

CONNECTICUT DEPARTMENT OF
CHILDREN AND FAMILIES

Interim Consolidation Report



A Near Final Report on the Consolidation of Riverview Hospital
for Children and Youth with the Connecticut Children's Place

June 21, 2011

This interim report has been prepared as promised in

The Future of Riverview Hospital Report:

Ten Steps Forward, April 2011

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Part I: Changes in the Connecticut Department of Children and Families

Over the period beginning in early March, staff members from the Connecticut Department of Children and Families' two behavioral health facilities -- Riverview Hospital for Children and Youth, and the Connecticut Children's Center -- have been engaged in a process of review and administrative reorganization. The first phase of this process was described in the *Future of Riverview Report: Ten Steps Forward*, released on April 13, 2011.¹

Over the same time period and under the leadership of Justice Joette Katz as the department's commissioner, other parts of the agency have also been undergoing review and transformation. Central to this work has been a redefinition of the agency's mission, to expand it from a focus largely on child safety and placement to one that asserts the following:

All children and youth served by the department will grow up healthy, safe and learning, and will experience success in and out of school. The department will advance the special talents of the children it serves and will make opportunities for them to give back to the community.

The department aims to accomplish this goal for the children it serves through the removal of bureaucratic silos at the Central Office level, reconfiguring the agency's area offices in order to promote the development of a comprehensive system of regional children's services, realigning its institutional services and better connecting them to regional and community services, and building an expanded learning entity called the DCF Academy for Family and Workforce Knowledge and Development. The *institutional realignment* for which progress is reported here is a fundamental part of the department's transformation.

Five cross-cutting themes have been identified as essential to this transformative work. First, the agency and its service partners will implement a family-centered/family strengthening framework in all of its work. This will involve the development and implementation, over the coming year, of a new Strengthening Families Practice Model and the launch, by December of 2011, of a regional Differential Response System. Second, the department will advance trauma-informed practice, related both to the children and families we serve and also to the workforce that serves them. Third, we will apply the emerging neuroscience of child and adolescent development to all aspects of our work. Fourth, we will learn how to support communities in their vital role as partners in the success of children and families. Finally, we will advance high level leadership, management, supervision and public accountability.

Over the period February through June, agency staff members have been engaged in several short-term intensive work groups – in addition to the Riverview/Children's Place consolidation

¹ This report is online at -- www.ct.gov/dcf/lib/dcf/latestnews/rvh_final_report_webmed.pdf

described within -- designed to result in changes that support our capability to fulfill our mission. Each is summarized below:

- *Fostering the Future*: An examination, with the support of the Child Welfare Strategy Group, of the department's current and desired foster family system. The goal of this work is recommend an expansion of relative, core foster family and therapeutic foster family care and support. A report from this group is expected in mid-July.
- *Congregate Care Rightsizing*: An examination, supported by the Child Welfare Strategy Group, of all children in congregate care who are ages 12 and under, all children and youth in the Voluntary Placement Program, and a full description of the functioning of therapeutic group home program policy and practice. The goal of this analysis is to recommend improvements that reduce or eliminate the placement of young children in congregate care, reduce the length of stay in residential treatment, and result in more effective use of therapeutic group homes. A report from this group is expected in mid-July.

The Department has also begun work to advance a performance-based contract process for services we purchase, beginning with an analysis of a subset of community programs. Over the coming 24-36 months, all grant, contract and purchase-of-service programs will be involved in a performance-based engagement with the Department. In addition, the Department is moving to implement Connecticut's Results-Based Accountability framework over the coming 24 months.

Finally, data-driven changes in policy and practice are being implemented to allow the Department to reach compliance levels required in the *Juan F* Consent Decree over the next 12-24 months.

Taken together, these actions and changes create the context in which the consolidation of the Riverview Hospital for Children and Youth and the Connecticut Children's Place has been undertaken.

Part II: The Planning Process and Outcomes

Phase I: Development of the *Future of Riverview Report: Ten Steps Forward*

The *Future of Riverview Report: Ten Steps Forward*, was issued as required by Section 32 of Public Act 10-3 and was published electronically on April 13, 2011. Representatives of the Office of the Child Advocate participated in this work from March 2011 through issuance of the April report.

