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An Alliance of Agencies Helping
Children, Adults & Families

Recommendations for NC DHB Carve-Out Plan: Child Welfare and Foster Care

December 2020

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Introduction

North Carolina houses the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (NC MH/DD/SAS), the NC Division of Social Services (NC DSS) and the Division of Health Benefits (NC DHB) under the NC Department of Health and Human Services (NC DHHS). Like most states, the divisions experience challenges integrating their work because the federal funds supporting each division require different federally mandated regulations, outcomes, accountabilities, and incentives. The Divisions utilize different IT systems which reinforces this siloed approach. The sheer logistics of the 100 counties' DSS administered system and seven LME/MCOs' software platforms, add additional challenges in moving forward with integration. There have been multiple attempts to integrate mental health and child welfare work through System of Care and local pilot projects, but none have achieved systemic change across the state.

Benchmarks represents providers who straddle and work in both child welfare and mental health systems. As such, we are positioned to identify the ongoing challenges of integrating mental health and child welfare services at the local level. In 2011, Benchmarks began researching the problem to try and identify solutions which led to the development of the Partnering for Excellence (PFE) pilot between Cardinal Innovations and Rowan County DSS, in partnership with Duke University Center for Child and Family Policy, which conducted the outcomes research, and The Duke Endowment as the funder.

Since that time, PFE has expanded into 5 more counties and two other LME/MCOs. PFE redesigns the local child welfare/behavioral health system, changing the way county DSS agencies, LME/MCOs, local providers, and the wider community understand trauma and the need for accessible, appropriate mental health services for children, youth and families who have experienced potentially traumatic events. PFE aims to lead communities to an understanding of the importance of trauma-informed and trauma-responsive communities, and to create a lasting change in the identification and treatment of trauma within the community.

Key components of PFE include a trauma screening conducted by the social worker, referral to a trauma-intensive assessment which utilizes critical DSS information, holistic recommendations for the youth which are incorporated into the family's plan and a focus on building a preventive service array of evidence-based practices.

We have consistently found, from our outcomes research through Duke University Center for Child and Family Policy, that PFE has a positive impact on the services provided to youth as well as

the partnership between the local systems. PFE has demonstrated that early screening and assessment reduces restrictive behavioral health services, such as the residential treatment homes and PRTFs, as well as crisis services including hospital stays and emergency room visits.

Youth receive more appropriate diagnoses which are critical to identifying appropriate treatment, allowing them to be served in a lower level of care within their own community. Notably, PFE also demonstrates a reduction in excessive placements. Together, these findings lead to significant cost savings for the Medicaid system and a reduction in the number of traumatic incidents for the child. Qualitatively, PFE helps to make work more efficient for social workers, creates a deeper understanding of trauma behaviors by foster/kinship parents, and allows professionals to build stronger relationships with others.

Benchmarks' local pilots have provided a wealth of information about the fundamental challenges of integrating behavioral health and child welfare to improve outcomes. PFE identified five core tenets that help to create viable partnerships that improve outcomes:

1. ***Establish a shared vision and outcomes for child welfare services between NC DSS, NC DHB, NC MH/DD/SAS***
   The DSS and LME/MCOs (hereafter referred to as "the current MCOs") are charged with different mandates that influence culture and decision making. The misalignment in these outcomes negatively impacts the type and length of service children and youth receive. The county DSS agencies are primarily tasked in child welfare to keep families together whenever appropriate, while ensuring safety of children in the home. If that is not possible, they are responsible for the placement, well-being, and safety of the child with an expectation to achieve a permanent placement for the child within one year. The current MCOs are primarily tasked with providing MH/DD/SAS services for Medicaid eligible individuals and for which Single Stream funds are available. As the Medicaid system has moved away from a fee-for-service model to a managed care system, the current MCOs are investing more in preventive and evidence-based services to provide better quality and more cost-effective interventions.

   Clearly this is a simplistic overview of both county DSS agencies and the current MCOs, but it provides clarity to the underlying drivers of each. Aligning a shared vision and associated outcomes creates the opportunity to harness the collective resources of both and can improve the overall outcomes for children and families that receive service.

   For example, DSS agencies are federally incentivized to limit the number of placements/ moves for a child in the effort to secure permanency but Medicaid incentivizes Managed Care Organizations to move children to lower levels of care as quickly as clinically appropriate. These federal incentives have generally created different approaches between DSS and the current MCOs in their care of youth in foster care.

