NCACDSS Committee Meeting **MINUTES**
Virtual Children's Services Committee
2:15 pm to 4:15 pm
February 10, 2021

Item #	Agenda Item/Presenter	Attachments	Time	Action Needed
1	Welcome/CSC Tri-Chair(s)		2:15 pm	No
2	Approval of January 2021 Minutes	PDF Attached	2:15 pm	Yes
3	**Kinship Care** – Carla McNeil, MSW, Section Chief – Permanency, NCDHHS, DSS **Update – County Record Reviews –** Teresa Strom, MSW, Section Chief for County Operations, NCDHHS, DSS **Regional Abuse and Medical Specialist** – Dr. Molly Berkoff, MD, MPH, UNC School of Medicine/Wake County Human Services & Emi Wyble, MSW, NC DHHS Safety Strategist	Presentation(s) Attached	2:20 – 250 pm 2:50 – 3:05 pm 3:05 – 3:40 pm	No
4	Questions		3:45 – 4:15 pm	No
5	Adjourn		4:15 pm	Yes

- **Meeting called to order and welcome given by CSC Tri-Chair – Katie Swanson.**
- **Minutes reviewed/approved – Motion by Nancy Connor of Martin County and seconded by Tracy Murphy of Randolph County.**

Kinship Navigator – Kimaree Sanders, Foster Care Manager & Mary Mackins, Interim Permanency Coordinator, DHHS/DSS

- Driven out of CFSR 5 year strat plan, program alignment and system-level evals and Rylan's Law
- Within CFSP there is a commitment to permanency being achieved in a timely manner or to transition successfully into adulthood
- CFSP Priority 2: Permanency Targets need to be achieved. There are 3 targets:
  - Decrease days to exit foster care and increase rate of permanent exits.
  - Increase placement stab by recruit and train sufficient pool of ethnically and racially diverse families who can safely meet the needs of kids experiencing foster care.
  - Max use f FC 18-21 program
- 11454 kids in care
  - Regular care = 10,603
- Permanency Design Team doing work to connect to the CFSP Targets
  - Ex. How OSRI data is being used to show metrics of targets
- September of 2020 – 5 permanency initiatives reviewed
  - KinGAP
  - Caring for our Own
  - Permanency Roundtables
  - Permanency innovation initiative
  - NC Kids
- Moving Forward:
  - FFPSA -> Congregate Care -> Kinship Placement ->
- FFPSA
  - Enacted in 2018

    - Historic Reform
    - Federal Funding back end to front
    - Prevention Service focused (IV-E funded)
        - Parenting programs
        - Substance Abuse Tx
        - Mental Health Tx
    - Decrease congregate care
- FFPSA – decreased use of congregate care with focus on family foster home – 10/1/2021 deadline for funding of youth in these settings
    - Must find appropriate placements in place of these congregate settings
        - 1214 youth impacted – where will they go? That is one of the focuses.
    - Requires a culture shift – focus on FAMILY/KIN connections
- Therapeutic Placements and Congregate Care
    - 1214 in congregate care settings
    - 1060 in therapeutic foster care settings
    - Overwhelming number of kids in the 13-17-year-old range living in congregate settings
        - This is where most attention needs to be focused. How can we enhance and support alternate placements to congregate care?
- Kinship Navigator Program
    - I&R to grandparents raising children
    - 2350 children/youth living with family
        - Kids living in congregate care settings will be grandfathered in on 10/1/21 but if they move placement will no longer be eligible from IV-E
    - Partnerships w/ Children's Home Society, UNC, and Regional Child Welfare Consultants
        - Need partnerships for this work – Caring For Our Own, for example, as CHS provides this training and info. Last report in January they had completed 4 classes with 31 families having been trained. More classes rolling out.
        - UNC assisting with bringing awareness to KinGAP and Kinship Care
            - Educational material – fact sheet/handout to CW professionals
            - Info sheets for caregivers, etc.
            - Booklet "Know Your Options" (guardianship, etc.)
    - Policy and Practice Changes along with Culture Shift to move forward in this work
        - Clear and consistent messaging rolling out
- **Questions?**
    - How many NC facilities meet the requirement for QRTP currently?
        - We'll look into that – don't currently know.
    - Is anyone advocating to the General Assembly for a higher rate in regular foster homes (perhaps targeted to care for older children?
        - None known.
    - Is there a possibility that the Caring For Our Own Training would allow for licensing of kinship families?
    - Licensing and Regulatory chief CFOO is not able to be used to license kin families
    - Catawba County made the modification to CFOO in conjunction with the state and CHS and it was approved for licensure. We have approved several Kinship providers using CFOO.
        - Carla M – Linda Waite can respond.
        - There was a reason why it could not be done at this time – but that is in conflict with Catawba County's experience.
        - Carla followed up and said DCDL did come out allowing CFOO to license kin.