The report describes the current functioning and challenges of the Riverview Hospital for Children and Youth, an inpatient psychiatric facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Connecticut Children's Place, a residential treatment institution established in 1883. It recommends the consolidation of the two institutions and outlines a ten-step action agenda, as summarized below:

1. Consolidate the administration of Riverview Hospital with that of the Connecticut Children's Place
2. Integrate pediatric services across the consolidated institution and the Connecticut Juvenile Training School
3. Plan for operation of six inpatient psychiatric hospital units at the South Campus (formerly Riverview) and six specialized treatment units, two at the South Campus and four at the North Campus (formerly the CT Children's Place)
4. Improve linkages between the new behavioral health institution and the department's regional service areas
5. Assign oversight of the consolidated institution to a new division in the department's Central Office
6. Continue to serve as a teaching hospital for residents in child psychiatry
7. Expand strategic relationships with other state agencies providing services for children and adults with complex behavioral/mental health needs and individuals with developmental disabilities
8. Participate in the department's new Academy for Family and Workforce Knowledge and Development to expand training opportunities within and among the department's institutional and regional units
9. Develop agency guidelines on restraint and seclusion by October 1, 2011
10. Apply implementation science and a Results Based Accountability framework agency-wide over the next 24-36 months.

In addition, the Department of Children and Families promised to prepare and publish an *Interim Consolidation Report* by June 15, 2011 and an Implementation Report on October 1, 2011. A first draft of the interim report was prepared on June 13th, reviewed internally between June 13th and June 20th. It will be released as a "near final draft" to the Implementation Steering Committee, described later in this report, at its first meeting on June 22nd.

Phase 2: Development of the Consolidation Plan

Working Group Members

Development of this *Interim Consolidation Report*, represents a continuation of effort begun over the period March 1 through April 13, 2011. An internal working group has met nearly weekly beginning in mid-April, with participants as listed below. In addition to departmental staff, the *Juan F. Court Monitor* has been a welcome participant in this Phase 2 planning and action process.

The following chart presents an alphabetic listing of Phase 2 participants.

Name	Current Job Title	Location
Debra Anderson	Superintendent through May 31, 2011; Assistant Superintendent as of June 1	CT Children's Place
Jennifer Avenia	Program Manager	Riverview Hospital
Muhammad Azeem, M.D.	Medical Director, consolidated entity/ Chief of Psychiatry, Institutional Services	Riverview Hospital
Linda Blackmon	Assistant Superintendent	CT Children's Place
Carlos Bonilla	Director of Residential Care	CT Children's Place
Donna Cambria	Superintendent, DCF Unified School District #2	DCF Central Office
Linda Carabetta	Director of Nursing I	Riverview Hospital
Nancy DiMauro	CT Behavioral Health Partnership	DCF Central Office
Wanda Estrella	Director of Human Resources	DCF Central Office
Elizabeth Graham	DCF Deputy Commissioner for Administration	DCF Central Office
Francis Gregory, Ph.D.	Director of Treatment Services	CT Children's Place
Janice M. Gruendel, Ph.D.	DCF Deputy Commissioner for Operations	DCF Central Office
Diane Haggis, Ed.D.	Principal, USD #2	CT Children's Place
Lisa Hayden, Ph.D.	Program Manager	Riverview Hospital
Scott Kupis	Principal, USD #2	Riverview Hospital
Raymond Mancuso	Juan F. Court Monitor	
Treena Mazzotta	Quality Assurance Manager	Riverview Hospital
Carol Orme-Hughes	Director of Residential Care	CT Children's Place
Mark Root	Director of Nursing II, consolidated entity	Riverview Hospital
Michelle Sarofin	Superintendent as of June 1, 2011; formerly Director of Clinical Operations	Riverview Hospital
Arnold Trasente, Ph.D.	Supervising/Consulting Psychologist	Central Office Program Review and

		Evaluation Unit
Joyce Welch	Superintendent through May 31, 2011	Riverview Hospital

Work Agenda: April 15 through June 15, 2011

Over this 60-day period, the work agenda of the consolidation planning group included the following items:

- Development of a proposed consolidated administrative structure
- Review of functional job descriptions
- Updates for the CT Department of Administrative Services
- Program specification and admission process for the six specialized non-inpatient units
- Population identification for the six specialized non-inpatient units
- Target timelines and benchmarks through October 1, 2011
- Identification of training and consultation needs, including on trauma-informed practice
- Identification of infrastructure challenges related to staffing, data systems, policy and procedure, and educational issues
- Identification of internal and external strategic communications needs.

The Implementation Steering Committee

On June 7, 2011 the Department of Children and Families announced establishment of the Implementation Steering Committee as outlined in the *Future of Riverview Report: Ten Steps Forward*. Tasks assigned to the Steering Committee include:

- Reviewing additional data that may be required by key stakeholders or by statute
- Identification of changes in policy, program and practice that will arise from the consolidation of Riverview Hospital and the CT Children's Place
- Assistance in the decision-process related to target populations for the six new specialized units
- Recommending client and performance benchmarks and data necessary to implement an automated, data-rich, facility-wide quality assurance process, track progress, identify challenges and improve accountability for outcomes.²

In addition, senior agency leadership will seek the assistance of the Implementation Steering Committee to determine if the revenue benefits that could accrue to the State of Connecticut if the North Campus units were staffed sufficiently to achieve Medicaid reimbursement as a Psychiatric Residential Treatment Facility would offset the additional staffing costs necessary to achieve and maintain that status.