   However, research shows that a shared child welfare and behavioral health vision to move children to permanency, with as few moves as possible, would support improved outcomes for children across both systems. A study done by Casey Family Foundation found that each out-of-home placement, whether a treatment placement or not, diminishes the likelihood of the child moving back home. As many as 95% of children are likely never to return home

after three out-of-home placements. The study also found that well-being suffered from placement disruptions, including poorer educational outcomes and increased behavioral and mental health issues. Child development research finds that children need consistent attachment to a caring adult to thrive. This is especially true for children in foster care, who have generally experienced trauma before the initial removal, and go on to experience subsequent traumas as a result of being separated from their families. The study notes that children without externalizing behavioral problems in their first placement, are likely to develop behavioral challenges given the additional trauma that accompanies increased placements. The report cited a study which found that children with multiple placements had between 36 and 63 percent greater risk of developing behavioral challenges than did children in stable placements. This example shows how incentives that seem contradictory to care on the surface, can be effectively aligned to create a win-win situation for both organizations.

Once a shared vision and outcomes are established, DSS agencies and the current MCOs 's will need ongoing cross-training on one another's systems (e.g.: access, service array, and federal requirements) to ensure an understanding of how to effectively work together.

Tools like shared staffing, co-location and care coordination have been beneficial in some instances, however, the current lack of shared outcomes and goals continues to be limiting on effecting large scale sustainable change

2. ***Create the ability for electronic sharing of data and communication between the two systems.***
   Data is stored on multiple state and local software systems including NCFAST (DSS) and NCTracks (Medicaid). NCFAST and NCTracks were not designed to work together, as such, the current MCOs and county DSS agencies do not have a shared data or communication system. In addition, individual DSS agencies have their own document management and data systems.

   The current MCOs are reliant on the county DSS agency to notify them if a child is receiving child welfare or foster care services. County DSS agencies do not have access to electronic systems that can identify if a Managed Care Organization is, or has been, providing treatment for the child(ren) or parent(s) unless the family discloses the information. A shared system could ensure better coordination and timeliness of services for children and families.

3. ***To improve outcomes, early identification of needs through screening, trauma informed assessments, and interventions, are needed, preferably before children enter DSS custody.***
   There is not a standardized process of when to administer or what type of screening or assessment should be done for families and children who come to the attention of DSS.

   Early screening and behavioral health services are not the norm for families who are at risk of their child being removed but are often provided after a child has come into the custody of DSS and experienced a disruption in placement. That may mean missed opportunities to

intervene early, potentially preventing removal from the family, or later, multiple failed foster or kinship placements prior to receiving a Comprehensive Clinical Assessment .

A strong trauma assessment is key to identifying the interventions needed and avoiding misdiagnosis. In our PFE pilot project, prior to implementing the trauma-informed assessment, it was common to see a diagnosis of conduct disorder or ADHD for the child. Under a trauma-informed assessment, the diagnosis shifted to PTSD or other trauma-related diagnosis as the specialized approach was able to separate out the behavior exhibited and identify the cause of the behavior. Ensuring an accurate diagnosis is a critical first step to ensure youth receive the appropriate treatment.

Along with a trauma-informed assessment, it is important that county DSS agencies, the current MCOs, and their network of providers become trauma-informed to more appropriately intervene and respond to family needs. Again, without this trauma lens, it is easy to misunderstand a child's symptoms such as resistance to treatment, belligerence, defiance, and other acting out as simply bad behavior. Key components of being trauma-informed include initial trauma training, an ongoing commitment to continued training regarding trauma and resilience, and trauma-informed supervision.

4. ***Collectively identify gaps and design a service continuum that meets identified needs and shared goals.***
The current MCOs regularly conduct gaps analysis to identify where there are issues with access to care. Even when gaps are identified, there may not be providers within the network to fill these gaps, particularly in more rural areas. Some of the current MCOs have created "in lieu of services" to improve quality/outcomes and provide flexibility of services in rural areas.

Many of these "in-lieu of" services have enhanced community-based services to provide support for children in the community to avoid entering a behavioral health treatment facility. However, the current MCOs do not usually develop these services in partnership with DSS. Developing child behavioral health services without DSS engagement leaves gaps in care that may require the use of county dollars to cover treatment. These gaps can lead to disruption of placements, an increase in time to permanency for children in foster care, and the need for higher levels of out-of-home care that are costly to the current MCOs.

