addition, due to the increase in the number of youth who can be served, RTC placements are occurring more quickly and LMHAs report there is not always time to initiate services prior to placement.

**Liaison Recommendation:** The LMHA wraparound facilitator should have input in the timing of the placement decision. Some families need more time to engage in LMHA services prior to receiving a wraparound placement. While the YES Waiver may not be a great fit for some families, other families agree to try the YES Waiver, but when an RTC placement becomes available within a couple of weeks, they haven't had enough time to determine if it will successfully meet the family's needs.

Once youth are admitted to a RTC, the LMHA liaisons describe the main tasks as weekly check-ins with the family and the RTC, which is either done by the liaison or by a case manager. The majority (7 out of 9) of RTC Liaisons specifically mentioned the Family Partner service as a part of the ongoing family support while the youth is at the RTC. Other descriptions include:

- Family Partner support occurs 1 or 2 times per month;
- The assigned family partner checks-in regularly with the assigned case manager;
- Family Partner and/or the case manager use the Nurturing Parenting curriculum;
- Few in-person appointments generally occur in the beginning, with weekly check-ins typically done by phone;
- It varies whether or not liaisons or case managers participate in treatment team meetings. in addition to receiving weekly updates.
- A few liaisons described having regular phone calls with the youth while at the RTC; and
- Some families refuse the service (family partner) altogether;
- One liaison acknowledged that service provision is probably not happening on a regular basis because the LMHA does not always notify case managers and family partners of RTC Initiative cases; and
- LMHA involvement in treatment planning was described as minimal and primarily focused on staying informed of progress towards discharge. A few liaisons cited billing issues as a barrier for more involvement in treatment planning.

***Ideally families would receive skills training and the Nurturing Parenting curriculum, but many families decline because they feel like they've already done similar programs.***

**Liaison Recommendation:** Wraparound teams should continue to provide family skills training, in addition to family partner services, while the youth is in placement. The wraparound team should continue with intensive

case management, including direct contact with the youth in placement, so that not all information about RTC progress is secondhand.

LMHA liaisons indicated that their involvement in planning for discharge varies, and primarily is driven by the RTC. One liaison described being an active participant in discharge planning, with their role being engaging the family to enroll in services in preparation for the youth being discharged. Other LMHA liaisons noted that they have not been very involved in discharge planning and that the information they receive with the estimated discharge date is not very helpful in knowing whether the discharge is expected to be delayed and, if so, why. One LMHA liaison reported that discharge planning was disjointed, making it difficult to plan. Several LMHA liaisons noted a lack of capacity within their wraparound programs and uncertainty about whether youth discharged from an RTC had priority over other families on the inquiry list. One liaison noted that engaging families after discharge can be challenging, because families report the youth is doing great, but then they reach out when a crisis arises.

**Liaison Recommendation:** One liaison recommended having quarterly team meetings, in person if possible, where the LMHA representative goes to the RTC with the parents/caregivers to discuss discharge plans collaboratively with the RTC staff.

**RTC Services and Supports.** RTC liaisons were asked to describe the services and supports offered by the organization. All indicated offering individual and family therapy, although they differed significantly in the frequency. One site noted that they will try to have the family attend in person or meet them half way for family therapy, if possible, as they have noted better results. Other RTCs are using web-based platforms or phone calls to connect with families. Several RTCs reported focusing significantly on interventions for trauma and several noted that therapists identify the preferred therapeutic modality, based on the needs of the youth. One site noted that the HHSC requirement for assessment by a psychiatrist at admission was a significant barrier, as they did not have a psychiatrist on staff and this would frequently delay placement of the youth. Several liaisons noted using behavioral modification programs and level systems. Other RTCs noted that they are moving away from level systems following participation in the Building Bridges Initiative. They noted a significant reduction in restraints and seclusions as a result of these activities. RTC liaisons reported supporting youth through positive social and recreational activities, including movies, sports, and outings. All reported some form of family visitation and/or passes to leave the setting, with some reporting support for transportation or staffing support for safety. None of the RTCs described an opportunity to provide follow-up care after discharge, although some noted families who continued to check-in and provide progress updates.