² *The Future of Riverview Report: Ten Steps Forward* (April 13, 2011), p. 31

Other emerging policy issues that will require the attention of the Implementation Steering Committee include:

1. The identification of who, at the regional office level, serves as the responsible party for youth admitted to the consolidated facility under “parole” status
2. Reinforcing the construct that children and youth can return home or to a foster family placement with appropriate support services following inpatient or brief treatment services
3. Clarifying the roles and responsibilities of the hospital and brief treatment units to support families in return of their children following treatment
4. Clarifying the need for concrete regional staff capability to propose realistic discharge plans for children and youth for whom they seek admission to the brief treatment units
5. Development of the department’s emerging guidance on the use of restraint and seclusion.

Members of the Implementation Steering Committee are listed below, alphabetically.

- Debra Anderson, Assistant Superintendent, consolidated facility
- Dr. Martin Anderson, Deputy Commissioner, CT Department of Administrative Services
- Dr. Muhammad Azeem, DCF Chief of Psychiatry, Institutional Services
- Dr. Daniel Connor, Chief, Division of Child and Adolescent Psychiatry, UCONN School of Medicine and Health Care
- Janice Currier-Ezepchick, DCF Area Director, New Haven Region
- Libby Graham, DCF Deputy Commissioner
- Dr. Janice Gruendel, DCF Deputy Commissioner (Chair)
- Raymond Mancuso, *Juan F.* Court Monitor
- State Senator John McKinney, CT General Assembly
- Jeanne Milstein, CT Child Advocate, Office of the Child Advocate
- Dr. Geraldine Pearson, Chair, Riverview Hospital Advisory Committee and Associate Professor, UCONN School of Medicine and Health Care
- Dr. Mark Schaefer, Director, Medical Care Administration, Department of Social Services
- Dr. Lesley Siegel, DCF Chief of Psychiatry, Regional Services
- William Rosenbeck, DCF Superintendent, CT Juvenile Training School
- State Representative Diana Urban, CT General Assembly.

The Implementation Steering Committee is expected to meet monthly through its 120-day tenure and to assist in development of the full implementation report to be presented to the Commissioner, the governor and the Connecticut General Assembly by October 1, 2011. The superintendent will participate with, but not sit as a member of, the Implementation Steering Committee.

Phase 3: *Report of the Implementation Steering Committee, October 1, 2011*

No later than October 1st, the Department of Children and Families (DCF) will publish the *Implementation Report*. In addition, key agency staff will make themselves available for any hearings or presentations requested by key Connecticut General Assembly committees to present or discuss the October *Implementation Report*.