5. ***Identify and address Social Determinants of Health (SDOH) needs to keep families together.***
A major contributing factor that results in families coming to the attention of DSS is related to the SDOH of financial insecurity. Connecting families to community resources and helping them secure critical supports such as safe and affordable housing, access to healthy food, child-care, education/training to increase their earnings, etc. are crucial to ongoing family and hence, community, stability.

Investments that focus on SDOH supports that keep families together result in improved outcomes that are much more cost effective than recruiting and paying for substitute families (i.e.: foster families) for children and youth. North Carolina, like most states,

spends exponentially more money on placements outside the family rather than investing in services that address SDOH and/or behavioral health needs of the parent(s) that would keep families together. This defies clinical or financial logic, and, in the process, the system inadvertently causes harm to children, families and communities.

Medicaid Transformation's Impact on Child Welfare and Foster Care

When North Carolina began developing the Medicaid Transformation plan, NC Division of Health Benefits (DHB) also introduced the concept of a statewide carve-out plan for youth in foster care who are currently served under the seven LME/MCOs. This was in response to the ongoing challenge of maintaining uninterrupted services for children across the multiple LME/MCO catchment areas. For children placed outside of a MCO catchment area with relatives or in another placement, access to mental health services can require long drives to the original catchment area or the delay of access to services in the new catchment area. A single statewide carve out would also standardize the support services received by the 100 county DSS agencies. As the five tenets have demonstrated, the partnership between the Carve-Out and each county DSS is critical to make comprehensive service delivery successful.

Knowledge gleaned from years of PFE experience demonstrate that there is a tremendous opportunity under the Child Welfare Carve-Out to design a system that breaks down existing barriers and restructures services that align and incentivize an early "up-streamed" family-centered intervention system.

As noted previously, most behavioral health screening, assessments and interventions take place *after* a child is removed from the home which does not take advantage of the opportunity to intervene early in an effort to *avoid* removal from the family. The Carve-Out provides a unique opportunity to systemically shift behavioral health and SDOH support systems to serve families, in coordination with the implementation of the Family First Prevention Services Act (FFPSA), before removal of a child in an effort to keep families together.

Benchmarks has engaged in discussions with DHB, NC DSS, and MH/DD/SAS regarding the design of the proposed Child Welfare Carve-Out based on our PFE knowledge. When it became clear that Medicaid Transformation was moving forward, Benchmarks felt it was important to strengthen the recommendations for the Child Welfare Carve-Out by having discussions with our community partners on their perspectives. We reached out to DSS County Directors, LME/MCO staff, and providers of mental health, child welfare and substance use disorder services to create a Child Welfare Carve-Out working group.

Our group met weekly to consider what is needed in a carve-out system in order to:

a. keep families together and thus reduce the number of children coming into foster care;
b. minimize moves for children coming into foster care (diminish trauma impact); and
c. assure that children in foster care achieve permanency quickly and preferably with their family or relatives.

The meetings brought rich discussions and varied perspectives. Even given the varied professional backgrounds, we shared the same goal of supporting healthy and vibrant families, granted, our approach, priorities, and interventions were not always aligned.

As expected, many of the lessons learned from PFE were brought forward in our conversations which, as you will see below, were wrapped around the context of designing the Child Welfare Carve-Out. This pushed us towards a deeper level of discussion and understanding. Outlined below are the primary themes the group identified as important consideration in order to establish an effective infrastructure for the Child Welfare carve-out.

NC DHB Child Welfare Carve-Out Recommendations

The NC DHB Child Welfare Carve-Out must incentivize early intervention *prior* to a child being removed from their family

Historically, in both Medicaid and child welfare services, we have waited until there is a crisis to provide services. A wealth of research has shown that this is a costly and time-consuming approach. While many other countries have realized the effectiveness of prevention versus intervention, the U.S. Medicaid and Child Welfare systems are just beginning to embrace this approach. North Carolina DHB is a leader in moving this concept forward through the CMS approval of the "Healthy Opportunities" grant within their Medicaid Transformation plan and the development of the NCCares 360 program. These programs recognize the value of addressing SDOH and its potential impact on reducing/preventing physical and behavioral health needs prior to them becoming chronic, and, therefore, costly.