Update – County Record Reviews – CQI Process/Review Tools: Teresa Strom, MSW, Section Chief for County Operations, NCDHHS, DSS

- Regional Child Welfare Consultants (RCWC) realigned and now doing monthly contacts with counties. Some onsite despite Covid. Each month reviewing records. On-site in-depth consults will provide list of

cases to be reviewed and provide data on consultation form to inform agenda and to seek county input on concerns to be addressed.

- What does the monthly on-site visit look like?
    - Meet with designated county staff.
    - Record reviews
    - Provide record review tools to the county
    - Provide TA – usually planned, as requested
- Targeted Reviews
    - Include Screen out decisions
    - CPS assessments
        - Contacts adequate to assess safety and risk
        - Safety assessments
        - Case decision
        - FIH – contacts sufficient to assess safety/risk
        - Case plan – do they address strengths/needs of families
        - PP – same contacts/case plan reviews
    - Not a lot of records each month (10?)
        - Hopefully develop pattern of needs to work on over time
    - Child Welfare Data Review Tool – example shown
    - CQI Assessment
        - Process Measures Data and Outcome Measure Data on one doc
        - Provides consistency across NC for data, law, rule, and policy expectations that have greatest impact on children and families.
    - Screenshot of CQI Assessment Tool – shown
        - Aggregated data from program monitoring from last 6-12 months
        - Averages across the state are not great but helps focus on areas where most help is needed so we can see averages go up.
    - Questions?
        - Random sample pulled and reported to County rather than County pulling random sample?
            - Yes – State pulling sample
        - Who will be selecting the cases?
            - State
        - How much notice is given about cases being pulled?
            - Week in advance
            - Entire record not being reviewed but targeted areas in the case
            - Comment: If state pulls cases, Counties need more than 1 week to prepare.
                - Teresa will discuss with her team next week and will everyone know ASAP
            - Has consideration been given to the total increase in sheer number of reviews taking place in counties?
                - Ex. In one county every 2 months between IV-E, SSBG, AA, CFSR, etc. etc.
                - Answer:
            - Will each service area be reviewed every month?
                - Quarterly plan laid out to cover screen outs, FIH cases, PP cases, CPS Assessment cases, etc. over the quarter. So each month may or may not be cases from each area pulled. If you have a preference, let your RCWC know.
            - Final slide indicated FTE from 18-21. Has state discussed caseload standards for 18-21 program area?
                - Carla McNeill – they are aware and considering this info.
            - It would be helpful to the CQI process for the findings of all counties to be posted.
                - Teresa – we are working on creating dashboard for this purpose to share.

Regional Abuse and Medical Specialist – Dr. Molly Berkoff, MD, MPH, UNC School of Medicine/Wake County Human Services & Emi Wyble, MSW, NC DHHS Safety Strategist

