NCACDSS Committee Meeting MINUTES

**Children’s Services Committee**

**Wednesday April 10, 2024**

2:15-4:15

**Virtual Zoom Meeting**

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| **MINUTES** |
| **Welcome from CSC Chairs:** Jennie Kristiansen, (Chatham County) Kathy Ford, (Pasquotank County), Kimberly McGuire, (Wayne County), and, Bobbie Sigmon, (McDowell County) |
| **Approval of March 2024 Minutes**Motion to approve the March 2024 CSC Minutes was made by Karen Harrington and seconded by Laura Harrison. |
| **Behavioral Health Funding** was originally on the Agenda; however, was not presented on this date. **FFPSA Update**, PowerPoint included, Heather McAllister* Implementation continuously underway and working at state level on policy and training plans to support Home Builders (an intensive, in-home, skill-based program, well-supported – evidence-based practice for families with children 0-17 at imminent risk of placement or needing intensive services to return home from foster care group or residential treatment/ short -term services/ crisis-intervention to help address the concerns for those at risk of entry into foster care) implementation; ‘implementation of title IVE underway also.
* Several components being worked on also.
* Home Builders (HB) - began Feb. 2024 to provide services to the county;
* Working with providers in counties with implementation process and continuous quality framework and fidelity measures.
* Institute of Family Development, model purveyor and strict fidelity to the service – will reference how this impact of building capacity across the state.
* Challenges – CNDS number is critical – specific child identifier for federal reporting… must report post services at 12 months and 24 months and whether the child entered foster care.
* Insuring that trauma screening is provided and sharing with providers as part of the service plan with the family to help with communication w/ parent and help with families.
* Working on plans to provide supports to counties
* Transitioning IFPS services to HB; selected 3 agencies to provide services to the 7 regions across the state:
	+ CHS (Regions 1,2,4);
	+ Crossnore (Region 3); and,
	+ Coastal Horizon Center (Regions 5,6,7)
* Prescriptive training process for the HB Specialist
* HB Specialists must be within a 60 mile range of the families served as they are expected to be able to respond to crises if needed – working closely with providers to address capacity and availability of the service within the counties. Expanding to provide the service.
* Initiation training was virtual but looking at in-person training with next round of 4 counties with the prevention specialist assigned to the county and the provider.
* Referral processes reviewed - List of counties onboarded – 22/ not handy and will pull out the map and share via email unsure about staff testifying in court;
* Goal to stay in the home and prevent entry into foster care/ explain model to the caregivers and at least 1 must be willing to participate
* An intensive service – family commitment to services to keep child in the home.
* Developing early CQI process and for collecting the federal data and what is needed for that
* What changes may need to be made is the purveyor of the model involved in the CQI? They have their own process. we will bring them in as we find early challenges and/or issues that the providers may have with respect to implementation the model within their agencies.
* Feedback process underway. State is contracting with both providers and
* What is the capacity for the state and when we will have full implementation for all 100 counties? Heather will get back to us with projected numbers. We are at week 8 and rolling in 26 counties. Capacity building has had restraints and contingent on the hiring
* Providers must keep counties informed weekly of capacity to serve and no wait list due to the imminent risk of foster care.
* Next steps – finalizing policies
* How to address barriers for better implementation
* Have had positive feedback from counties and the providers – specifically re: communication and using lessons learned to improve the process.
* # of counties enrolled 26
	+ Region 1 - 2
	+ Region 2 - 6
	+ Region 3 - 6
	+ Region 4 - 2
	+ Region 5 - 2
	+ Region 6 – 2
	+ Region 7 - 6