The same concept of prevention applies to child welfare. The NC DHB Child Welfare Carve-Out (hereafter referred to as "Carve-Out") must institute incentives that focus on family preservation as opposed to highlighting the treatment of families once they are in a crisis that could result in the removal of their children. The truest form of prevention would be identification of families at-risk before coming to the attention of the County DSS, and the provision of SDOH supports to avoid problems from developing. There are many opportunities for early identification and intervention through childcare, schools, health departments and pediatricians' offices.

A *family* approach is paramount to avoid removal and promote permanency

The Carve-Out must create services and payment structures to support *families*, not just their children who meet medical necessity requirements, that come to the attention of a county DSS agency and are identified as at-risk of the children being removed. Families receiving DSS in-home services represent one of the best opportunities to interject early family screening, assessment, and support services to avoid children being removed from families. Providing needed SDOH and behavioral health services would serve to strengthen family stability and functioning to avoid further DSS engagement. Based on clinically appropriate assessments and screenings, the option for more intensive family-centered services should also be available.

This represents a dramatic shift in how the current MCOs approach treatment for families within the child welfare system, not only by upstreaming the services, but also shifting the focus solely away from the child and onto the whole family. This shift allows us to learn what the family needs

first, and then move to the child-specific needs. The primary focus on the child has often ignored the critical role that families play in determining what intervention or treatment placement a child receives. This is crucial as many of the child's needs are frequently met if the family's SDOH, substance use disorder, and/or behavioral health needs are addressed.

Parents must be engaged early and continuously to make a meaningful impact on what are often complex, multi-generational problems. When parents are disengaged because of untimely or inappropriate interventions, child welfare services are extended and can result in increased costs and poorer outcomes for children and parents.

This shift toward a preventative family approach that mimics the preventative care model that the medical community adopted years ago cannot be emphasized enough. Children enter foster care because of issues their parents are experiencing. Until we recognize that healthy parents equal healthy children, we will continue to remove children, pay a substitute volunteer family to care for them, pay for the treatment of trauma the children experience from being removed, and potentially perpetuate this into another generation of North Carolina children.

The Carve-Out should cover the family, not just the child

As noted above, a "family" approach is crucial to the success of child welfare services. Families identified as being "at-risk" of a child coming into care should have their Medicaid coverage moved with the child under the Carve-Out. That means, parents insured under another PHP through Medicaid, would move with their child(ren) to the Carve-Out. Families separated under two different insurance systems results in treating the parent and child in separate siloes, likely impacting efficacy of treatment and length of services.

Including whole families under the Carve-Out umbrella is particularly important for uninsured parents of children in foster care and at risk of out-of-home placement. This may require recognition within NC's Medicaid program through the Carve-Out waiver request that achieving permanence for children is medically necessary and that the whole family is the focus of treatment, without having to identify a specific individual i.e., the child.

Shared goals, understanding and cooperation is key to integration

Shared goals and outcomes must be clearly identified between the child welfare system and Carve-Out. Keeping families intact should be the primary goal in both systems. When that is not possible, moving children to permanency expeditiously should become the primary focus. This shared message is crucial for families receiving services. A major struggle for most families is navigating government systems that collectively exist to support them but do not share common goals and outcomes. This can result in mixed messages and confusion for the families which can lead to disengagement. Keeping families together and moving to permanency revolves around parent (family) support, engagement, and quick access to needed resources to mitigate the conditions that resulted in child welfare's involvement.

North Carolina's five-year plan for child welfare emphasizes that all children in North Carolina should be safe, healthy, and well. Shifting to a primary focus of "permanency" incorporates of all three of these outcomes. The Children's Bureau has developed language to create a broader

definition of permanency that recognizes these priorities and establishes the concept of safety as an important component of permanency.

This represents a more holistic approach to child welfare services. DSS agencies must have the resources and training to be able to implement the accompanying practice changes through the new practice model. The concepts of emotional and physical safety, the impact of trauma, and disrupted relationships are important in the decision-making framework that DSS workers use.

Developing a structured decision-making tool around a behavioral health family assessment and behavioral health supports would help ensure consistency between county agencies and mitigate potential regional difference in how families are served. DSS and parent attorneys as well as judges also need this same information as they have significant influence over decision-making when child welfare services are being provided.