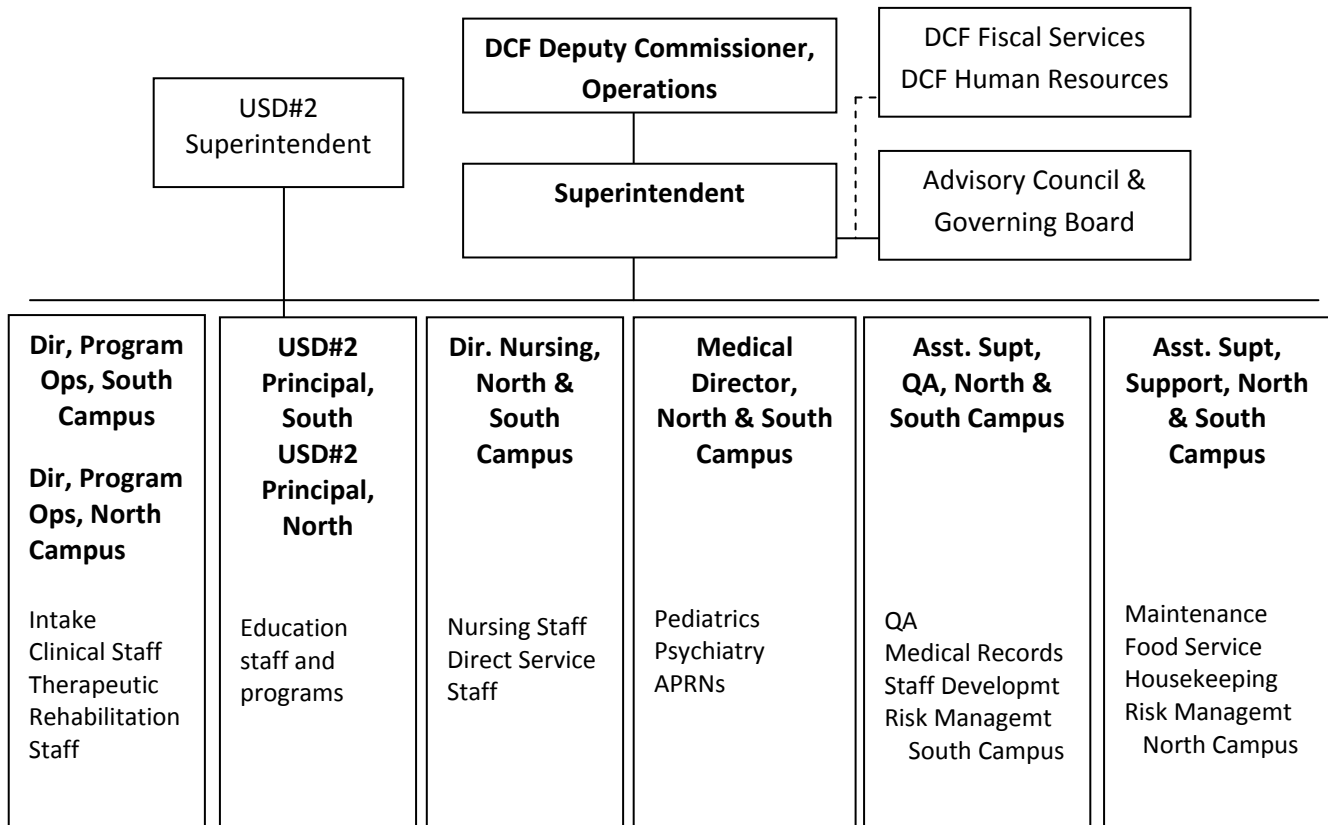
Part II: Consolidation Progress

Development of a Proposed Consolidated Administrative Structure

As currently proposed, the consolidated institution will operate with a single superintendent and eight additional key leadership positions. On May 31, 2011 Riverview Hospital Superintendent Joyce Welch retired and Children’s Place Superintendent Debra Anderson returned to her former position of Assistant Superintendent of Riverview Hospital. On June 1st, following a six-week process of candidate review, Michelle Sarofin was appointed by DCF Commissioner Joette Katz to serve in the role of superintendent of the consolidated institution.

Sarofin was one of eight candidates who requested consideration for appointment. Four were current staff members at either Riverview Hospital or the Children’s Place, and four were external to the department. Six individuals were interviewed, three from within and three external. Two final candidates (one internal and one external) were interviewed twice, and Sarofin was named. She formerly held the position of Director of Program Operations at Riverview Hospital for Children and Youth and has been a staff member and leader at the hospital since 2006. Prior to this, Michelle served as Program Director and Clinical Director for the North American Family Institute and as a crisis clinician at the Waterbury Hospital Health Care Center.

The following table of organization is proposed to provide for leadership of the consolidated entity.



Senior Leadership Functional Job Descriptions

Proposed functional job descriptions have been developed to date and will be presented to the Implementation Steering Committee for the following positions:

- Assistant Superintendent for Support Services
- Assistant Superintendent for Quality Improvement
- Medical Director/Chief of Psychiatry for Institutional Services
- Director of Nursing II
- Director of Nursing I
- Director of Program Operations, North Campus
- Director of Program Operations, South Campus
- Coordinator for Staff Development, Policy and Procedures
- Quality Assurance Manager
- Program Managers, Inpatient Hospital Units.

Updates for the CT Department of Administrative Services

As part of the department's bi-weekly personnel development meetings with the Department of Administrative Services, progress towards a consolidation continues to be presented. A preliminary set of contract and labor issues to be resolved has also been identified as part of the consolidation planning process and will be shared with the Department of Administrative Services.

Financial Considerations of the Merger

Facility fiscal management requires the analysis of many factors to determine the best combination of managing resources and potential revenues, while determining the necessary level of care and the best delivery system for that care.

Units on the South Campus will continue to offer the highest level of care through the inpatient hospitalization program's six units and the two new brief treatment units. This level of care requires maintaining JCAHO accreditation, Private Residential Treatment Facility (PRTF) status, and utilizing the placement support of the Behavioral Health Partnership. All of these factors allow the South Campus to be able to claim Medicaid reimbursement.

An analysis will be required to determine if the population to be served at the North Campus would benefit from accreditation and PRTF staffing. Accreditation and maintaining PRTF status both require specific infrastructures and staffing models that might not be necessary to effectively treat the target population. Costs associated with accreditation and PRTF status will need to be weighed against the potential Medicaid reimbursement activities and the need to have placements and length of stays approved and monitored by the Behavioral Health Partnership.

A cost benefit analysis will be performed on the various operating options and the potential revenue that might be claimed as a result, to come up with the most cost effective method of conducting business while recognizing the treatment needs of the population.

