NC Placement First Demo

Who are we trying to target?

• Those in the custody of county social service agencies who have been found to be abused, neglected and/or dependent and are difficult to place.

• Experienced significant trauma and need strong supports to grow and build resiliency.

• Disproportionally marginalized youth who are experiencing foster care.

Basis for this Work:

• All counties are apt to have youth in their care at any given time that need placement. Over the past few years, the challenge of placement and services for these youth has intensified and with that, counties have intensified their efforts with DHHS and the LME/MCOs to address this crisis unsuccessfully.

• Counties attempted to collect their own data and many, as resources allowed, developed county plans to address the issue. While counties continue to work to solve placement and service issues every day, county solutions are not the answer.

• The urgency of the issue requires key partners to come together and plan creatively for immediate system solutions founded on promising ideas.

• DHHS created three cross divisional teams made up of subject matter experts and executive leaders from DMH/DD/SAS, DSS, and NC Medicaid to develop and implement near and long-term solutions to prevent youth with significant behavioral health needs from languishing in inappropriate settings.

• These youth and the services being proposed align with the goals and outcomes of child welfare reform and FFPSA.

• System solutions must be planned, implemented, and funded.

• The design of this pilot is intended to address this crisis for youth regardless of where the live.

Why can't the current system serve these youth?

• The reality is that it should, but these youth are marginalized due to the "leveled system" that exists in NC.

• The current board rates are based on traditional congregate care to serve youth with similar lower acuity levels. The cost model assumes a certain number of youth can be placed together who blend well.

• These youth need more individualized attention in a smaller setting, but the current rates and structures in place do not allow enough flexibility or economies of scale to allow for support targeted services.

Data:

• Based on an April study conducted by NCDHHS, we can clearly see what our many of our vulnerable youth are experiencing.

• Because we struggle to get youth into the lowest level II & III settings, and other types of wrap around supports/treatment, they decompensate and have worse outcomes creating an even higher demand for PRTF settings. We are simply perpetuating the outcome none of us want for these youth.

Service Values:

• DSS offices/ER/hotels and other non-family like environments are never appropriate.

• Youth should be given immediate access to resources to begin to heal.

• Placement and services go hand in hand.

• Family-like environments promote stabilization.

• Address these issues more upstream by providing supports to youth, kinship, and professionalized foster care settings that allow them immediate access to the least restrictive settings that best meets his/her needs (no cookie cutter approach).

Tenants for Placement and Services for Providers:

• Be committed to Child Welfare outcomes as defined by the Youth's Bureau (those around Safety, Permanency and Well-Being).

• Demonstrate a commitment to Trauma Informed Care.

• Have strong understanding and commitment to youth who likely have significant therapeutic and placement needs and a deep understanding and commitment to meeting child welfare outcomes.

• Be committed to serving youth regardless of their county of residency.

• This is a "placement first" demonstration project with the primary goal of reducing the number of youth who are in unstable living arrangements such as DSS offices, hotels, emergency rooms etc. but it is not "emergency shelter care". We are looking to those agencies currently licensed by DSS and who are already in the space of providing Medicaid services (or have a strong interest and are moving toward this), are providing wrap supports to youth to prevent disruptions of placements. We are looking for agencies who will commit to transitional care for up to 60 days post discharge. **NOT** looking for placement for youth who have been confirmed to need higher acuity levels of care such as PRTF or other care based on a DSM diagnosis.

• This is a time-limited to placement with a goal of finding placement at the lowest level possible (kinship, family foster, TFC). The goal beyond getting these youth somewhere safe, in an environment where there is as much normalcy as possible, is to begin to offer "stabilization services". This includes having loving responsible adults providing consistent around the clock care and supports. We like the

model of profession parenting where the number of adults coming in and out of their lives as caregivers is minimized and limited. We also believe these adults must be well trained to appreciate and manage significant behaviors because of the child's trauma and their limited resiliency skills.

• Youth need intensive attention; therefore, there should a limit in the number of youth placed in a home at any given time. In fact, there will likely be situations where they may need to be the only young person in the home (at least until they are stabilized).

• A system that is "ready" to receive placement with little notice. These youth are in unstable living conditions and need an immediate and appropriate place to sleep.

• Participate in finding appropriate longer-term placement as quickly as possible

• Actively participate in child and family team meetings and partner in working toward permanency goals including participating in court if needed.

• Accept all youth that fall into the demonstration criteria when space is available.

• Partner with MCO's (as they currently do) for any enhanced services.

• Include the voice of the child throughout the process.

Service Goals:

• Reduce the number of youth who are without placement and minimize placement disruptions.

• Collect robust information about "who these youth are", their histories, their families' histories, their service and placement needs.

• Provide upfront stabilization services to prevent youth from needing higher levels of care.

• Document a longer-term solution based on information collected during the demonstration.

• Align with other child welfare reform efforts where this crisis has been identified.

Core Offerings:

• Beds would be paid to be held to serve these youth.

• Family like setting with full-time, live in 24/7, professionally trained substitute families/staff who can provide more direct level interaction (using a mixture of Foster Homes, TFC, and/or cottage care models depending on the needs of the child).

• Must ensure consistency among baseline offerings, but providers can use their own standards/modalities if they commit to the child's treatment plan to include physical, behavioral, educational and social needs (with an emphasis on their permanency plan) all using a trauma informed lens.

• Standardize referral, admission, and discharge process with clear role delineation of provider and DSS.

• Staffing and placement within 24 hours.

• The local DSS will lead a CFT Meeting within the first 7 days to discuss the youth's Plan of Care and at intervals no longer than 14, 30, 45, 60, 90, and 120 days. Discharge occurs when appropriate placements needs are documented, and placement is secured.

• When a child reaches the 90-day threshold if there is not movement in his/her plan, the youth will be escalated/staff with the NCDHHS team for resolution and further analysis as to the reason.

• Weekly Treatment Team meeting to assess the progress of each child.

• Wrap-around supports including a space for stabilization of behavioral issues.

• Core offerings include:

o Initial Health Assessment within 24 hours of Admission

- Initial Individualized Treatment Plan within 24 hours of Admission
- Initial development of a Safety/Crisis Plan within 24 hours of Admission
- Educational Assessment within 48 hours (and enrollment when available)
- Initial Medical Assessment within 7 days of Admission
- Psychiatric Services Assessment and Medication Management, if needed
- Comprehensive Medical Assessment within 30 days of Admission
- Comprehensive Individualized Treatment Plan within 30 days of Admission
- Individual and Group therapeutic services
- Recreation

Independent Living Skills training (age appropriate)