The outcomes of the Carve-Out contract need to be aligned with the federal regulations, DSS priorities, FFPSA requirements and North Carolina's 5-year plan for child welfare. The Carve-Out needs to also address one of the primary conflicts between county DSS agencies and the current MCOs that revolves around "placements versus treatment." Without a foster placement for the child, the county DSS identifies the Medicaid services as a "placement" needed immediately to avoid the child sleeping in a DSS office or hotel room while waiting for an authorization. The current MCOs see the DSS referral as a request for "treatment" that does not hold the same level of urgency. A Carve-Out model that begins with an early comprehensive assessment of a family's behavioral health needs can play a critical role in the development of a DSS service plan that engages appropriate treatment *before* a child experiences a failed placement.
The "placement" versus "treatment" conflict is enhanced by a lack of knowledge and understanding between the systems. Having a working understanding of the behavioral health system would help county DSS agencies recognize the opportunities to secure early intervention and supports from the Carve-Out. This would help mitigate the "placement" versus "treatment" conflict as the Carve-Out would already be partners in working with the family and able to authorize services to avoid placement disruption.

It is critically important that NC DHHS, county DSS agencies, and the provider network work together to ensure that the outcome alignment, cross-training, and communication needed for a shared vision, goals and outcomes take place. Shared outcomes will not be achieved if changes are made to one system but not to others. This alignment will need to be held accountable through the deliverables and penalties of the Carve-Out contract and the performance-based contracts with its providers. NC DSS will need to support the 100 county DSS agencies through shifts in policy, implementation of the new practice model of care, development of monitoring and accountability, and the assurance that training supports are in place.

Creating ongoing horizontal communication between the county DSS agencies and the Carve-Out will require a shared IT system and infrastructure to train and re-train on consistent communication and partnership. Embedding connectivity between the systems, such as co-located case managers, would be helpful but continue to require frequent and effective communication and understanding of all systems.

Any tool created to provide cross-sectional understanding, communication, and cooperation, must be created in a way that can be accessed in all 100 counties recognizing that the service needs vary. Exploring the ability for NC FAST and NCTracks to communicate effectively may be a potential first step toward a solution.

Provide needed behavioral health services in the *first* placement of a child with the intent to achieve permanency

Under Medicaid regulations, a child in foster care may receive behavioral health services in any placement setting for which they meet Medicaid medical necessity requirements. However, over the years North Carolina has built a child welfare and behavioral health system that served to bifurcate care for youth who experience foster care.

When a child is removed from the home, County DSS agencies often place the child with a relative, children's home residential setting or in a foster care home that is supported through IV-E, county and state dollars. While many children receive Medicaid outpatient services in these DSS placements, few receive intensive individual or family behavioral health treatment services.

If a DSS placement is not successful, the general default (because of the way the bifurcated system has been built) is to reach out to the current MCO to request behavioral health supports. These support services usually entail a placement move such as Therapeutic Foster Care or a behavioral health treatment facility. There are some important changes that need to be made to dismantle this unintended bifurcated array of services that have been built:

> ***First***, implement a consistent protocol that all youth are screened to determine if they need to receive a trauma-informed comprehensive clinical assessment (completed, preferably, before a child enters foster care) and provide appropriate services to address the identified needs in the *initial* out-of-home placement of the child. This change would engage the Carve-Out early on in the well-being of the youth entering foster care and would help limit placement disruption.
>
> A philosophical shift is needed in NC to recognize that when a child is removed from their family, anything other than the need for therapeutic supports in a placement is a misnomer. All youth in foster care need therapeutic support, regardless of placement, as simply the act of being removed from the family is traumatic both for the child and the parents. It will be important to allow for the involvement of the DSS in the assessment process to prevent further siloing of the child welfare and mental health supports for the child. This requires that the NC DSS policy and the practice model include the importance of a partnership with the Carve-Out care coordinator and recognize the value of identifying and addressing behavioral health needs when the child and their family come to the attention of DSS.
>
> ***Second,*** NC DHHS needs to address the bifurcated foster and therapeutic foster placement settings. Therapeutic Foster Care (TFC) families only receive 10 more hours of training than a foster home. The extra 10 hours do not provide families with skills needed to care for children with higher needs. It is primarily the additional support the TFC families receive from the private agency they work with that allows them to care for higher need children in their homes. But to receive the extra agency supports provided for TFC families,

usually requires the child to disrupt from their foster care placement to move into a TFC family placement. Once the child begins to function better emotionally and behaviorally, the child ceases to meet medical necessity for TFC services which usually requires another placement disruption (unless the TFC family is willing to serve as a FC family) to step down from this service.

