BRIDGING LOCAL SYSTEMS

ALLIANCE, CUMBERLAND, DURHAM, JOHNSTON & WAKE

DISCUSSION FOCUS: BUILD CAPACITY, PLACE CHILDREN LOCALLY, AND PREVENT DISRUPTIONS

PROBLEM #1: Inadequate Supply of Regular Foster Homes

HYPOTHESIZED CAUSES:

1. The number of children entering foster care has increased.
2. Foster parents choose to become therapeutic parents to earn substantially higher rates
3. Although rates for therapeutic parents are substantially higher, the training, skill and service required are often similar.
4. Private child placing agencies have a financial incentive to provide therapeutic home care over foster care and to encourage foster parents to become therapeutic parents
5. Private therapeutic agencies are competing with DSSs for persons wanting to provide foster care. Persons completing new foster parent training provided by DSSs are signing up to become therapeutic home providers for private agencies.

NEGATIVE IMPACTS:

1. Children entering care cannot be placed in a family foster home in their home county.
2. Foster children are placed in congregate settings, more costly therapeutic placements, or foster placements outside their home county. Such placements add to trauma children already have experienced, make permanency more difficult to achieve, and drive up costs for both DSS and MCOs.

PROBLEM #2. Therapeutic homes, treatment placements and crisis placements for foster children are in short supply and take too long to be accessed and approved for funding.

HYPOTHESIZED CAUSES:

1. The number of foster children has increased, and many foster children have significant behavioral health needs.
2. Therapeutic home and other treatment placements used by foster children in North Carolina are Medicaid funded. This creates cost savings for NC but means beds are not dedicated to foster children.
3. While DSS must provide a placement immediately for children who enter care and every night thereafter, the Medicaid funded mental health placements DSS relies upon for children with high behavioral health needs require medical necessity determinations that may require assessments and take several days.

NEGATIVE IMPACTS:

1. Foster children sometimes do not receive prompt, timely mental health services.
2. DSS workers are often in a crisis mode looking for placements and are frustrated.
3. Tension between DSSs and MCOs.

PROBLEM #3: Many of the foster and therapeutic home beds that exist in each county are filled by children from other counties.

HYPOTHESIZED CAUSES:

1. The financial incentive for providers is to fill beds as quickly as possible, not to hold a bed for a child within their county.
2. DSS and mental health providers may not have good information about open beds in their counties and nearby.

NEGATIVE IMPACTS:

1. Foster children placed outside of county are removed not only from family but also from school, friends, church, community, and other activities and supports. Visitation with family is less frequent, integration of family into treatment more difficult, trauma is increased for both children and parents, and reunification less likely.
2. DSS staff must travel to visit children in their custody, make courtesy visits to children placed from other counties.
3. Mental health costs rise with increased trauma, longer stays in foster care.

PROBLEM #4: Children disrupting from foster and therapeutic placements

HYPOTHESIZED CAUSES:

1. Alliance data indicates that the most frequent reason for disruptions from therapeutic homes is that the parent's or agency find the behavioral demands of the children to be too great.
2. Provider agencies are not adequately screening, training and supporting therapeutic parents.

NEGATIVE IMPACTS:

1. Placement disruptions re-traumatize children
2. Placement disruptions exacerbate the problem of placement shortages
3. Children who experience placement disruptions often move from foster homes to therapeutic homes or from therapeutic homes to treatment group homes and PRTFs. Such moves are associated with
    a. poor wellbeing outcomes for children
    b. poor permanency outcomes for children

    c. increased mental health and foster care costs

PROPOSED JOINT STRATEGIES FOR ALLIANCE AND DSSs:

1. Collaborate to provide services to parents to prevent children entering foster care or to prepare parents for reunification
2. Explore how Alliance might help DSS license and retain regular foster parents.
3. Collaborate to provide services to help regular foster placements and kinship placements successfully work with children with challenging behaviors.
4. Use geo-mapping to give information to DSSs on the location of open therapeutic home beds in the Alliance catchment area.
5. Jointly communicate to the provider network a priority to place children within their home county.
6. Possibly in collaboration with state DHHS and provider groups, explore options for providing incentives to child placement agencies to serve children close to their homes and preferably within their home counties.
7. Possibly in collaboration with state DHHS and provider groups, explore options for:
    a. Strengthening training and supports for therapeutic parents
    b. Establishing expectations of therapeutic parents that are clearly differentiated from expectations of foster parents
8. Possibly in collaboration with state DHHS and provider groups, explore implementing a system model of trauma informed care.
9. Establish outcome measures to jointly track and work towards.
10. Develop a report that would be shared with DSSs and providers on placement stability and placement outcomes by provider.

STRATEGIES CURRENTLY BEING IMPLEMENTED OR EXPLORED IN ONE OR MORE COUNTIES

1. Tier 3 case management
2. Crisis diversion beds
3. Co-located staff
4. Foster family summits to address training needs