**Liaison Recommendation:** LMHA's would like to have more information on the level systems used by RTCs and how they correspond to discharge status. LMHAs feel unable to use this information to understand a youth's readiness for transition to the home.

## Results: Document Review

To gain more knowledge about the scope of the RTC Initiative and roles and responsibilities of participating agencies, TIEMH research staff reviewed current HHSC contracts with the LMHAs and RTCs, the DFPS Investigation and Referral to DSHS Residential Treatment Center Resource Guide, applicable sections of the DFPS Policy Handbook for CPS, DFPS Form 2037 Referral for DSHS Funded RTC Bed (Child Not in DFPS Conservatorship), the current Notice of Open Enrollment for RTCs and Program Evaluation Tool, the Senate Bill 44 Needs Assessment, the DFPS and DSHS Joint Report on Senate Bill 44 (Companion to Needs Assessment), and the 2016 Hogg Foundation Mental Health Guide. Additional program level documents including a Program Description for LMHAs and RTCs (in draft form), the Relinquishment Avoidance Agreement with Roles, the weekly update template, and

the RTC Initiative Brochure were also reviewed. Understanding the intent and design of the RTC Initiative was critical for identifying current strengths and challenges with implementation, providing outcome data and feedback, and identifying recommendations for enhancement.

The following observations were made based upon this review:

- The program lacks guidelines and/or policies and procedures to support the responsibilities outlined in the contracts between HHSC and the LMHAs and RTCs.
- Program information cannot be found by searching the HHSC or DFPS websites. There appears to be no online presence for program information available to the community or participating agencies (LMHAs and RTCs).
- There is inconsistency between the DFPS Investigation and Referral to DSHS Residential Treatment Center Resource Guide and the contract terms set forth by HHSC on how recent the psychological assessment needs to be. On page 3 of the DFPS document, under the heading “Get the child’s recent psychological evaluation,” it references a psychological evaluation completed within the last 6 months. Section B.3.b. in HHSC’s contract with the LMHAs states “Obtain a psychological assessment that includes both intelligence and personality testing for the child/youth within 30 days, if an assessment has not been completed in the past 12 months. If an assessment has been completed in the past 12 months, obtain a copy to be included in the RTC placement packet.” Section I.A.2. in HHSC’s contract with the RTCs references “A psychological assessment completed within the past year.”
- The DFPS Investigation and Referral to DSHS Residential Treatment Center Resource Guide is dated November 2015. In gathering information about the program from state-level staff, TIEMH research staff learned that this document has not been updated and is not necessarily referenced by those processing referrals, although it is the sole source of written program guidance available through DFPS.

## Results: Child or Youth Record Review

The HHSC RTC Coordinator maintains a variety of case documentation records, and documentation was reviewed for 28 youth currently placed in RTCs. Records were organized into files representing referrals and CANS, admission packet and authorization, communication logs, treatment plans, progress notes, and additional correspondence. TIEMH evaluation did not do a comprehensive review of records, but rather reviewed materials to identify opportunities for use in evaluation and to note strengths and opportunities related to programmatic oversight.

The degree to which records were complete appeared to vary. A strength that was noted is that all files contained complete referral and admission records, including the DFPS referral form (Form K-908-2037), the eligibility CANS assessment from the LMHA, the DFPS Common Application (Form 2087), and the Authorization for Placement Letter from DSHS/HHCS. The majority of files contained the initial treatment plan ( $n=15$ , 53.6%) and in fewer instances treatment plan updates ( $n=7$ ) were included. Files containing updates from the RTC, including progress notes and incident reports, appeared to vary in terms of the type and amount of information provided. The communication records, formatted into a log appeared to be an important management tool, but also utilized somewhat inconsistently.

At present, child or youth records serve as important documentation of programmatic processes, but are unlikely to be sufficiently representative to be used for evaluation purposes or quality management reviews. HHSC should consider identifying the minimum expectations for documentation of quality treatment from the RTC and ensure compliance. The communication log is likely a critical tool for staff overseeing the program to quickly identify the nature of any outstanding issues. HHSC should consider developing a database or other tool for entering

communications, thus allowing staff to query for specific information and create reports. As the program grows, the current system is likely to be increasingly challenging to utilize efficiently.

