Project Broadcast Annual Trauma Summits

Each year, Project Broadcast sponsors an Annual Trauma Summit to provide a forum to share information, highlight project successes, and develop strategic plans to help build a trauma-informed child serving system in North Carolina.

Focus Areas

2012 – The nine demonstration counties came together with their community partners to review baseline data and understand the impact of trauma on the children in North Carolina, and develop local plans for building a trauma-informed system in their county.

2013 – The nine demonstration counties and their stakeholders were invited back to highlight accomplishments, review lessons, and discuss how to begin building a trauma informed system in the remaining 91 North Carolina counties.

2014 – Focus on improving relationships between LME/MCOs and local DSSs. North Carolina has been engaged in series of mental health reforms for over 12 years. This constant change has been the leading challenge to securing effective mental health services for children in foster care. In 2013 all areas of the state transitioned to a behavioral health managed care system which has exacerbated tensions between local departments of social services and their regional managed care organizations.

2015 – Focus on improving relationships between LME/MCO and DSS. There continues to be uncertainty as to how North Carolina will proceed with mental health reform (will behavioral health managed care continue to be separate if the state pursues managed care for physical health for Medicaid beneficiaries). The current LME/MCOs continue to consolidate which makes for a challenging provider environment and has created ongoing confusion for the child welfare agencies.

2014 Trauma Summit: Challenges/Strategies Session

The 104 participants in the 2014 Trauma Summit answered three questions: 1) What are some of the challenges you are currently experiencing with your LME/MCO or DSS? 2) What are some of the strengths of your relationship with your LME/MCO or DSS? 3) What is something you learned the 'hard way' over the last 12 months related to serving the mental health needs of the child welfare population?

NC DSS, DMA, and DMH staff reviewed these issues and selected 15 to address at the Summit. A document entitled "Let's Talk About Some Challenges and a Few Potential Strategies to Assist" was developed and given to participants upon their arrival. It should be noted that there were many more than 15 issues submitted, but these were selected based on frequency and

our ability to address adequately at the Summit. Further work is required to address all concerns identified.

The tables below outline the issues and scores as ranked by the participants.

TABLE 1: ITEMS RANKED MOST CRITICAL TO ADDRESS

At times, children's behavior escalates which leads to an abrupt placement disruption. Often there is nowhere for the child to go while awaiting authorization for residential treatment. (n=72) This question was repeated at the end to ensure there was not issue with familiarity with iClicker® technology (n=67)	Ranked #1 – Very Critical Ranked #1 – Very + Somewhat 94% indicated this issue was very or somewhat critical 91% indicated the issue was very or somewhat critical to address when repeated.
It is difficult to find providers willing to accept Medicaid and/or willing to work with dually diagnosed or sexually offending populations. (Participants clarified during large group discussion that the primary issue is the dual diagnosed or sexually offending population). (n=72)*	Ranked #2 – Very Critical Ranked #2 – Very + Somewhat 83% indicated this issue was very or somewhat critical
It is difficult to find treatment services for parents who are uninsured. (n=74)	Ranked #3 – Very Critical Ranked #5 – Very + Somewhat 76% indicated this issue was very or somewhat critical
The behaviors of a child in therapeutic foster care have stabilized, and the LME/MCO is ready to discharge the child from treatment. However, the child welfare team believes that these stabilized behaviors cannot be maintained outside of a therapeutic treatment setting. (n=73)	Ranked #4 – Very Critical Ranked #3 – Very + Somewhat 81% indicated this issue was very or somewhat critical
We struggle with continuity of treatment services for children aging out of foster care. Participants clarified during large group discussion that their primary issues were broad in nature (not treatment necessarily) but general community supports and educational needs. (n=74)	Ranked #5 – Very Critical Ranked #4 – Very + Somewhat 77% indicated this issue was very or somewhat critical

*item would be separated for clarity if conducted again.

TABLE 2: ITEMS RANKED 'IN THE MIDDLE' TO ADDRESS

We have Judges who court order specific treatment models, but the child does not medical qualify for treatment. (n=71)	Ranked #6 – Very Critical Ranked #9 – Very + Somewhat 56% indicated this issue was very or somewhat critical
There is an impression that this population needs to 'fail their way' up to a higher level of treatment. This has the potential to retraumatize a child. (n=73)	Ranked #7 – Very Critical Ranked #6 – Very + Somewhat 70% indicated this issue was very or somewhat critical
The child's Medicaid is from one county but the child is placed in another county served by a different MCO. (n=73)	Ranked #8 – Very Critical Ranked #7 – Very + Somewhat 70% indicated this issue was very or somewhat critical
The therapist is unwilling to allow visitation with the biological parents citing it will be a trauma trigger, but the plan is reunification and the social worker is stuck. Or the social worker wants the clinician to be the one to tell the child the plan has changed from reunification to adoption. (n=73)*	Ranked #9 – Very Critical Ranked #8 – Very + Somewhat 68% indicated this issue was very or somewhat critical
As a therapist, I want to attend every Child and Family Team meeting, but I cannot afford to take that much time away from billable hours. I basically lose money every time I attend a CFT. (n=73)	Ranked #10 – Very Critical Ranked #11 – Very + Somewhat 55% indicated this issue was very or somewhat critical

*item would be separated for clarity if conducted again.