Program Specification and Population, Six Brief Treatment Units

Following several weeks of review and analysis of the characteristics of youngsters placed at in-state and out-of-state residential treatment facilities, it was determined that the six brief treatment units on the North and South Campuses will serve adolescents with complex psychiatric needs behaviorally evidenced through such behaviors as serious aggression or self injury. The two units on the South Campus will serve a total of 16 youngsters, all girls. The four units on the North Campus will serve a total of 38 youngsters, all boys. Length of stay is targeted at up to 120 days. Four beds, two on each campus, will be available to the department's regional offices through Hot Line for emergency placements not to exceed 72 hours.

Together, the six units will provide appropriate assessment as needed, behavior stabilization and treatment for youngsters for whom a short length of stay is appropriate and expected. Discharge planning will comprise a fundamental part of the intake process to assure that youngsters do not "get stuck" at any of these six brief treatment units.

Admission Criteria, Brief Treatment Units

Admission criteria have been set for both the South Campus Psychiatric Residential Treatment Facility as well as the North Campus Residential Treatment Facility. The criteria were developed to set a standard for brief treatment with the goal of providing intense, short-term quality therapy which is child-centered, gender-responsive, family-focused, culturally-sensitive and trauma informed. The treatment focus on both campuses will take a cognitive-behavioral approach, requiring all youth to be of average intelligence and without a *primary* diagnosis of autism spectrum disorder, conduct disorder or substance abuse dependence.

Family and prospective community placement resources will be included in the placement and treatment process from intake through return to the community. Family involvement is expected and will be supported.

South Campus Psychiatric Residential Treatment Facility (PRTF)

The South Campus will offer 16 beds for adolescent girls ages 13 through 17 who require a 24-hour brief inpatient residential setting and structure. The PRTF units are less intensive than an acute inpatient hospital unit and more restrictive than a residential treatment facility or community-based treatment programs such as partial hospitalization or intensive in-home services. The PRFT units on the South Campus will serve as a step down from inpatient

psychiatric units and as a diversion to inpatient psychiatric care such as provided by the Emergency Departments.

Girls admitted will:

- Have recently met acute inpatient psychiatric hospital criteria while not meeting continued care criteria
- Have shown intermittent acuity and a recent history of rapid decompensation
- Have had less restrictive treatment interventions that were not successful
- Require medication evaluation and adjustment that can be managed in a PRTF setting
- Present with complex psychiatric needs amenable to short-term intervention
- Have the ability to participate in cognitive behavior therapies
- Have a discharge plan, presented at admission, which can be effectuated within 120 days of intake.

North Campus Residential Treatment Facility (RTC)

The North Campus Residential Treatment Facility will offer 24-hour care to 38 boys ages 13 through 17 years of age. The RTC is reserved for boys whose psychiatric and behavioral symptoms require the structure and support of an all-inclusive, contained, therapeutic and educational environment. The North Campus RTF will serve as a step down from inpatient care, transition from out-of-state residential treatment and/or be the treatment choice for some youth who have been unsuccessful with community treatment interventions. Referral packets will demonstrate a need for this level of care as evidenced by documentation of all efforts to provide youth with less intensive levels of intervention.

Boys admitted will:

- Have recently shown a series of behaviors such as self injury, aggression, impulsivity that cannot be contained, treated or evaluated in a home environment with community services and support
- Be at moderate risk for requiring intensive interventions that require 24-hour awake supervision
- Present with complex psychiatric needs amenable to short-term intervention
- Have the ability to participate in cognitive behavioral therapies
- Have a discharge plan, presented at admission, which can be effectuated within 120 days of intake.

Admission and Census Timelines and Benchmarks: June through October 2011

The initial identification of youth for admission to the North Campus 120-day treatment program is now underway. This process has included consultation with leadership and staff of Value Options as well as staff from the South Campus of the consolidated facility and from the department's area offices. To date, four youth have been newly admitted, with pre-placement

interviews being arranged for three more. Specific discussions have been initiated with reference to an additional six youth currently in out-of-state placement.

The goal for the North Campus residential treatment units is to admit approximately six additional youth over each 30-day period during the coming 120 days, in manner reflective of the admissions criteria outlined above and the family engagement and educational planning considerations outlined below. The timing of specific admissions will be impacted in part by the current residence of young people being considered for admission (e.g., whether they are in-state or out-of-state). If successful in achieving these targets, the North Campus program will attain full census during October.

Among the challenges to achieving these census and occupancy targets is the fact that for many youth in congregate care, discharge goals included in their plans to date have not been specific in terms of a return to family or to a community setting. Thus for many of the cases being reviewed for admission, the task has involved working to identify a viable plan for community reintegration in which the North Campus program is not “the plan” but rather a means toward achieving the plan within a 120-day period. Not all of the department’s area offices have been preparing discharge plans as part of their case planning, and as a consequence, the task of generating appropriate admissions has proven to be more complicated, and less swift, than initially expected.