## **Additional Evaluation Activities**

In addition to the initial evaluation described in this report, TIEMH evaluation staff conducted activities to prepare for answering additional evaluation questions. The primary evaluation questions related to the experience of families and youth involved in the RTC program and the outcomes of families following participation. TIEMH evaluation staff reviewed various existing instruments and developed a stakeholder feedback instrument. This instrument was shared with families with relevant lived experience and modified based on this feedback. TIEMH staff also reviewed instruments that could be used to measure relevant indicators of quality and innovation at residential treatment settings.

TIEMH staff also developed a research protocol that was submitted to the HHSC and UT Institutional Review Boards. It was approved by the HHSC Board and deemed “not research” by the UT Board. TIEMH also developed consent forms for caregivers and youth participating in the evaluation and had initial discussions with some LMHAs and RTCs about optimal ways of recruiting families for participation.

## **Conclusions and Recommendations**

Overall, the RTC Initiative was identified as meeting an important need within the system of care. The program was targeted to families of children and youth with high needs as a result of serious emotional disturbances at risk of parental relinquishment to DFPS. Key informants indicated that the program was frequently the only thing available for children and youth with this intensity of need and praised its focus on engaging families throughout the treatment process and regular coordination with community-based providers. This was noted to be a different way of practicing for both the RTCs and LMHAs, and was strengthened by expectations being documented in agency contracts. There was clear benefit to referred families who were engaged with the LMHAs to assess eligibility and receive services while waiting for a residential placement, with 40 of the 228 youths referred to the program successfully treated in intensive outpatient programs. The perceptions of caregivers and youth participating in the program and the long-term outcomes of families will be evaluated in the next phase of the project.

Stakeholders within the LMHAs and RTCs also noted some challenges and barriers to the program. Representatives of both providers noted the importance, but also the challenge, of engaging caregivers in the treatment process. Barriers included distance from the facility, caregiver strain and burden, attitudes, and practical challenges, such as available time and work demands. Both LMHAs and RTCs seemed to understand the purpose of the RTC Initiative, but also reported a lack of information eligibility criteria, roles and expectations of the various partners, and the processes from referral to stabilization in the home. The relatively small number of youth served through the program and their distribution across the state resulted in many agencies lacking clear procedures or staff training.

Results of the evaluation lead to the following recommendations for HHSC and DFPS:

1. HHSC and DFPS should develop online training, tools and resources and ensure awareness of existing resources through communication strategies. Audiences for these resources include caregivers, CPS case managers and supervisors, RTC administrators and staff, LMHA administrators and staff, and other mental health providers. Suggested areas to be addressed include an overview of the RTC initiative, history of the



RTC initiative, roles and responsibilities of DFPS, HHSC, LMHA and RTCs, frequently asked questions, what caregivers should expect when calling CPS, and contractual expectations.