Recommendations from the regional meetings included:

- Implement Project Broadcast trauma screening in all 100 counties
- Increase training for therapeutic foster parents to ensure they have the adequate skills and competencies to work with children exhibiting difficult behaviors and complex trauma histories
- Develop an incentive plan to keep beds available in homes of skilled parents who could care for children with extremely challenging behaviors
- Develop trauma-informed agencies across disciplines (schools, law enforcement, medical community, child care, etc.) and ensure all are screening appropriately for trauma
- Provide training for providers to appropriate address medical necessity in their authorization requests
- Explore options for a more structured step-down process for youth which would include, among other things, reducing the level of supervision on a trial basis so children can gradually experience 'normal' activities

Education: participants were asked if they learned anything during the Summit that they did not know previously. More than 100 comments were received and they generally fell into three categories:

- Information learned about the Managed Care 'World' including EPSDT, IAFT, Facility Based Crisis Program for Adolescents and Children, history of the mental health reform efforts, MCO capabilities and services, and some MCOs piloting incentivized payments evidence-based treatment.
- Information learned about the Child Welfare 'World' including general knowledge about the number of children in care, psychotropic medication usage, some DSSs developing clinical teams, Child and Family Team meetings, the way the financial allocations are appropriated for treatment vs. room and board, and the Continuous Quality Improvement efforts underway.
- Information about other resources/information/roles such as assessment tools, Management Assistance website, SAMHSA's TIP 57, and Community Care of North Carolina.

Expectations Changed: participants were asked ways their expectations changed based on what they learned at the Summit (of themselves or of others). More than 25 comments were received and they generally fell into the following categories.

- DOCUMENTATION – importance of authorization documentation, addressing medical necessity, requesting/offering help regarding documentation to ensure children get necessary treatment timely, focusing more on placement stability and prevention of disruption.

- COMMUNICATION – increase communication especially on the front end of the case, ensure the leadership at agencies are involved in decision making, increase team approach and use of community partners.
- COLLABORATION – assume good intent, be open to asking questions and hearing all perspectives, realizing that change is a slow process, look for opportunities to collaborate.
- KNOWLEDGE – increase cross training opportunities, ensure consistent language, more information about trauma's impact on mental health, better understanding of each other's agency culture.

Communication Strategies: participants were asked to identify communication strategies they might try in the coming months. More than 35 comments were received and they generally fell into the following categories.

- REACHING OUT – to providers, to LME/MCOs, or to DSS to discuss services, provide presentations, coordinate efforts, understand roles, provide or receive training.
- USE OF EXISTING MEETINGS – ensure representation on system of care community collaboratives, child and family teams, and joint DSS/MCO care coordination meetings where they exist.
- ADVOCACY – be more proactive, contact sooner, increase meeting frequency, ask clarifying questions, talk to more people, keep 'tension slide' in mind to help with partnership, get legal team involved in working with Judges.

Next Steps Progress Report:

2014 ACTION ITEM	PROGRESS
Development of an official training for Child Welfare staff on Mental Health evolution in NC, frequent tensions, and working with LME/MCOs	NC DMH/DD/SAS working with UNC to launch online course to live on ncswLearn.org.
Development of a series of recorded webinars to address the relationship between LME/MCOs and DSS	One recorded webinar completed via MRS Call on 9/21/15.
Series of educational flyers for various target audiences (MCO/DSS)	*no significant progress to-date*
Development of additional training on adequately addressing medical necessity	*no significant progress to-date (currently rely on each LME/MCOs to educate their provider network)*
Increased involvement of LME/MCO's in Project Broadcast Leadership Team activities and	*no significant progress to-date (the Project Broadcast Leadership Team has not been active)*

2014 ACTION ITEM	PROGRESS
workgroups to help develop a more trauma-informed system	
Develop a 'package' that could help guide an LME/MCO in investing in staff, programming, etc. to ensure the counties in their coverage area could become trauma-informed, implement trauma informed screening, trauma-informed comprehensive clinical assessments, and work collaboratively with their DSS	A list of successful strategies and common challenges were developed and used at the 2015 Summit to facilitate discussion. A training was developed on Trauma-informed Comprehensive Clinical Assessments. *More progress needed.*
Review additional challenges identified by participants during the registration process, but not brought to the Summit and where possible, develop strategies for those issues disseminate that information	*no significant progress to-date*

HIGHLIGHTS FROM BREAKOUT MEETINGS AT 2015 TRAUMA SUMMIT

Any cell not entered does not indicate there is nothing to report; only that is was not captured in the notes.