Since Feb 2024 - 42 children served thru the HB services.Challenges – hiring of the provider staff and training and making sure we are bringing in the right number of counties to insure the new staff have the cases to train with following approval by the Institute. Also, issue with referral process (need to work with the CW staff) and insuring that all required components are included as part of the referral. Ie., CNDS # is important for federal reporting and impact of the service. Next training with the county staff will be ‘in person’. Unknown regarding testimony in court; Heather will share which counties are currently enrolled.**NC Psychiatric Access Line (NCPAL)/**PowerPoint IncludedDr. Courtney McMickens and Dr. Alexis FrenchDr. French – provided background on children’s mental health in NC/ 17% increased since pandemic; only 345 child and adolescent psychiatrists in NC; and more than ½ of the counties have no child/adolescent psychiatrists thereby resulting in primary care providers faced with managing these conditions.* As a result developed NCPAL and the goals of the program are to build mental health knowledge and capacity to equip them with meeting the mental health needs of children;
* Provide education, resources, consultation;
* REACH formal behavioral health training program
* Began in 2017 – funding to do a pilot in 6 counties from Cardinal; and in 2018 received another grant;
* Access line for pediatric and perinatal.
* Monday – Friday/ 8-5 anyone can call this line to talk with behavioral health consultants and/or child and adolescent psychiatrists to talk about diagnosis, screening, resources, treatment, medications
* REACH – 3 day training; if interested, link is listed in the ppt... Free for primary care providers in NC – free pediatric mental health training
* 2022 received funding from DHHS and DHB to expand programs to other areas (social services, schools, early childhood and IDD population). Have received additional funding in the fall of 2023 and per state legislation thru 2025 to receive funding
* Coordinated Action Plan aims to address urgent crisis of children w/ complex behavioral health needs who come into the care of child welfare; transformation child welfare and family well-being - a coordinated effort dedication to creating prevention and treatment – NCPAL is included in the state’s coordinated action plan
* NCPAL Child Welfare Collaborative (the social services program) 2 things provided – part of the rapid response team (M-F @ 8am to staff cases w/ placement disruptions and provide consultation around mental health needs of the children)
	+ pilot program known as the PPC-CW/ Pediatric Psychiatry Collaborative for Child Welfare;
* As part of the team – has a number of social workers, other relative professionals and an administrative team members. Led by 2 doctors referenced.

Dr. McMickens* Some of the providers are on the RRT calls in the AM and once transition to the pilot program, the psychiatrists and providers are part of the pilot program also including admin staff to support education resourced shared with counties.
* Started pilot as a part of the child welfare collaborative as learned from RRT that there were opportunities for earlier engagement with mental health providers and services that may lend itself to a psychologist and psychiatrist consulting with DSS staff on a local level to help support children involved in child welfare – mental health needs and offer mental health support to local clinicians; reduce placement disruptions by working earlier in the case process.

PPC-CW Pilot components* Engagement – visited the 3 counties worked with
* Evaluation – to understand the challenges and the successes experienced by DSS around obtaining mental health services for children and engaging with providers;
* Education – quarterly learning community meetings to discuss topics addressed in the focus group materials or site visit;
* Consultation- meet weekly with counties and send out bi-weekly bulletins

3 counties working with – Wilkes (year); Sampson; BrunswickYear 1 progress….. mapped out in the PPTWeekly clinical drop in hours…variation by county with goal to meet with staff with the DSS office re: diagnoses, medication, discuss case in depth; and other topics. Strategies to address such crisis and work with community/out-patient providers, etc. Reviewing types of assessments to be done. Ie., ASD; side effects of med; discussion around trauma, trauma symptoms and treatment.Resources – Example of the resources emailed every few weeks – picks topics to share; some available some designed by pal based on comm with countiesLook at making changes based on feedback from the counties. Looking ahead year 2 of PPC-CW Program; would like to expand to additional counties.Rethinking for next year as it relates to ‘weekly’ drop ins and make it every other week and making it avail to all staff within that county; the Learning communities valued by all 3 counties;Want to building upon relationships with local providersNCPAL Consultation service – not direct service/care…. Value would be to connect with the local providers within the local area – maybe even visit those providers/ reach out and connect w/ them. Had been able to do the REACH program (educational component of the NCPALs program) with some of the Brunswick/Wilkes county providers to support more primary care providers in serving children with behavioral health needs.Less utilized in the first year – complex case consultation…. Wants to do more of this…. review and bring together pieces of the puzzle to conceptualize what is happening with the child. Doing this before it gets to RRT. Wilkes county team, brought in MCO and meeting with the supervisors – have been most active in the pilot with a set time to discuss cases and high-risk cases and MCO has joined to provide additional support. Less participation with counties has been issues with staffing and acuity as an issue. Wants to be able to support counties in those areas as well.Common questions about the PPC-CW Program….. are re: direct services. The goal of the program is NOT to conduct direct services but rather to ‘connect’. Connect children to providers who can provide direct services and appropriate services;Has a list of providers they use from the larger NCPAL program… Main issues around kids in the DSS office and in emergency rooms. NCPAL is not able to provide a crisis management service. Other questions? **NCPAL open to any provider working with in your county. Including primary care providers.**NCPALDSS@duke.eduFor Wilkes, this has been a great resource – esp. preventing kids from being in the DSS office.Working on how to best assess that given only working with 3 counties and the variables – including kids admitted to emergency room – don’t have the documentation and previous data. Have anecdotal situations * Talked with a group home re: why this was a safe situation at this time / talked the group home through it to help show the effectiveness of what they are doing.