2. HHSC should increase collaboration and communication among participating LMHAs and RTCs through quarterly or semi-annual conference calls to discuss what's going well, areas to improve upon, provide an open forum for questions and answers, and opportunities to learn from each other and conduct shared problem-solving.
3. DFPS should provide additional guidance to relevant staff to increase awareness of the program and their roles and responsibilities in the referral process. DFPS could opt to re-establish regular web-based training opportunities, which were initiated during the roll-out period. DFPS should consider quality management checks to ensure staff who respond to calls indicate awareness and respond appropriately.
4. HHSC and DFPS should develop resources to provide clarity and reduce confusion between similar programs such as the RTC Initiative, YES Waiver, and Joint Conservatorship.
5. HHSC and DFPS should examine re-establishing the screening process for caregivers/families to attempt to accurately identify the opportunities and challenges related to reunification. The DFPS Resource Guide describes a collaborative process between the HHSC RTC Coordinator, CPS Mental Health Specialist, CPS investigation worker and the LMHA worker to determine the family's level of investment in treatment for the youth and motivation for family reunification. Additional areas for assessment could include:
  - a. Family's needs/barriers related to engaging in services at the LMHA;
  - b. Strengths and barriers to reunification;
  - c. Likelihood of successful outcomes in intensive outpatient care;
  - d. Attitudes about family involvement in treatment; and
  - e. Youth perceptions of reunification (if developmentally appropriate).
6. As the program grows, HHSC should consider enhancing the tracking database to allow for increased availability of data. Enhancements could include identification of LMHA case number or ID, tracking RTC transfers, tracking of critical incidents, tracking of clinical updates, and regular tracking of family service engagement. Additionally, the communication log should be migrated to a database system to allow for efficient searching a reporting. Much of this information is currently documented in electronic files, but cannot be easily aggregated to identify trends. Additionally, documentation of the tracking database elements and procedures would enhance the consistency of the data over time, if the HHSC RTC coordinator changes.
7. HHSC should begin to establish additional processes for assessing quality of care and outcomes of youth served in the RTC Initiative. This may include identifying a variety of program qualities, ranging from required to preferred, and assessing the initial status of each RTC on these elements through a site visit and/or interviews. Standardized methods for measuring program quality and outcomes would enable the HHSC RTC Coordinator and caregivers to identify the preferred setting for their family's needs.
8. HHSC and DFPS should develop additional written guidelines, policies and procedures for program implementation and daily operation, including process maps for referral, enrollment, wait list, placement, and transition.
9. Several of the recommendations highlighted by LMHA or RTC liaisons align with goals of Texas System of Care. In particular, several RTCs mentioned the benefits they received through participating in the Building Bridges Initiative. Increased partnership between the RTC Initiative and Texas System of Care could ensure that RTCs are encouraged to align with residential best practices and offered opportunities for training and technical assistance. Additionally, the HHSC RTC Coordinator should partner with Texas System of Care in the development of wraparound services and supports for families at risk for or engaged in residential services, a core goal of the 2018-2021 Texas System of Care cooperative agreement.



## Next Steps

TIEMH will present key findings from the Year 1 evaluation to HHSC staff and discuss next steps for the evaluation. TIEMH would also like to prepare a brief document highlighting findings to share with LMHAs and RTCs. TIEMH is prepared to begin initiating procedures to consent and enroll caregivers and youth in the evaluation and begin conducting interviews of caregivers at 12 months and 36 months following admission. Conducting interviews with relevant DFPS staff could also provide additional information about the barriers faced in the referral process and strategies to improve that component of the process for families. TIEMH would also propose continuing to explore available clinical records to identify trends and/or missing information, perhaps creating a review tool that serves as an initial measure of quality. TIEMH can also assist with implementation support, if desired by HHSC, such as the coordination of quarterly support calls or the hosting of web-based training opportunities. TIEMH can also support the documentation of processes and other programmatic materials.

## APPENDIX A

### Residential Treatment Center (RTC) Telephone Interview and Data Reporting Survey for LMHAs

“Hello, my name is \_\_\_\_\_ and I work for the Texas Institute for Excellence in Mental Health at the University of Texas. We are gathering feedback from staff at the Local Mental Health Authorities and the contracted Residential Treatment Centers as part of our program evaluation for the HHSC/DFPS Residential Treatment Center Project. We will ask you questions about your experiences in coordinating with families, providing continuity of care, and collaborating with HHSC and other involved agencies. We will ask questions that help us understand program successes and challenges, lessons learned, barriers, and recommendations for improvement. Just a reminder that your responses will be confidential. Information gathered will be combined across all staff interviews and reported in a way that does not identify you or your organization. Are you willing to help us by answering some questions? Do you have any questions for me before we get started?”

Comments:

#### Role and Understanding

*First, I'd like to learn more about your role and responsibilities with the RTC Project.*

1. Please describe your role and responsibilities with the RTC project. How long have you been in that role?
  - a. Is there a designated Continuity of Care Coordinator (LMHA) or RTC Point of Contact? For example, who does the HHSC RTC Coordinator get in touch with when there's a referral?
  - b. How do the RTC Project responsibilities fit with your job position overall?
  - c. Does your organization have any capacity/resource limitations related to this project?
  - d. Do you have supervisory support or additional staff / co-workers that also play a role in providing continuity of care to RTC Project families?
2. Do you feel like you have a good understanding of the RTC project? How would you describe the program?
  - a. Were you given any specific training or information about the RTC Project?