LME/MCO	MEETINGS	INITIATIVES	STRENGTHS	NEEDS
LEADERSHIP MEETING	DJJ/MCO meeting monthly with TA from UNCG (moving forward, may benefit from that structure)	N/A	Consensus that relationships and communication were key. Lack of knowledge of both system contributing factor to challenges.	Feedback loops Data collection for counties AOC Judge Education Moving Medicaid Over for 'stable' foster care placements
Alliance	MCO/DSS have quarterly meetings	CQI on therapeutic placements specifically placement disruptions Crisis Facilities/Crisis Response Fidelity wrap around/exploring?	Good communication at manager level. Desire to jointly request General Assembly allocate beds at Cape Fear Hospital for older youth. Increased commitment to quality and communication about blind spots each agency was unaware of.	Need to improve communication at worker level; Providers need more education on expected protocols – especially discharge planning; Level 2 home need increase support; Seeing more complex needs; LME/MCO calls from law enforcement; DSHR licensed homes hesitant to accept aggressive youth for liability issues; DJJ involved youth gifted by court.
Cardinal	Not consistent; some MCO/DSS have been meeting; Will ensure	**Enhanced rate TFCBT/PCIT** Family Centered Treatment High Fidelity Wrap-Around	CWTTT/RPC	Discharge from high level Access services after discharge

LME/MCO	MEETINGS	INITIATIVES	STRENGTHS	NEEDS
	meetings with all moving forward.	Triple P Public-Private Partnership ABC PFE Short term services w/ CANS for identification needs Study re: school district transitions	Trauma Screen to EBT Alamance (ABC, Physical environ)	
CenterPoint	Did not have a regional meeting. All members from MCO/DSS were in leadership room and felt their needs were met during that session. **Have developed an MOU on how CenterPoint and Forsyth County will work together – is in the final stages of signatures/legal department.**			
Eastpointe	Eastpointe offered meetings to Directors, but they did not have any response.		Eastpointe's website is updated with training opportunities and services	Services for undocumented clients; Front line staff at MCO not fully informed (DSS often needs to goes up the chain to get services); DSS would like to explore co-located MCO staff similar to other counties. DSS would like to better understand what their county dollars (342K) are purchasing.
Partners	MCO/DSS looking at reinvestment into gaps Will compare data on medication usage	Family Centered Treatment MST for Sexualized Behavior PRTF Diversion Critical Time Intervention TFC for Dually Diagnosed High Fidelity Wrap-Around	Catawba Clinical Unit (Assess quickly) MCO/DSS relationship strong RPC	Strengthening out-of-network services (do not review/monitor like the others; need county to work through them – not place first)

LME/MCO	MEETINGS	INITIATIVES	STRENGTHS	NEEDS
	Committed to Regional Meetings and look at data	MCO/DJJ meeting quarterly Collective Impact/Adult SOC ARC Reflections (Foster Parents) Gaston/Cleveland/Lincoln Mobile Crisis for FC/TFC under development		Medication Oversight
Sandhills	Leadership to meet quarterly	CQI on FC moves Churches/Providers involved	DJJ Programming Strong	MCO staff more aware of PB, Screening
Smoky	MCO/DSS have been meeting every 2-3 months.	**Enhanced rate TFCBT** High Fidelity Wrap-Around Crisis Respite	Rowan - Trauma 101 in Community New Psychiatrist in November	Clinician turnover Supply/Demand TFC Discharge planning Access to Psychiatrist (meds)
Trillium	Pitt/Trillium have been meeting monthly. Want to set up regional quarterly meetings (Northern, Central, & Southern)	**Enhanced rate TFCBT** Defined children 0-25 CPP Child First (CF) Case Rate for CPP, MST & CF Compassion Reaction Schools Rachel's' Challenge MHFA My Strengths (web self-help) Playgrounds	Pender (TFCBT, ABC, SPARCS) Craven (TFCBT, ABC, SPARCS, Celebrating Families, Infant Massage, Angel Bear Yoga) Pitt (TFCBT, SPARCS, Fatherhood, Parent Partners) Trillium Learning Portal (online trainings)	QSAPS for Work First Over 18 guardianship Transition to adult services