To reduce placement disruption between foster and therapeutic foster care, it is recommended that all foster families receive additional trauma training and the necessary support services, to assist children in recovering from trauma under the Carve-Out plan.

Third, if a child does achieve permanency and exits DSS custody, continued support services should be incentivized to avoid placement disruption and re-entry into care since most families require a transition period to practice new skills and routines to ensure long term stability.

It is important to recognize that about half of all placements are made with relatives (often referred to as kinship care). Kinship care providers are suddenly placed in a situation where they are caring for children and navigating complicated family dynamics which can create stress and strain. When the placements fail, it is often because the kinship family does not understand or know how to effectively support the child in their care and/or is overwhelmed with balancing the involvement of other family members and DSS. Providing behavioral health supports to relatives willing to serve as caregivers is an incredible opportunity to improve child well-being outcomes in NC. It also conveys value and honor to the family system that we all agree is the foundation to any modern society and stable communities.

DSS should incentivize relative placements to support permanency in a standardized way rather than leaving the decisions up to each individual county DSS office. Examples of possible incentives include:

- Pay a minimum of half the board rate for relatives going through licensure training to help them offset their costs and deter financial disincentives that could disrupt placement.
- Allocate funds to support costs that relatives incur to take children into their care, i.e.: beds, linens, clothes, school supplies, car seats, diapers, etc.
- Streamline the licensure process for relatives and allow as much training as possible be completed via teleconference to reduce the burden of time and travel for completion.
- Ensure that kinship providers are getting the same supports as licensed foster families like home visits with licensing/kinship DSS workers and regular training.

Enhance community-based interventions

Many of the current MCOs have recognized that the continuum of care for children within the NC service definitions is inadequate. As a result, NC has experienced a flurry of "in lieu of" services developed by the current MCOs over the last few years such as High-Fidelity Wraparound and ACTT Youth.

Under the Carve-Out, similar types of "in lieu of" services will be needed; however, it is recommended that a service be supported that encompasses a hierarchy of promising and evidence-based practices (EBPs) for agencies to utilize that support a fluid "family" approach to meet the family where they are and adapt accordingly (a similar type service exists in Tennessee).

An example of the array could be Home Builders, Family Centered Treatment model, Intercept, High Fidelity Wraparound, Child First and ACTT Youth. This type of broad service definition would need incentives around achieving permanency and family well-being. There must be a recognition that funding and costs to provide these services across all 100 counties may be different based on population size and need. It is not practical to ask families with limited or no transportation to travel to the next metropolitan center to access a needed service.

The Carve-Out needs to include language requiring that mobile crisis services be available within each community across the state. This service is particularly important for "unknown" children coming into care. Mobile crisis units must be established so that a first responder is available to the county social worker for screening, assessment, emergency placements, etc. These units can provide immediate trauma-informed assessments to help best determine appropriate first level interventions. Partners Behavioral Health Management is piloting a New Jersey model called MORES and Vaya's early DSS intervention pilot provides for a similar mobile crisis response.

Another critical component under the Carve-Out is the development of family-based substance use disorder (SUD) services. One of the primary contributors for why a child enters foster care is related to a parent's substance use disorder. Identifying and replicating innovative family SUD programs is imperative to reduce out-of-home placements and achieve permanency. An example of this type of innovation can be found in a Duke Endowment funded pilot called Family Centered Treatment-Recovery (FCT-R) that was developed through a partnership between Henderson County DSS, the SPARC Foundation and the Family Centered Treatment Foundation.

The pilot serves parents with a SUD diagnosis whose children are at risk of removal from the home. The SUD interventions are provided in the home by Licensed Clinical Addiction Specialists who are trained in the Family Centered Treatment model. Every family has a family-centered plan, that is inclusive of recovery, and provides substance abuse education to the entire family. FCT-R utilizes Peer Support Specialists and focuses on the reunification and preservation of families.

Other key resources to develop are Peer Support (also called Parent Partners or Family Navigators) and the Recovery Specialists program. Peer Supports are invaluable in developing a "partnership" between the family and DSS with what feels and looks like a neutral party for the family. It is a low-cost service that reduces reentry rates of children in care, increases reunification, and increases parent participation in family team meetings, behavioral health/SUD services and legal hearings. The START (Sobriety Treatment and Recovery Team) program, currently being utilized in Buncombe County, provides peer support to parents with an SUD diagnoses while the family is receiving in-home services. In Kentucky, children whose families are involved with START are half as likely to enter custody and the program saves $2.22 for every $1.00 spent.