The goal for the South Campus Brief Treatment Units is two-fold. First, we must re-open a closed unit; second, we will vacate and then re-open a unit presently in use as part of the inpatient facility. Training is required for existing staff in the delivery of residential care (as compared with inpatient hospital stabilization and treatment) that aids youth in life skills development and successful community integration.

We do not anticipate a shortage of referrals since there are a number of girls now receiving inpatient treatment at the facility who are stable but at risk for placement out-of-state who would be eligible for the South Campus Brief Treatment Units. There are also girls in out-of-state placement who would benefit from the 120-day treatment environment to aid their transition back to their homes and/or communities.

One challenge to be addressed prior to opening these two brief treatment units on the South Campus is staffing shortages currently resulting from retirements, departures and transfers of clinical and nursing staff to other state agencies. If these staffing challenges can be addressed, the programs and the girls will be ready for a mid-summer opening. The expected rate of admission will be two-three girls a month beginning in the month of July.

Required Documentation

A referral to either the North or South Campus program must be accompanied by a completed DCF Treatment, Family and Community Transition Form (attached in draft form as Appendix A), insurance authorization and the following documentation:

- Completed Treatment and Community Transition Form (South / North Campus Referral Form)
- Recent psychological assessment and/or psychiatric evaluations
- Medical assessment
- Laboratory results
- Immunization records
- Insurance information
- Birth certificate
- Social Security Card
- Information from past placements, including past hospitalizations
- Current medications
- Signed releases for past placement and/or providers
- Current Individualized Education Plan (IEP), CT Mastery scores, most current report card and school disciplinary record
- Signed Permission to Treat form
- Signed authorization to obtain educational records.

In addition, admission to the North Campus units requires completion of the CANS (Child and Adolescent Needs and Strengths Comprehensive Multisystem Assessment). If reunification with the family is the expected discharge plan, staff will work the family at the time of admission to assure their agreement with this goal at the 120-day treatment period.

Family Participation

Families will be supported as full and equal partners in the behavioral healthcare services provided to their children. Behavioral healthcare generally, and congregate care in particular, has not consistently met this standard. It is clear, however, that this is the standard against which the consolidated facility should and will be judged. Making this a reality – that is, moving from value to practice – will require honest communication and the ability to create shared goals and mutual expectations with families as partners.

Concrete action steps to achieve this goal will include but not be limited to:

1. A pre-placement interview will be held with the youth, his/her family and appropriate stakeholders, including the department's regional area office staff. During this interview, the provisional discharge goal will be discussed, along with the respective roles of the facility team, youth, family and other stakeholders in helping to achieve that goal.
2. The intake/orientation process will include a family component that explains trauma-informed practice and/or dialectical behavior treatment with the goal of fully integrating the family into the care and treatment of its child. This orientation will

provide information about the educational services, rehabilitation therapy and clinical groups as well as individual and family therapies and psychiatric care that comprise the treatment experience.

3. Barriers to family participation (e.g., language diversity and transportation needs) will be identified and addressed. Family needs and preferences related to religion or culture will be prioritized in the delivery of treatment in order the services delivered are culturally sensitive.
4. Families will be included in treatment and discharge planning meetings. Scheduling for treatment sessions and treatment team meetings will seek to align with times that facilitate the participation of the family.
5. Families will be provided with specific contact information for the members of their youth's treatment team. They will be encouraged to communicate their wishes and concerns throughout the course of care.
6. Families will have concrete opportunities to provide feedback regarding their satisfaction with care. This information will be included within the facility evaluation plan.
7. Therapeutic interventions should have relevance for families and facilitate youth and family functioning outside of the facility. These interventions will include opportunities for training and support that assists families in understanding and effectively addressing the needs of their youth.
8. Clinical staff will participate in family therapy training and will be invited to identify additional staff development opportunities that promote family-centered practice.

Education Planning

Education planning in a placement context begins when planning for the placement begins. Assuring that a youngster's educational needs can be met is essential to the success of the treatment process.

- For a youngster who is identified as in need of special education or related services, planning begins with the examination of the Individualized Education Program (IEP). The IEP must be included with the Child and Adolescent Needs and Strengths Multi-System Assessment (CANS)³ so that the prospective placement facility can assess and plan for meeting the educational needs of the youngster.

³ This particular assessment is a required tool of the CT Behavioral Health Partnership. The CANS manual can be accessed online at -- www.ctbhp.com/providers/rescareteam/CANS_MANUAL.pdf

- For a youngster with a disability identified under Section 504 of the federal Rehabilitation Act, a copy of the 504 Accommodation Plan must be included with the CANS, along with its corresponding evaluations.
- For students who require “regular education,” information regarding the students’ current grade in school along with information on academic and behavioral functioning in school must be included in the CANS. This information should include but not be limited to a report card, attendance and disciplinary records, and current Connecticut Mastery Test (CMT) or Connecticut Academic Performance Test (CAPT) scores.

