

MINUTES

North Carolina Chapter Foster Family-Based Treatment Association
August 3, 2011 Raleigh, NC

Members present: Jenny Rahilly and David Winfield (Alexander Youth Network), John Shackelford (The Bair Foundation), Danny Nolen and Celeste Dominguez (Barium Springs), Karen McLeod, Tara Fields, Michelle Hughes, and Leslie Kellenberger (Benchmarks), Whitney Andringa and Sharon Johnson (Boys & Girls Homes/Lake Waccamaw), Karen Cowan (Brandi Nicole Family Enrichment Center), John Lauterbach (Caring for Children), Debbie Perez and Tracy Pait (Children's Home Society), Pasheena Days (Community Specialized Services), Regina Ferguson and Emil Goergen (Community Support Service), Maureen Murray (Duke University Medical Center), Phyllis Stephenson, Jean Kenefick, Cindy Thomas, Katy Cordell, Richard Edwards and Crystal Keiley (ESUCP), Tammy Cody (Grandfather Home Community Services), Lynn Loomis (Guilford DSS), Tom Culver (KidsPeace), Bethany Vause, Matt Hembree (Lutheran Family Services), Erica Burgess (Methodist Home for Children), Neil Walker (Nazareth Children's Home), Stacy Darbee (NC Foster & Adoptive Parent Association), Marci White (NC Mentor), Chris Rogers (Omni Visions), Kim Morgan and Kelli Holdt (The Children's Home), Lisa Kiser (Thompson Child & Family Focus), Lee Spearman, Jeff Jenkins, Sarah Gupta and Lisa Iezzi (Touchstone Residential Services/Coordinated Health Services), Kate Peterson, Jennifer Taylor, Paul Roodhuyzen (Triumph), Julie Ross, Asheli Thompson, Tosha Corpening (Turning Point Homes), Kimberly Hale (VOCA Corp. of NC DBA New Horizons), Jennifer Evans (Wake County Human Services), Kisha Ellison (Youth Haven Services), Beth Waterson (Youth Focus)

Non-Members present: Paula White (Community Support Agency), Cathy Isaacs (Family Preservation Community Services), Wendy Maguire (Hope Services), Bethany Rice (Youth Unlimited)

Guests: Catharine Goldsmith (DMA), Bob Hensley (DSS)

Chair Phyllis Stephenson opened the meeting, welcoming the newest chapter members and recognizing the Board. Focus of the meeting, the new proposed Therapeutic Family Services (TFS) service definition. Phyllis gave special recognition to the volunteer members of the TFS Service Definition Workgroup who've given more than 500 hours of their time for intense discussion and consultation with internal, state and national resources since the group was convened 4-8-11 at the request of DMH: Karen McLeod, Tara Fields, Phyllis Stephenson, Catharine Goldsmith, Bob Hensley, Celeste Reed, Tom Culver, Kate Peterson, Marci White, Cathy Isaacs, Regina Arrowood, Matt Hillman, Alisa Russell, Leslie Kellenberger, Susan Frankfort-Winningham, and Kim Hale. Phyllis presented a special plaque to Karen McLeod for Benchmarks' leadership and unrelenting commitment to this effort. The Workgroup's recommendations go to DMA for their consideration.

Karen McLeod, CEO of Benchmarks, opened with some background, that Benchmarks and DMA had serious concerns that when DMA sent the new TFS SPA to CMS that CMS would unbundle the service, requiring billing in 15 minute units. Dr. Laura Boyd with FFTA has worked this issue at the federal level. At the state level, Level II Family Services/TFC has seen an increase in licensure requirements and decrease in the rate. That, along with the significant reduction in Level III and IV and increase in PRTF placements has resulted in more kids with tougher issues presented to TFC and a real need for a new definition to take higher needs children. Benchmarks was key in developing the Specialized Residential Services definition to replace III and IV, is a very specific type of service for outlier children who cannot be served in TFC and PRTF, very clinical and provided under CABHA. SRS and TFS would expand the state's service continuum to keep children out of PRTF and acute inpatient. The challenge for the TFS workgroup is straddling the two divisions, DMA and DSS, and to get approval quickly. The recent legislative session included yet another rate reduction of two percent. The new definition will come with a higher rate.

Karen updated the group on the new 1915(b)(c) waivers which will decrease the number of LMEs and create regional Management Care Organizations (MCOs). If you are a good small agency, and there are some great ones, as NC moves to a waiver environment, economies of scale will be increasingly

important. Small agencies will be in a fragile position financially. To prepare for this environment, study Piedmont Behavioral Health (PBH). They did not experience the Community Supports debacle, had only one child in an out of state PRTF, and has fewer providers than the LMEs because the Waiver allows them to close their networks. If you are really small, with an amazing specialty niche, this will give you an edge. But if you are very small and not specialized you may not make it.

Chair Phyllis Stephenson added that there is national chatter about how we have done the definition, thinking outside the box, using Florida's definition as a resource and then when we got stuck, called in Dr. Laura Boyd who assisted as did FFTA national to see if NC could get CMS to recognize the FFTA Standards. This is a very different way of doing a definition

Phyllis reported that the Workgroup's final draft definition is 23 pages long so what will be presented today is a PowerPoint with the most important concepts. It will also be sent out via e-mail after the meeting. After today, Benchmarks' Tara Fields will reformat the Definition and send it as a formal presentation to Catherine Goldsmith at DMA.

With DMA's emphasis on licensed clinicians, the Workgroup stressed to Catharine how important it is to keep the bachelor's level staff, the backbone of treatment foster care. What was crafted is a two tiered definition. Catharine had already written the Intensive TFS service and our charge was the standard TFS definition. Both were tweaked. DMA will take our recommendations, finalize their own definition which will go to the Physicians Advisory Group, then out for public comment before the SPA goes to CMS.