Another opportunity to strengthen community-based services is through the development of an alternative model of foster care called Professional Parenting. Family foster care and therapeutic foster care (TFC) are the only "volunteer" government systems set up to house and care for one of our world's most vulnerable populations – our children, most of whom are suffering from trauma. Families that provide both foster care and therapeutic foster care are considered "volunteers" under employment law because they are not paid as employees or staff but instead receive a monthly stipend to help offset costs of their service. Volunteer families are expected to manage significant mental health needs as well as frequent acting out behaviors for the youth they serve. They have limited training and skills to manage such needs. The acuity of care needed by so many youths is exhausting many of our volunteer families and our system frequently blames them or the child if the placement is not successful. Furthermore, these disruptions have lasting effects on the lives of children.

Our foster care system requires that at least one of the foster parents in the home must be receiving an income, which for most is through employment. However, many children require multiple appointments with doctors, clinicians, social workers, shared parenting visits, school meetings, etc. every week. For particularly high need children, the foster parent may be receiving daily (or multiple) calls from the school that require their attention or the need to disrupt their workday to pick the child up immediately. This places many foster parents in a situation where they lose workdays/hours (and pay) to adequately meet the needs of the child, but if they stop working, they cannot meet the income requirements.

An alternative to the volunteer foster family is a model gaining favor across the country called Professional Parenting. House Bill 630 authorized the LME/MCOs to utilize the Intensive Alternative Family Treatment (IAFT) to initiate a professional parenting pilot to provide specialized foster treatment for youth who may otherwise need residential treatment.

The project was challenged due to the limited time allowed for the pilot through the legislation. This led to challenges in securing enough families to garner statistically sound data regarding the pilot's outcomes. However Rapid Resource for Families, the program that oversees the IAFT services, noted that if the program were established with longevity, they believe services would have a positive impact on hard to place youth and would reduce their placement disruption. For the families involved in the pilot, an increased level of commitment and energy from the treatment family to address issues with the youth in their home was observed.

Several private provider agencies are currently starting their own professional parent pilots that would pay parents approximately $40,000 in a stipend per year, offer 6 respite days a month and provide daily consultation. Parents would be required to take a certain number of child placements per year. Under the Carve-Out, NC could replace the existing foster care and TFC system with a foster care program that receives wrap supports based on the needs of the child and professional parents for children whose assessments indicate that a higher level of care is needed.

Performance-based contracting under the Carve-Out

NC DHHS has placed an emphasis on expanding Performance-Based Contracting (PBC) under the Medicaid Transformation plan. The Carve-Out will likely have similar requirements but greater

complexity in meeting performance-based benchmarks as it will require partnership compliance by county DSS agencies, private providers and the Carve-Out.

It bears repeating that an alignment of goals and outcomes between the NC DSS, the county DSS agencies, private providers and the Carve-Out is paramount in the effort to achieve a PBC system.

Behavioral health case management needs, on some level, to be embedded in the county DSS agencies to ensure ongoing communication, partnership, and understanding between the two services. This could be full-time co-location, which may be more appropriate for the large urban counties, or on-site case staffing, for more rural counties. DSS is the legal guardian for children who come into care and therefore must be a partner in the behavioral health their children and families receive.

Moving to Performance-Based Payment (PBP) contracts will be difficult to achieve quickly under the Carve-Out. It will take some time for NC DSS, MH/DD/SAS and DHB to identify shared outcomes and goals. NC DSS will have to align their policy and practice model to direct the county DSS workflow to support the outcomes. This will also require training for all 100 counties to comply with the changes. PBP contracts will also require years of case management data from the county DSS agencies to have the information required to develop the algorithms needed to calculate the terms of a PBP contract. North Carolina does not have an adequate statewide DSS electronic case management system yet that can produce that type of data. Once a statewide system is put in place, it will take a couple of years (if not longer) before historical trends can be identified. Permanency outcomes are also impacted through judges' rulings for children in custody. Judicial District data will also need to be compiled to identify what type of ruling trends need to be included in the algorithms.