The Decision Process

The decision to admit rests with the consolidated institution. For North Campus, the required documentation specified above for youth meeting the inclusionary criteria for the brief residential program will be reviewed by the Campus Clinical Director or her/his designee. Youth deemed appropriate will be matched to North Campus available vacancies in the brief treatment program within 5 days of receipt of the referral information, CANS and BHP authorization in its entirety. For South Campus, the required documentation specified above for youth meeting the inclusionary criteria for the brief residential program will be reviewed by the Campus Clinical Director or her/his designee and if appropriate for treatment, youth will be admitted after BHP authorization.

Whenever possible, youngsters approved for admission to either the North or South units will have a pre-placement meeting including a tour of the facility for the youngster and his/her family or adult support system.

Youth in Brief Treatment Who May Require Acute Inpatient Services

Youngsters being cared for in the six brief treatment units are the most behaviorally and psychiatrically complex youth in Connecticut. Due to this complexity, there may be a need for a short term inpatient hospitalization. In the event that a youth in care at one of the six residential treatment units is deemed to require acute inpatient psychiatric care, transfer to the inpatient program at the South Campus will be effectuated with Medical Director/designee approval. Leadership is currently working with legal staff to confirm this position.

Training, Consultation and Staff Development Needs

The consolidated facility will partner with the Department’s Academy for Family and Workforce Knowledge and Development in all existing and future training initiatives. Staff liaisons have already been identified. This relationship will be instrumental in the success of the consolidation.

In assessing our strengths and challenges as we move forward to become a center of excellence and to set a standard of care which other similar facilities will eventually mirror, the consolidation team has identified an essential set of training initiatives.

The proposed populations to be treated at both the North and South Campuses require demonstrable staff knowledge and skill in the use of trauma focused – cognitive behavioral therapy. The plan is to train clinical staff in this approach and to receive consultation in the implementation of this therapy to ensure adherence and a level of supervision that has shown successful in the sustainability of a treatment approach.

Over the past year and a half, both facilities have been receiving monthly as well as individual case and program consultation from Kristine Kinninburg, co-developer of ARC (Attachment, Self-Regulation and Competency) for the trauma institute at the Justice Resource Institute (JRI). She has been well received by our staff. On the South Campus, the young child unit has adapted a milieu program based on the ARC model that has shown tremendous results including the reduction of restraint and seclusion. The proposed training will consist of 2 two-day trainings, one on each campus, and 24 hours of consultation following the initial training.

Two ongoing training initiatives will remain a priority: American Humane Association Supervisors Training and training and consultation on Dialectical Behavior Therapy. The Humane Society's Supervisors Training has shown benefits in the implementation of concepts related to supervision and leadership, while the Dialectical Behavior Therapy training initiative has been sustained for almost four years and serves as a model for collaboration between state and private facilities.

Lastly, a multidiscipline team has been identified to review milieu programs from both campuses and identify training needs cross campuses. This work will be conducted with the DCF Academy for Family and Workforce Knowledge and Development, with results reported to senior facility leadership and the Implementation Steering Committee.

Emerging Union Labor Issues

An expanded subcommittee of the Consolidation Working Group has begun to meet to identify and then address an emerging set of labor and contract issues resulting from creation of a single institution. A representative set of these issues follows:

- Hours of work, work schedules and overtime
- Promotions and lateral transfers
- Stipulated agreements related to in-charge pay
- Shift over- and under-coverage and temporary transfers across sites
- Sick leave
- Worker's compensation
- Vacations, holidays and personal leave
- Members on Labor Management Committees.

Emerging Infrastructure Issues

The Consolidation Working Group is identifying a series of infrastructure issues to be presented to the Implementation Steering Committee. These issues include:

- Incompatible data systems across the original two behavioral health facilities
- The need for policy, procedure and forms review across the consolidated entity (including a common treatment plan)
- Development of performance measures for the brief treatment units, and
- An implementation strategy for the use of Results Based Accountability and “implementation science.”

In addition, the senior leadership team of the consolidated facility is actively reviewing the broad variety of ongoing staff meetings across the two facilities to determine where redundancy can be reduced and where joint attendance is required. Opportunities for teleconferencing and video conferencing are being explored with the department’s Director of Information Services.

Work will also continue to include the two South Campus units under the hospital’s JCAHO status.

Strategic Communications

Two aspects of strategic communications have been identified as key to the successful consolidation of Riverview Hospital for Children and Youth and the Connecticut Children’s Center. The first concerns the continued commitment to ongoing, predictable and interactive information exchanges with staff across the consolidated facility. Meetings with staff at each facility as well as cross-facility staff visits and meetings have been underway prior to release of the *Future of Riverview Report: Ten Steps Forward* in April 2011. In addition, the new superintendent will begin a process of weekly formal email updates.