Process for addition additional counties. If interested, let them know. Hopefully starring July or August to add counties??? When LME/MCO rep has been involved – is that someone within the org or the embedded care coordinator? In Wilkes, it has been the embedded care coordinator.**Child and Families Specialty Plan (CFSP) Update**, PowerPoint includedChameka Jackson, DHBJackson presented on the background of Managed Care; CFSP and an overview of the key design areas. DHB is currently in the ‘silent period’ and cannot reference anything regarding the procurement of the CFSP. * Medicaid Enrollment Options slide/ re: Phase 3, the final phase (launch CFSP) was referenced via legislation but the date is not realistic and DHB is discussing this for the purposes of updating.
* Children in foster care and receiving AA and former foster youth aged out of FC are carved out of managed care and not enrolled with any managed care plans; therefore are still under Medicaid Direct (fee for service) – they will be eligible to enroll in managed care via the CFSP once it goes live.
* Innovations waiver will be enrolled in the Tailored Plan.

CFSP is designed to address current system challenges… recognizes that the system is confusing right now and among workers across counties. There is a lack of service coordination which impacts access to care. A child in foster care may be receiving care management through CCNC (primary care management entity for Medicaid direct as well as the LME/MCO). Later had children still in Medicaid Direct but enrolled in Tailored Care Management. DSS agencies are having to work across entities to manage care. Creates challenges. * CFSP Objectives
	+ Improve members’ near-and long-term physical and behavioral health outcomes;
	+ Increase access to care;
	+ Strengthen and preserve families; (Prevent entry into foster care)
	+ Coordinate care and facilitate seamless transitions;
	+ Improve coordination and collaboration with county DSS agencies, EBCI Family Safety Program and more broadly, with Community Collaboratives;
	+ Provide services that meet children’s behavioral health needs;
	+ Advance health equity.
* Shared an overview of the CFSP Design Process. Started discussions back in 2017.
* Stakeholder input on CFSP design was via a CFSP Workgroup in 2023 which included diverse representation across sectors impacting access to care for children/families involved in child welfare.
* From a national standpoint – there is no other plan like this and NC will be the first; no other plan to holistically serve families.
* Key Design Areas
	+ This will be a single-statewide plan and only 1 provider will be awarded the plan; there will not be multiples
	+ Any external vendor may contract;
* CFSP will be launched in 2 phases. Phase 1 for children in foster care, those receiving Adoption Asst. and those youth over 18 who have aged out of foster care.
* Phase 2 no earlier than June 30, 2026 – parents/guardians/family members/siblings of children in foster care but they must be enrolled in Medicaid and will have the option to ‘opt in’.
* People in phase 2 must be enrolled in Medicaid and will have the option to enroll;
* Inquiry about whether KinGap was included in the design? No - later confirmed that Medicaid is part of KinGap. (Important to flag… clarified that children may continue to have Medicaid in such situations).
* Will be working together with other divisions to identify those eligible. Will have to build a process to associate via a Medicaid id number to gauge population size.
* Working with CWIS to determine the needs for collaborating.
* Comprehensive set of benefits identified on page 17 –CFSP will not have the same small subset of services to report.
* Family Centered - Care Management in close coordination with DSS – full scope/benefit yet to be seen – regardless of geographic location.
* There will be requirements around contacts.
* Care managers can be sub-contracted but can also be co-located in the DSS agency.
* Care Management Extenders – family partner/ peer-support specialist to help support the family and then the care manager can do more to support the family.
* Network capacity issues to be reported.
* Provider Network / slide pg 20
* Concern brought forth about ‘any willing provider’…. Some providers may submit an ‘exception’ and may occur with CFSP because there will be certain services that providers will not be able to be located.
* Has there been exploration for funding models to address such – ex. When distance is an issue vs. a home-based service.
* Expectation is for CFSP is to ensure that the members in this plan have access to all Medicaid state plan services regardless of where they are.
* Quality/ Performance Improvement projects/ clinical and non-clinical; annual plan around utilization and other demo factors. Via ECDU system and all health plans are required to send in report data.
* With 10 – 12k kids in foster care in NC, anticipate they will serve many adults given currently 32k – former foster youth with age out at 18 thru 26 means more time in the plan plus continuous enrollment. And, their children can enroll in this same plan also.

RFP Schedule – Deadline for proposals – May 2024; Contract Award by August 15, 2024 |
| No additional questions or suggestions of future agenda items. No committee meetings in May – June is the next CSC meeting.Adjourn |