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- b. Are there any program areas where clarity is needed or desired?
  - c. Are there any areas where additional training or resources would be helpful?
- 3. Can you please tell me a little bit about what happens when a new RTC project referral is received and how you become aware of a new case?
- 4. Can you describe how RTC Project youth and families are tracked locally? For example, do you have a way to check who has been referred in the past, currently in RTC?

### **Successes and Challenges**

*Now I'm going to ask you a couple of questions about the overall program successes and challenges.*

- 5. In your experience, what has been going well? What are some strengths of the program?
  - a. What qualities does the RTC Project have that sets it apart from other available programs or services in the community?
  - b. How well is this program working with the YES Waiver? Other programs?
- 6. What are some of the weaknesses of the program? For example, are there any recurring issues or concerns?
- 7. Are there any characteristics of the RTC project that lead to youth/families not accessing the program?
- 8. Do you have any concerns about being able to meet a family's needs? For example, this could be upon receiving a referral, working through eligibility, continuity of care while in RTC placement, post discharge.

### **Multi-Agency Coordination**

*These next questions are related to your experience with the various agencies including HHSC, DFPS, LMHAs, and RTCs in coordinating care for RTC Project families.*

- 9. Would you say that the program is efficient and effective with regards to communication and collaboration among the different agencies that are involved in serving a particular youth and family?
  - a. Can you describe a typical communication flow between agencies? For example, weekly phone calls, email updates, team meetings.

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b. Do you know who to contact at HHSC / DFPS / LMHAs/ RTCs if necessary?

1. ASK: Can you tell me who the HHCS RTC Coordinator is? (Answer: Vontrice Dorsey)

10. (LMHA): Do you have any feedback about the referral process and how the LMHA receives a referral to conduct the clinical assessment?

(RTC): Do you have any feedback about how the RTC receives a request for admission and coordinates with the LMHA and HHCS RTC Coordinator?

### **Eligibility and Enrollment**

*These next questions will focus on families gaining access to the program through the eligibility and enrollment process.*

11. Do any barriers exist to timely access to eligibility assessments, enrollment, and RTC admission?

12. Does the eligibility criteria and assessment process seem appropriate and useful?

13. What types of services can a family receive while waiting for RTC placement? Are there particular services that are typically used / why?

a. Are there additional services or supports that would be helpful that are currently unavailable?

### **Treatment Planning and Discharge Planning**

*We'd like to learn more about the continuity of care process for youth and families so I am going to ask you some specific to treatment planning and discharge planning.*

#### **LMHA Treatment Planning and Discharge Planning**

14. Are you able to provide services to the family while the youth is in residential care?

a. If yes, what services are typically offered and received?

b. If not, what are the barriers to this?

15. Do you maintain communication with the RTC and participate in treatment meetings?

a. If yes, what does that communication and participation look like?

b. If not, what are the barriers to this?

16. What do you feel would be most helpful to families to prepare for the youth's return home?

17. How involved are you (the LMHA) in discharge planning?

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- a. When are families engaged in community services and supports?
- b. What community services and supports are utilized?
- c. Are there services provided after a youth is discharged?

### **Outcomes**

- 18. Have you seen success with youth and families that have participated in the RTC project?
- 19. In your opinion, what are some key elements of the program that lead to a successful reunification of youth with their families upon discharge? Similarly, do you notice any family characteristics that tend to lead to a more successful outcome?
- 20. Once enrolled, have you noticed any program factors or family characteristics that make a successful reunification of youth with their families less likely upon discharge?

### **Recommendations and Final Comments**

- 21. What would you like to see done differently? Do you have any recommendations for improvement?
- 22. Is there anything else you'd wish to share about your experiences with the program?