The second area of concern is the need to develop new descriptive materials that depict for external audiences, including parents, providers and policy makers, what is new and what remains the same in the process of consolidation. This includes a rapid revision to departmental web pages that describe both Riverview Hospital for Children and Youth and the Connecticut Children’s Place. The need for strategic communications assistance will be brought to the Implementation Steering Committee at its July 2011 meeting.

Part IV: Ten Steps Forward Progress Update

1. Consolidate the administration of Riverview Hospital with that of the Connecticut Children's Place

Responsible Parties: Consolidation Working Group and the Implementation Steering Committee as identified in Part II of this report.

Progress Update: The administrative consolidation is underway and a new superintendent of the consolidated entity began work in that role on June 1, 2011. Other aspects of the administrative consolidation are outlined in Part III of this report

2. Integrate pediatric services across the consolidated institution and the Connecticut Juvenile Training School

Responsible Parties: DCF Chief of Pediatrics, Dr. Fredericka Wolman with Superintendent Michelle Sarofin of the consolidated entity and William Rosenbeck, Superintendent of the Connecticut Juvenile Training School

Progress Update: Planning is actively underway to effect this change. With the retirement of one of 2.5 FTE pediatricians across the three facilities, existing physicians will be reassigned to cover all youngsters in a coordinated manner.

3. Plan for operation of six inpatient psychiatric hospital units at the South Campus (formerly Riverview) and six specialized treatment units, two at the South Campus and four at the North Campus (formerly the CT Children's Place)

Responsible Parties: Consolidation Working Group; Consolidated Senior Leadership; Implementation Steering Committee

Progress Update: Progressing as reported in Part II of this report. Generally on time and on target.

4. Improve linkages between the new behavioral health institution and the department's regional service areas

Responsible Parties: DCF Central Office, DCF Regional Directors and senior leadership of the consolidated institution. This work will be aided by the Implementation Steering Committee.

Progress Update: Agency personnel are regularly briefed on the progress of all ten action elements. A representative of the DCF regional services structure is a member of the

Implementation Steering Committee. The consolidated entity's Chief of Psychiatry for Institutions (consolidated entity Medical Director) is working as a leadership team member with the Chief of Psychiatry for Regional Services and the Chief of Pediatrics. A more formal process to explore ways to improve linkages will begin in August when the six DCF new regional directors are hired and begin their assignments.

5. Assign oversight of the consolidated institution to a new division in the department's Central Office

Responsible Parties: Commissioner and Deputy Commissioner for Operations; Key Department of Administrative Services leadership

Progress Update: This is one action item that has demonstrably changed since issuance of the Future of Riverview Report in April 2011. As the departmental reorganization continues, it has become clear that a more appropriate reporting relationship for both the consolidated entity and the Connecticut Juvenile Training School is directly to the Deputy Commissioner for Operations. That change is being implemented now. There will be no new division related to residential and institutional services as earlier conceived.

6. Continue to serve as a teaching hospital for residents in child psychiatry

Responsible Parties: Dr. Muhammad Azeem, Medical Director and Chief of Psychiatry for Institutional Services and the Training Director for the consolidated entity

Progress Update: New residents for the coming state fiscal year have been identified and will begin their residencies shortly.

7. Expand strategic relationships with other state agencies providing services for children and adults with complex behavioral/mental health needs and individuals with developmental disabilities

Responsible Parties: Central Office staff and leadership from the Department of Mental Health and Addiction Services, and the Department of Developmental Services

Progress Update: Strategic planning discussions are underway with draft Memoranda of Understanding in preliminary draft form at the present time.

8. Participate in the department's new Academy for Family and Workforce Knowledge and Development to expand training opportunities within and among the department's institutional and regional units

Responsible Parties: Senior leadership of the consolidated entity, training staff across the consolidated entity, and leadership from the Academy for Family and Workforce Knowledge and Development, Dr. Michael Schultz and Jodi Jill-Lilly.

Progress Update: An inventory of ongoing training across the consolidated facility is underway as part of a similar inventory for the rest of the agency. Training staff and liaisons have been identified and are beginning to work with Academy leadership.

9. Develop agency guidelines on restraint and seclusion by October 1, 2011

Responsible Parties: Agency work has been underway on this action item for over a year, prior to issuance of the Future of Riverview Report. That effort is lead by Dr. Arnold Trasente and Dr. Lesley Siegel.

Progress Update: It is expected that this action will be accomplished by the October 1 self-imposed deadline.

10. Apply implementation science and a Results Based Accountability framework agency-wide over the next 24-36 months.

Responsible Parties: This is an agency-wide initiative with all leadership assignments yet to be made.

Progress Update: One component of this work has already begun through a performance contracting initiative related to RBA led by the Deputy Commissioner Libby Graham. Ongoing Results-Based Accountability training is being completed by Academy staff member Anne McIntyre Lahner.