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NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
DAVE RICHARD • Deputy Secretary for NC Medicaid
KODY H. KINSLEY • Deputy Secretary for Behavioral Health and Intellectual/Developmental Disabilities

Date: December 22, 2020

To: Local Management Entities-Managed Care Organizations (LME-MCOs)
DSS Directors

From: Victor Armstrong, Director, DMH/DD/SAS
Dr. Carrie Brown, CMO, DMH/DD/SAS and DSOHF
Susan Osborne, Assistant Secretary, DHHS
Debra Farrington, Chief of Staff, NC Medicaid

Subject: DSS Involved Children

NC DHHS is aware that many children with high-intensity behavioral health needs, particularly latency and adolescent foster care youth, do not have rapid access to services that meet their needs. This causes them to remain in clinically inappropriate settings such as an Emergency Department (ED) bed or DSS office for days or weeks while they wait for treatment. While there are numerous systemic and process issues that drive or exacerbate this problem, including lack of an adequate network of providers who can manage children with serious emotional disturbances (SED) who also exhibit violent, aggressive, sexually inappropriate, or other complex behaviors, the fact remains that our system is too often ineffective in meeting the needs of these children and their family systems. In addition, children with comorbid SED/IDD needs have presented unique challenges in identifying appropriate treatment settings.

Long term, this is a complex issue that will need to be addressed with a comprehensive, multi-faceted set of solutions that require input from a myriad of stakeholders, including DHHS, DSS agencies, LME/MCOs, hospitals, provider organizations, families, advocacy organizations, and the juvenile justice system. In the short term, we need an algorithm that creates a plan of action, and clearly delineates responsibilities for a child in need of immediate placement, even while awaiting long-term family placement.

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Many of these issues may be mitigated by the forthcoming Foster Care Specialty Plan, however, we must respond and address the needs of the children whom this is impacting now. In response, DHHS leadership has established an internal workgroup consisting of representation from DMHDDSAS, NC Medicaid/DHB, and DSS that is charged with outlining an immediate plan for how to effectively address this urgent problem while longer-term structural fixes are designed and implemented.

To address the immediate needs of these children, a cross divisional response team will meet daily to determine where crises exists (i.e. children in EDs, local DSS offices or other inappropriate settings) and take swift action to address the immediate need. The cross divisional Response Team of DHHS leaders will convene daily, Monday through Friday at 8am, along with relevant LME/MCO care coordination, utilization management, and child psychiatry staff, and senior DSS staff, in order to staff any DSS involved children/youth in hospital EDs or in immediate danger of losing current placement, or DSS involved children for which DSS Directors are asking assistance. An additional review team, consisting of DHHS Executive leadership will convene Tuesday, Thursday and Friday of each week at 8:30 am, to review cases involving DSS involved children who have been in DSS offices or in EDs in excess of 7 days, or cases where the response team asks for assistance.

Local Departments of Social Services should ensure that prior to referring a case to the cross divisional response team that they have exhausted all attempts to escalate the case within the LME/MCO management and a resolution has not been identified resulting in the child/youth remaining in a placement that does not meet their treatment needs. Where escalation has been ineffective, this will need to be documented for DHHS follow-up.

Whenever possible, DSS and LME/MCO staff will jointly complete the referral and will participate in the initial response team meeting when the case requested for escalation is reviewed. The purpose of this participation is to allow the response team to ask questions that will facilitate a resolution.

A critical element of this process is ensuring that all clinical information needed to identify crisis issues is provided to the response team in order to facilitate a thorough review. To this end a communication tool has been developed and is attached.

Referral Process:
Local Departments of Social Services will refer cases by completing the attached document in collaboration with the LME/MCO Care Coordinator if one is assigned to the case. Completed documents are to be sent to the local DSS assigned Regional Child Welfare Consultant and copying the Child Health and Development Coordinator, Heather McAllister at heather.mcallister@dhhs.nc.gov and Wendy Wenzel at wendy.wenzel@dhhs.nc.gov

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Local DSSs and LME/MCOs will be notified prior to case review by the response team via an email invitation to the 8am team meeting. Local DSS staff that have the most knowledge of the treatment needs for the child/youth and the LME/MCO staff are required to attend this initial call to provide any additional information needed by the response team.

When a resolution for a case is identified this will be communicated to Local DSSs via email from the Child Welfare Regional Consultant.

If at any time during the escalation process the child/youth has shown an escalation of behaviors, had an immediate disruption in placement, been admitted to an ED, or moved into the appropriate level of residential treatment, Local DSS staff will communicate this to their Regional Child Welfare Consultant and the Child Health and Development Coordinator. Cases will be closed when an appropriate level of residential treatment is secured and the child/youth has been admitted.

Thank you for your continued partnership and collaboration to ensure that children have access to the right service, at the right time, in the right venue.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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