Date of Interview \_\_\_\_\_ Interviewer \_\_\_\_\_ ID# \_\_\_\_\_

**Residential Treatment Center (RTC) Telephone Interview and  
Data Reporting Survey for RTCs**

“Hello, my name is \_\_\_\_\_ and I work for the Texas Institute for Excellence in Mental Health at the University of Texas. We are gathering feedback from staff at the Local Mental Health Authorities and the contracted Residential Treatment Centers as part of our program evaluation for the HHSC/DFPS Residential Treatment Center Project. We will ask you questions about your experiences in coordinating with families, providing continuity of care, and collaborating with HHSC and other involved agencies. We will ask questions that help us understand program successes and challenges, lessons learned, barriers, and recommendations for improvement. Just a reminder that your responses will be confidential. Information gathered will be combined across all staff interviews and reported in a way that does not identify you or your organization. Are you willing to help us by answering some questions? Do you have any questions for me before we get started?”

Comments:

**Role and Understanding**

*First, I'd like to learn more about your role and responsibilities with the RTC Project.*

1. Please describe your role and responsibilities with the RTC project. How long have you been in that role?
  - a. Is there a designated Continuity of Care Coordinator (LMHA) or RTC Point of Contact? For example, who does the HHSC RTC Coordinator get in touch with when there's a referral?
  - b. How do the RTC Project responsibilities fit with your job position overall?
  - c. Does your organization have any capacity/resource limitations related to this project?
  - d. Do you have supervisory support or additional staff / co-workers that also play a role in providing continuity of care to RTC Project families?
2. Do you feel like you have a good understanding of the RTC project? How would you describe the program?
  - a. Were you given any specific training or information about the RTC Project?
  - b. Are there any program areas where clarity is needed or desired?

- c. Are there any areas where additional training or resources would be helpful?
- 3. Can you please tell me a little bit about what happens when a new RTC project referral is received and how you become aware of a new case?
- 4. Can you describe how RTC Project youth and families are tracked locally? For example, do you have a way to check who has been referred in the past, what LMHA they are connected with, who's currently in RTC?

### **Successes and Challenges**

*Now I'm going to ask you a couple of questions about the overall program successes and challenges.*

- 5. In your experience, what has been going well? What are some strengths of the program?
  - a. What qualities does the RTC Project have that sets it apart from other available programs or services in the community?
  - b. How well is this program working with other specialty programs in the community?
- 6. What are some of the weaknesses of the program? For example, are there any recurring issues or concerns?
- 7. Are there any characteristics of the RTC project that lead to youth/families not accessing the program?
- 8. Do you have any concerns about being able to meet a family's needs? For example, this could be upon receiving a referral, working through eligibility, continuity of care while in RTC placement, post discharge.

### **Multi-Agency Coordination**

*These next questions are related to your experience with the various agencies including HHSC, DFPS, LMHAs, and RTCs in coordinating care for RTC Project families.*

- 9. Would you say that the program is efficient and effective with regards to communication and collaboration among the different agencies that are involved in serving a particular youth and family?
  - a. Can you describe a typical communication flow between agencies? For example, weekly phone calls, email updates, team meetings.



b. Do you know who to contact at HHSC / DFPS / LMHAs/ RTCs if necessary?

i. Are you familiar with who the HHCS RTC Coordinator is? (Answer: Vontrice Dorsey)

10. Do you have any feedback about how the RTC receives a request for admission and coordinates with the LMHA and HHCS RTC Coordinator?

### **Eligibility and Enrollment**

*These next questions will focus on families gaining access to the program through the eligibility and enrollment process.*

11. Do any barriers exist to timely access to the RTC Project and gaining admission to the RTC?

12. Are you familiar with the eligibility criteria and assessment process? If so, does it seem appropriate and useful?

13. What services do you provide to families? Are there particular services that are typically used / why?

a. Are there additional services or supports that would be helpful that are currently unavailable?

