# Enhancing Care Journeys

## A Toolkit for Successful Treatment Placements

VAYAHEALTH

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# Pathways to Permanency Project

The *Pathways to Permanency* project aims to coordinate efforts between Vaya, county DSS (Department of Social Services) offices, and mental health providers to ensure youth in foster care have access to high quality behavioral health services. To this end, multi-sector focus groups conducted at the onset of this project highlighted needs related to shared understanding, accessible quality behavioral health assessments and interventions, and safe and supportive homes. Workgroups of cross-system stakeholders were then developed to generate, plan, and implement solutions for each of the identified needs.

Through this toolkit, the *Pathways to Permanency* project presents a collection of essential resources developed by our dedicated “Suitable Placements” workgroup to streamline and optimize the residential treatment placement process.

# Resource Background

The resources outlined in this document offer crucial guidance to County Department of Social Services (DSS) offices, child placing agencies, and clinical homes involved in securing placements in therapeutic settings. In this toolkit you will find:

**1. Roles and Responsibilities Guidelines:**
These protocols, designed for youth both with or without a clinical home, outline the recommended steps for County DSS offices, child placing agencies, and clinical homes to secure placements in residential treatments. Additionally, they define the roles and responsibilities of each stakeholder, fostering consistency and clarity throughout the placement process.

**2. Required Document List:**
Tailored for County DSS offices, this document provides a detailed outline of the necessary paperwork most frequently requested by providers before or upon placement in a therapeutic setting.

**3. Pre-Placement Meeting Guidance:**
This resource offers best practices for facilitating pre-placement meetings with potential placement providers. By following these guidelines, stakeholders can enhance communication and understanding, leading to more informed decisions and smoother transitions for individuals entering residential treatments.

These documents work together to enhance the placement finding and adjustment process, promoting improved collaboration among partners by ensuring uniformity in placement procedures and defining stakeholder roles. Our goal is to introduce these resources to establish a standardized and efficient approach, leading to a more cohesive and streamlined process that ultimately benefits everyone involved.

# Roles and Responsibilities Guidelines: Active Clinical Home

1. The Comprehensive Clinical Assessment (CCA) is completed with an appropriate recommendation by the clinical home or another evaluator.

2. The CCA is shared with the Department of Social Services (DSS) legal guardian/social worker and reviewed. Discussions regarding placement preferences should take place. Team decides on a planned meeting schedule over the next 30 days. *There may be a need for the team to meet more frequently dependent on the urgency/acuity of the child's needs.*

3. The clinical home completes the standardized referral form by conversing with the legal guardian.

4. The clinical home begins to make referrals to providers. The clinical home prioritizes the legal guardian's preferences but also reaches out to providers outside of those preferences to ensure placement. Clinical homes should not limit their referrals to specific providers.

5. The clinical home continues to follow up on referrals until placement is found ensuring that the legal guardian is kept in the loop. The clinical home provides any additional documentation requested by a potential placement provider.

6. After there is a match, the clinical home will inform the legal guardian and the intake process will begin if the legal guardian agrees to moving forward with the identified provider.

7. The clinical home will work with the legal guardians for the completion of any additional processes that are needed for placement (e.g., medical appointments).

# Roles and Responsibilities Guidelines: Active Clinical Home

8. Either an initial or an updated Person-Centered Plan (PCP) is completed in partnership between the legal guardian, current clinical home, and the receiving provider. The PCP is then signed by the legal guardian as required.

9. Once the member is accepted by a residential treatment provider, the following clinical documents are needed to facilitate the transition:

- PCP including signature page with Service Order
- CALOCUS/ASAM worksheet
- Comprehensive Crisis Plan
- Child and Adolescent Needs and Strengths (for ages 3-5)
- CCA with recommended level of care

10. Following the work with the North Carolina Child and Family Improvement Initiative (NCFII), providers receive a pass-through authorization for residential treatment. The only exception is for PRTF requests for children age 12 and under.

- Providers must have all required clinical documents on file at time of member's admission and can submit a notification SAR to Vaya's UM department alerting Vaya of the members admission.
- More information on the NCFII and the pass-through authorization process can be found here: PCB-09-30-22-Issue-16 | Vaya Health as well as in this FAQ document.