- Expansion of CMEP Services: Regional Abuse and Medical Specialists
- New positions going to be hired!
- Overall goal: to provide guidance to CW workforce in the management of high-risk child welfare cases that overlap with medical issues
    - Special focus populations:
        - Ex. Children 3 years of age and under who present with unexplained/poorly explained injuries
        - Children with complex medical needs
        - Substance Affected infants
        - Child required by policy to have a CME (since this group expanded)
- Why were these positions created?
    - To improve safety planning and identification of child-well-being needs
    - TO reduce barriers to accessing the most appropriate medical consultation for these children
    - Case reviews identified need for enhanced series for children under 3
    - CW policy now includes 4 mandatory CMEs for young children
- Why will counties appreciate these positions?
    - RAMS Staff will have specific expertise in the assessment of physical abuse in children
    - Be available to assist counties with pre-planning and safety assessment as well as case decision staffing
    - Have expertise in substance affected infants
        - One position dedicated to this
    - Have access to most current medical info/consultation
    - Be available 24/7/365
- Where positions fit?
    - Expansion of CMEP Service/RAMS: Houses within the NC CMEP under contract with DHHS with co-supervision form medical staff with NC CMEP and state division
    - 7 experts in assessment of young children with concerns for serious injury, sexual abuse as well as medically complex cases
    - One expert in Sub Affected Infants
    - How will the RAMS be successful?
        - Mandatory referrals process for reports that meet criteria for mandatory CME – auto referral
    - Other referrals that a county wants to send to the RAMS team for assistance
        - Ex. Older children
        - Children that have had multiple CMEs, etc.
- Functions for the RAMS position:
        - Guide staff and improve understanding for when to access CMEs
        - Monitor access to CMEs and impact on time to case closure
        - Help train medical aspects training
    - Current Barriers to counties:
        - Children are seen by medical providers who are not qualitied to diagnose maltreatment
        - SW believe these doctors, and fail to question their decisions/assessments, or don't know that they lack medical expertise in these cases
        - SW believe parents, especially parents that present well, SW are more family friendly than skeptical
        - SW turnover often prevents training to the level of expertise needed.
- Current and proposed efforts to support counties
    - Narrative interviewing training for all staff
    - Improvements made to Medical Aspects training including specific info about physical injuries to
- Questions:
        - Is 24/7 access be manned by LIVE staff? ☺

        - Yes – one person on-call each week. May not be your regionally assigned person but it will be a RAM SW.
    - Can the RAMS team assist with an In-Home case consultation?
        - Can assist with cases as it relates to safety – not to look at Family Services Agreement goals, etc.
    - You said RAMS referral would be automatic from Intake if it meets intake criteria. How does that happen?
        - Intake tool/SOP etc., being updated and when Intake Tool is revised it is the hope that a question will be included to prompt referral to RAMS Team once those revisions are made.
    - A lot of work the RAMS will be doing is so that evaluation the child gets – the SW is clear and understands what it says. (decision-making importance)
    - Will RAMS help with court testifying regarding these medical issues?
        - Not the intention – will help with SW so they can be fully prepared to present their case to the court.
    - How is medical society as a whole being informed to the critical need regarding injuries to children (Ex. ED Drs.)?
        - Committee with the NC Pediatric Society – presentations to local GPs, etc. understand what their limitations are, etc. Trying with professional associations to educate the field of Medicine. Hard when acknowledgement of issue is hard.
        - Also hard when first step for injured child tends to be Emergency Dept and then discharged from ED.
    - Suggestion for policy clarification: Clarify for when a child is in the hospital and then is being released to a CME afterwards. Emi will check on policy language. Other policy clarifications also need to be looked at (ex. entire family being referred rather than the vulnerable child.)
    - Is it possible to work on a plan to work on placing a licensed medical professional (Doctor) in each county hospital? Is this feasible?
        - Only about 270 child abuse experts/Drs across the U.S. so not possible. It is like a sub-specialty.
    - CFSR penalties when not referring ALL kids in the home for the CME.
        - Emi says not all kids need CME. Need to determine who and why CME needs to be made and how it can be beneficial to child/case decision-making. Document why a child did or didn't need a CME.
    - Some CACs recommend ALL children get CME.
        - Emi – Own your work and it's your work to determine if child needs CME.
        - Dr. Berkoff – can be confusing when policy does not match agreement between county and CAC.
- Further Questions?
    - None
    - Let us know what presentations you'd like to see at CSC in upcoming meetings.
        - One Suggestion – follow up review of the CME policy
    - Motion to adjourn made at 3:31PM