### **Treatment Planning and Discharge Planning**

*We'd like to learn more about the continuity of care process for youth and families so I am going to ask you some specific to treatment planning and discharge planning.*

#### **RTC Treatment Planning and Discharge Planning**

14. Treatment Planning (RTC)

- How did you keep families informed?
- Does someone from the LMHA participate in the Treatment Team?
- How do staff become familiar with the environment to which the youth is returning?
- How do staff generalize the skills taught to other settings?
- How are treatment goals identified and agreed upon?
- How instrumental are the child and families in this process?
- How are child and family strengths assessed and incorporated into the treatment plan?
- How are parent goals identified and incorporated?
- What type of system do you use? (level system versus goal attainment and youth and family having supports and skills needed to live together in the community)
- Are there any restrictions on family contact while the youth is at the RTC?
- (RTC) What practices do you have that promote integration into the community? Do you ever take away social activities as a consequence?
- (RTC) Do you encourage and allow access to technology to maintain relationships with approved family and friends in the community?
- (RTC) What treatment models / curriculums do you incorporate?

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15. Are you familiar with the services available through the LMHA for families while the youth is in residential care? (Family Partner, Case Mgmt, Skills Training)

16. What services do you require families to participate in?

a. Are there barriers to families participating in and receiving services?

17. What do you feel would be most helpful to families to prepare for the youth's return home?

18. Discharge planning

- At what point is discharge planning initiated?
- How often is it discussed?
- How involved is the LMHA in discharge planning?
- What goes into determining when a youth is ready for discharge?
- When are families engaged in community services and supports?
- What community services and supports are utilized?
- Are there any services provided after a youth is discharged?

### **Outcomes**

19. Have you seen success with youth and families that have participated in the RTC project?

20. In your opinion, what are some key elements of the program that lead to a successful reunification of youth with their families upon discharge? Similarly, do you notice any family characteristics that tend to lead to a more successful outcome?

21. Once enrolled, have you noticed any program factors or family characteristics that make a successful reunification of youth with their families less likely upon discharge?

### **Recommendations and Final Comments**

22. What would you like to see done differently? Do you have any recommendations for improvement?

23. Is there anything else you'd wish to share about your experiences with the program?

## **APPENDIX B**

### **Feedback on Program Training and Support**

#### **Promote Program Awareness and Understanding**

- Handouts describing the program and referral process to give to families and community referral sources such as State Hospitals, LMHAs and RTCs;
- Training, guidelines, and increased communication with CPS workers and supervisors on their role in the referral process; and
- Regular communication and check-ins with LMHAs and contracted RTCs.

#### **Referral and Eligibility**

- Guidelines and clarification on the referral and eligibility processes. Liaisons identified the following questions:
  1. Who can make a referral to CPS/DFPS or how can community referral sources inform CPS/DFPS about a family in need?
  2. How can we prepare families to contact CPS/DFPS to make a report or inquire about the program?
  3. What makes a family eligible for a referral from CPS/DFPS?
  4. What is HHSC's full eligibility determination process?

#### **LMHA Identified Needs**

- Training on the roles and responsibilities of the LMHA and the various staff that work with RTC Project families, including contract requirements;
- Detailed description of the enrollment process when a referral is received that provides detailed steps to follow leading up to RTC placement;
- Understanding of the involvement of CPS/DFPS in the referral process and throughout various stages of the program; and
- Use and understanding of required DFPS forms such as the Referral Form and Common Application to improve consistency in how the forms are filled out. For example, clarity is desired on the areas of the forms that designate Level of Care as this is different than the Levels of Care used by the LMHA. In addition, one RTC Project Liaison described the common application to be very time intensive, taking up to three hours to complete with the family.

#### **Continuity of Care**

- Increase transparency of roles and responsibilities of the LMHA and RTC to improve collaboration and communication. LMHA liaisons expressed that in some cases it appears the RTC staff don't understand the need for the LMHA liaison to have weekly updates, or their role in the treatment planning process. Although a few LMHA liaisons expressed that the RTC staff they have worked with have been very good about involving the LMHA, more often it was reported that it varies from RTC to RTC and that "some are very good at involving the LMHA and some are not"; and
- Highlight how the RTC Project differs from other programs and how other services and programs can support families at different stages of treatment to improve continuity of care.