11. Transition and/or CFT meetings are best practice to discuss placement.

# Roles and Responsibilities Guidelines: No Clinical Home

1. The Comprehensive Clinical Assessment (CCA) is completed with an appropriate recommendation by the selected evaluator. Counties with established assessment protocols for youth in foster care should utilize the assessment(s) and or provider(s) outlined in these protocols.

2. The CCA is shared with the Department of Social Services (DSS) legal guardian/social worker and reviewed. Discussions regarding placement preferences should take place. Team decides on a planned meeting schedule over the next 30 days. *There may be a need for the team to meet more frequently dependent on the urgency/acuity of the child's needs.*

3. The Care Manager should assist DSS (the legal guardian) in completing the standardized referral form.

4. The Care Manager should then begin assisting DSS by making referrals to providers. The legal guardian's preferences should be prioritized while also reaching out to providers outside of those preferences to ensure placement. Referrals should not be limited to specific providers.

5. The Care Manager and DSS should continue to follow up on referrals until placement is found, ensuring that the legal guardian is kept in the loop. Best practice would be to mirror this follow up with any standardized communication processes that have been outlined between the county and Vaya (e.g., County Coordinated Response Protocol).

6. The Care Managers will also work to support County DSS offices by providing any additional documentation requested by a potential placement provider that they have access to and legal authority to share.

7. If the Care Manager is informed there is a placement, DSS should be informed and vice versa. If DSS agrees to the identified provider, the intake process should begin.

# Roles and Responsibilities Guidelines: No Clinical Home

8. The legal guardian will work separately and concurrently to complete any additional processes that are needed for placement (e.g., medical appointments).

9. The Care Manager should assist DSS in obtaining either an initial or updated Person-Centered Plan (PCP). An updated PCP that has been signed by the legal guardian is required. This can be done by the Care Manager:

- Working with the assessing provider that recommended the enhanced service(s) or
- Working with the future treatment provider to complete the PCP

*Per Clinical coverage policy, the provider that will provide treatment should be able to develop or update the PCP based on the most recent CCA recommending residential treatment.*

10. Once the member is accepted by a residential treatment provider, the following clinical documents are needed to facilitate the transition:

- PCP including signature page with Service Order
- CALOCUS/ASAM worksheet
- Comprehensive Crisis Plan
- Child and Adolescent Needs and Strengths (for children 3-5)
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12. Transition and/or CFT meetings are best practice to discuss placement.

# Required Document List

In addition to the Universal Child Residential Placement Referral form, the following list of documents will likely be required for your child to be placed in a residential treatment setting (Therapeutic Foster Care through PRTF). Additional document requirements, timeframes for submission, and consents will vary by agency. This list should only serve as a guide and not a comprehensive list of documents required to initiate placements in residential treatment facilities.

1. Universal Child & Adolescent Residential Placement Referral Form
2. PCP with Signature Page
3. Updated CCA
4. Crisis Plan
5. Custody/guardianship documentation (Form 5760)
6. Financial form, Medicaid ID#, or insurance card copy
7. Immunization records
8. Birth certificate
9. Social Security card
10. Authorization/consent for emergency care
11. Most recent physical/health status documentation (DSS Form 5207)
12. Medication orders
13. School records/education status paperwork (DSS Form 5245)
14. Visitation plan (DSS Form 5242)
15. Transitional living plan (for youth 14 and older)

# Pre-Placement Meeting Guidance

This document was developed to serve as a guide for best practice when conducting pre-placement meetings with caregivers of youth in foster care. This process is different than traditional “meet and greets” and is meant to reduce any potential adverse effects of “meet and greets” that may occur after the Pre-Placement Meeting.

## Overview

The Pre-Placement Meeting, or PPM for short, is a virtual or in-person meeting between the child’s legal guardian, the identified potential caregiver, and the youth’s team of professionals that is meant to:

- ensure “goodness of fit”
- share information that would support placement success and longevity
- encourage open lines of communication
- set the standard for collaboration moving forward

It is suggested that the youth not be included in the PPM in order to avoid exposing youth to any potential rejection which could trigger negative views about themselves and the world around them.

## Audience

This protocol was developed for any agency or professional who is responsible for, or assists with, finding placement of a youth in DSS custody such as County DSS offices, child placing agencies (CPAs), care managers, GALs, etc.