Case Study: Tennessee

Tennessee has implemented PBC in foster care that includes PBP terms and conditions. This could serve as a model for North Carolina to follow as our states share similarities. They began the process with multiple siloed divisions overseeing services to children and slowly transitioned to performance-based contracts as the government services and private providers redesigned their policies, practice, and service delivery to drive clear outcomes.

It is important to note that movement toward the PBC in Tennessee began in 1996 when the state created the Department of Children's Services (DCS). Prior to the creation of DCS, the state's children received services through six uncoordinated and siloed government departments - Education, Youth Development, Finance and Administration, Health, Mental Health and Retardation, and Human Services.

There were efforts made to coordinate and improve services prior to the development of DCS. Youth Villages, a provider agency in both NC and Tennessee, received private funding and worked with Chapin Hall to create a report in 1993, *Solving the Puzzle.* In this report they noted, "In identifying dysfunctional families and children in need of support, the first line of fire is reaching them when their problems first appear – in the courts, schools, and social service agencies. At this point, long-term, family-based, in-home services should be provided, according to the needs of the families, with the goal of helping children and families to help themselves."

The report and recommendations from the private sector were not enough to elicit change.

Between 1991 and 1995, the total number of children in custody increased by almost 3,000 and the use of restrictive PRTFs increased as well. To manage the growing child welfare crisis, a decision was made to merge the departments. It was a difficult merger with conflicts over philosophy and vision for the department.

Early on, DCS agreed to adopt a model called "The Continuum". This model assigns a child and their family to one agency that is responsible for moving the child to permanency as quickly as possible, but within the federal child welfare standards of 12 months. The agency receives a monthly per diem to meet all the needs of the youth and can provide the needed services or subcontract them out. Tennessee began working on this model, led by Youth Villages, in 1995. Change was slow as the state was still not fully invested until a lawsuit in 2000 initiated by Children's Rights. DCS, under strong new state leadership, saw the lawsuit as the opportunity to make difficult decisions to hold the system accountable. Progress began with the development of a practice model that supported a philosophy that services were to be provided in a family setting whenever possible.

However, progress was not moving quickly enough, and Children's Rights began contempt proceedings in 2003. The contempt proceeding was mediated with the requirement that DCS develop an enforceable implementation plan, with clear goals, strategies, action steps and timelines, to remedy failure to meet the terms of the settlement agreement. The plan drove the work and reporting of the department toward policies and practices that emphasized permanency. DCS made a conscious decision to buy permanency, not services. The state procured a sole source contract with Chapin Hall at the University of Chicago to develop an algorithm-based system to help build the PBC system that is in place today.

Carve-Out PMPM funding considerations

One of the challenges this workgroup identified was the ability to accurately calculate current spending for families in the child welfare system. Without an integrated IT system, funds are being spent that are not clearly visible.

For example, the current MCOs are utilizing Single Stream funds on services for parents of children who are in foster care or at risk of coming into custody. There is no identifier in the Single Stream billing that would indicate if the individual receiving services is involved with child welfare.

As was noted previously, there are many children who should be receiving enhanced behavioral health services but are not until they move into TFC or behavioral health residential services. Partnering for Excellence (PFE) looked at the cost of promoting early services. In sites that successfully implemented PFE, 12-month cost savings for children in in-home services was 34% and 51% for children in foster care.

Another consideration is the amount of money that county DSS agencies spend on behavioral health services and the county costs paid to treatment providers to maintain children in families in order to avoid additional placement disruptions. This is not data that can be pulled from NC

FAST and will require a county DSS survey that all 100 counties would need to complete to effectively capture the amount.

Closing

North Carolina is experiencing an incredibly rare alignment of multiple simultaneous system overhauls. Medicaid Transformation, Rylan's Law, FFPSA, the rollout of the child welfare practice model and the creation of a child welfare managed care carve-out set up an unprecedented opportunity to improve the outcomes and well-being of families involved with DSS.

Only through the integration of child welfare and behavioral healthcare can the system truly improve outcomes, affect cost-savings, reduce the number of children taken into custody, length of stay in out-of-home placements, and time to permanency. NC must embrace this extraordinary opportunity, the results of which will have lasting impacts on generations to come. We need a strong partnership of DHB, MH/DD/SA, NC DSS, county DSS agencies and private providers to come together to develop a viable plan that values keeping families together and emphasizes permanency.

It is unlikely that any of us will ever have this unique opportunity present itself again. We have the chance to make historic fundamental changes to improve the lives of families across NC and should make every effort to maximize this prospect.