### **Guidelines and Strategies for Complex Cases**

- Youth that are approaching age 18 at referral or aging-out of the program;
- Clarification of the LMHA's role when a 16- or 17-year-old wants to work toward living independently and doesn't want residential treatment;
- Supporting youth that are involved with the criminal justice system, i.e. detention. For example, one RTC liaison described a case where the youth was not engaged in aftercare services at the LMHA due to the youth going to detention and the youth ended up back in an RTC but not through the RTC Initiative; and
- Engaging families in services and recommendations on how to handle more difficult cases where families may not be moving towards reunification for various reasons. The following examples were provided from LMHA liaisons:
  1. engaging families in wraparound services post-discharge;
  2. when the family has not had enough support in terms of addressing issues present in the home prior to the youth being recommended for discharge from the RTC; and
  3. when the parents disagree about reunification; and
  4. when the parents cannot be located.

### **DFPS/CPS Topics**

- Guidelines and training in the use and understanding of the RTC Initiative referral form and the Common Application to improve consistency in how the forms are filled out. For example, clarity is desired on the areas of the forms that designate Level of Care as this is different than the Levels of Care used by the LMHA. In addition, one LMHA liaison described the common application to be very time intensive, taking up to three hours to complete with the parents present;
- DFPS Joint Conservatorship program and what families need to be aware of in how Joint Conservatorship affects eligibility for the RTC Initiative and whether or not it's an option to access Joint Conservatorship after participating in the RTC Initiative reunification is not favorable. For example, one LMHA liaison reported that a family was denied the request for Joint Conservatorship when they were not ready to have their child return home upon completion of the RTC Initiative so were forced to make a decision to allow the child to return home or to relinquish custody. A CPS caseworker told the family that Joint Conservatorship is not an option because they participated in the RTC Initiative; and
- Programs for families with children that have been adopted in state and out of state and how it affects eligibility for the RTC Initiative. For example, one LMHA liaison reported having a youth that did not qualify because they found out he was adopted in a different state, but they didn't know that until all of the eligibility information was sent in.

## Appendix C

### Feedback on RTC Challenges and Barriers

1. **Contract Requirements:** The following two barriers were described:
  - One liaison described the requirement of the most recent contract for a youth to see a psychiatrist upon admission. “This is not a hospital and I don’t have psychiatrists on staff so that makes it really hard and almost have to delay the child coming here until we can get a psychiatrist to the clinic and even then they won’t have any information on the child”.
  - A few liaisons commented on the overall spirit of the contract being geared toward a medical model rather than the Building Bridges foundation that they had anticipated.
  - One of the biggest challenges is communicating with families at the desired frequency of the program and of the families. Some require daily updates on every little thing, some are fine with weekly, some are fine with being contacted as needed. The level of communication that some of the families are expecting and wanting are a challenge.

**Liaison Recommendation:** 1) Allow a 7-day time period to see a psychiatrist; and 2) Allow for a collaborative feedback process on the terms of the contract.
2. **Parents Requesting RTC Transfers:** One liaison described a barrier related to the tendency for some parents to want to move their child to a different facility rather than do what’s best for the youth. For example, if an RTC holds a youth accountable and the parent doesn’t like that they can request to move the youth to another facility. **Liaison Recommendation:** RTC placement should be less parent driven and more focused on what’s best for the youth.
3. **Medicaid Insurance:** In two interviews, barriers related to the youth’s Medicaid not allowing access to providers at or near the RTC were discussed. Liaisons described that when youth come, there are time when they are unable to switch over to the PCP and Psychiatrist at the RTC to get their basic medical needs met and the RTC ends up having to provide the services and just absorb the expense. For example, a youth needs to see an endocrinologist and Medicaid insurance won't allow for it to happen locally so parents have to come and get him and take him 3 hours away to Austin and bring him back. It seems to be an issue with the location/county that the Medicaid is restricted to. Similarly, families are supposed to ensure that the children maintain active insurance but all of a sudden it's not active or out of region. The impact is therapists and doctors can’t bill for services. **Liaison Recommendation:** To set up a Medicaid system for RTC Project youth. If on YES Waiver it ends within 90 days out of the home. In some cases, youth had the insurance provider Amerigroup, which was described to be a branch of Medicaid, but it is considered out of network in Houston.