## Participation

In general, the child's legal guardian, the current child placing agency and placement provider, as well as the the new placement provider and potential caregivers should be involved in the meeting. Below is a comprehensive list of parties to consider inviting to participate in this meeting. Please remember that the child is not involved in the PPM  for very intentional reasons. For youth who have already experienced trauma, having what may be viewed as rejection compounds previous traumatic experiences. Should the family decide to move forward with the placement, they may request a meeting with the child (i.e., a "meet and greet").

- The child's social worker—In most instances, the child's social worker is going to be helpful for additional details that may need to be provided during this meeting. However, it is most important that the person who attends this meeting be the most knowledgeable about the child from the agency's perspective. Depending on the length of time in custody, this may be the child's previous worker.

- The placement worker—In some agencies this person's role is much different than the child's assigned social worker.

- The potential foster parents—If there is more than one caregiver, both should be in attendance.

- The new child placing agency representative—This will typically be the assigned case manager or social worker. This individual should have an operational knowledge of the potential caregivers.

- The previous child placing agency representative—Again, this may vary. However, this person should have a good operational knowledge of the child's experiences (successes and struggles) with the previous placement providers.

- Vaya Care Coordinator (if applicable)

- Other: GAL, therapist, etc.

## Timing

While it is ideal to have a PPM before any placement, when a youth initially enters custody, it can be difficult to bring together a group of professionals in stringent time frames. Therefore, it is suggested that PPMs be held when there is a placement disruption or when a youth is changing levels of care (i.e., “stepping” up or down in service level). PPMs can also be helpful for youth who are placed in a temporary first placement prior to a second, long-term placement. The PPM should happen once a potential family is identified to determine if the family will accept the youth into their home. This could mean meeting with more than one family.

## Discussion

The PPM should focus on information sharing and making sure to discuss:

- strengths,
- challenges,
- current behaviors,
- relevant history, and
- solutions that have worked.

In addition, the PPM should be a place where the team can share what needs they have for the potential foster parent and discuss if the foster parents believe they can meet those needs. This is also the best time to discuss how DSS will interact with the family and share any expectations they have for the family, such as:

- participation in therapy,
- transportation, and
- shared parenting, etc.

## Scheduling

For a youth that has already been engaged in services and has an assigned clinical home, organizing and facilitating a PPM is the role of the clinical home. However, for youth without a clinical home, organization and facilitation of a PPM should be a team effort. Although, as the legal guardian, DSS should expect to take the lead in coordinating PPMs.

# The Role of Care Management

Vaya's vision is to create and maintain a support system for social workers that includes:

1. Continuity of member care and education and system navigation and that fosters quality care for youth and families involved with DSS
2. Efficient access to care manager through co-location and point of contact for DSS
3. Proactive integrated care and crisis planning forums
4. Local response to system issues

**Children & Youth Served by the Child Welfare System Care Management Summary**

| | Is the Child/Youth Enrolled in the NC Innovation Waiver? | Is the Child/Youth diagnosed with a SMI, SED, a severe SUD, an I/DD, or receiving services for a TBI?* | Is the Child/Youth Eligible for Tailored Care Management on 12/1? | Care Management Model on 12/1 |
|---|---|---|---|---|
| Children < age 3 | Yes | Yes | Yes | Tailored Care Management |
| | No | Yes | No | CMARC or CCNC |
| | No | No | No | CMARC or CCNC |
| Ages 3 + | Yes | Yes | Yes | Tailored Care Management |
| | No | Yes | Yes | Tailored Care Management |
| | No | No | No | CMARC (Children <5) or CCNC |

* Full diagnosis list for Tailored Care Management Eligibility can be found here: BH-IDD-TP-EligibilityUpdate-AppendixB-REVFINAL-20190802.pdf (nc.gov)

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# How Embedded Care Managers Can Assist

1. Serve as the primary point of contact between the LME/MCO and the County DSS

2. Support the identification and engagement of children and families eligible for and in need of care management through collaboration with DSS

3. Participate in relevant team meetings such as interdisciplinary and treatment team meetings, Child and Family Team Meetings, and discharge and crisis planning

4. Ensure that members are connected to appropriate services

5. Support strong relationships with the provider community and connections to community resources to confirm that an appropriate array of services is being accessed

6. Collaborate to identify and address barriers to accessing behavioral health services and residential placements

7. Collaborate with Provider Networks to identify vacancies, access community resources, and ensure continuity of care for members accessing services

8. Provide recommendations to improve access to services and the coordination of care between the LME/MCO and the County DSS staff

9. Document unique encounters in an electronic database approved by the LME/MCO