Catharine reiterated that the original charge was to draft the lower level of TFS to complement the Intensive TFS definition. Intensive TFS is a new a service in North Carolina's service array. Catharine is the Section Chief for Behavioral Health at DMA and has a long background in children services. Catharine saw how the service was valuable in Florida and was excited to look at NC's definition with goals of improving clinical oversight as well as get it back to the rate setting process. This initiative got a boost in 2009 when the legislature mandated reducing the numbers of kids in Level III and IV which matched Catharine's belief that kids should be treated in the least restrictive setting. Back then, DMA submitted a TFS definition to CMS who sent it back with 59 questions. All the community based residential services went up together. CMS was concerned about what rehabilitative services were being provided to the kids and by whom. Same as other optional rehab services, outpatient service: What are we paying for? Where is the treatment and who is doing it? That 2009 definition had a lot of supervisory levels which CMS felt was too much overhead. Wanted to bring the interactions of the clinical staff down to working with the parents. They do accept that this is a bundled service.

Borrowing on Florida's model, using clinical staff, licensed practitioner or master's with 5 years of experience we worked to develop a model to manage kids without access to level III who were tougher and in recognition that there is a lot of good work with established models.

In the two tiered approach, one is a mildly enhanced clinical model from what we have now, adding a clinical person. The step up is to Intensive TFS. We expect 80 percent of the kids will be in standard TFS and only 20% will be in Intensive TFS. Not all therapeutic foster care agencies will provide the Intensive service.

Nationally, TFC is getting more pressure to take tougher kids, particularly stepping down from expensive PRTF services. There's a real chance to put NC on the map if we can come up with a model to sustain these tougher kids. The challenge to us is to make sure that we can get CMS approval, that the service makes sense and implementation is only minorly disruptive.

In both levels of TFS, there is emphasis on working with the family to whom the child is returning. This is highlighted in both models. Build this into the work that the licensed person does so they are able to concentrate on working with the family.

In anticipation of managed care, we need to look at the professionalism of the service and to show clinical oversight. DMA is so interested because \$93 million dollars has been spent in PRTFs and DMA wants to move the kids back into the community. TFS is far more cost effective for managed care plans. 50 percent of kids in TFC now are in their parent's custody. A definition that results in quality outcomes for kids will have a good chance in a managed care environment.

Chair Phyllis Stephenson presented the broad concepts from the Workgroup's draft.

- Community based, intensive treatment services provided to children with serious emotional disturbances that reside in a state licensed therapeutic home
- Must include a clinical model, foster parents and clinical staff
- Will implement plans and team meetings when kids are hospitalized
- Built on the foundation that the Treatment Foster Parent is the agent of change. (Florida is redoing the definition to strengthen this in their definition.)
- Ensure there are measurable outcomes, increasing the accountability of the parents and the expectations for the outcomes of the children
- Two levels - TFS and Intensive TFS
- Enhance child's ability to adapt to and succeed in a lower level of care as they transition to permanency

Goals

- Build on child's strengths
- Increase the child's understanding of diagnosis, disorders, symptoms and behavioral triggers. Right now they don't know what it is, why they have it and why we continue to change their medications, how to control symptoms. Design a plan to offset triggers.
- More accountability for kids to have more self management skills. Make sure they are equipped for successful behavior management
- Provide healthy role models; have a definition where we don't hear from foster parents "Come and get this child." This is not a healthy role model, at either level, new expectation for families to go the distance and we are equipping you to go the distance. We are doing a disservice if they don't feel secure.
- Age appropriate skills in plans
- Establish sustainable relationships. The definition supports relationships that they form in the community.
- Successful transition for discharge; look at outcomes.

Process

- Therapeutic Parent is the primary agent of change and the point of engagement with clinical staff; licensed, provisional, masters, will be engaging with the Therapeutic Parents to better equip them to engage the children, to provide better services, prevent hospitalizations and decrease disruptions
- Every PCP will have a very specific transitional plan, with steps to measure for success
- Agencies achieve accreditation within one year of enrollment; directly enrolled service
- Provider adheres to Medicaid enrollment, bulletins and updates
- Will be first responder

Bob Hensley with state DSS gave the following update:

- North Carolina's IV-E audit went well; feds were very complementary of the process and brought folks from Tennessee to see how we do it; as result they are changing some of the ways they do things.

- The feds are going to do an administrative audit for county DSSes on if they spent their IV-E administrative funds correctly. Bob thinks there will be paybacks, something new the feds have started, we are one of the test states. This could have wide ranging effects on how IV-E dollars are spent in the future.
- There's not going to be a place in this new world for all 117 private Child Placing Agencies and the 50 on the waiting list. If you are a small agency, consider the future, that expectations and the cost of providing services will be higher.
- Bob is seeing an increase in substantiations of abuse and neglect by foster parents; more and more of the foster parents whose licenses are being revoked are challenging those decisions. DSS usually wins the appeal, but it takes hours of valuable time to testify that the license should be revoked and for at least five years they will not be allowed to foster. DSS is seeing two things: (1) some foster parents should have never been screened in to begin with; agencies don't have to license everyone that asks you. It is not a constitutional right. Improve the selection process. (2) DSS hears from parents they are getting children without the supervising agency providing the support they need to care for kids with high end needs.
- Changes in 70E rules: more face to face assessment time with prospective foster parents before you can submit their application; mirrors exactly what is asked of adoptive parents; meet individually with each parent, then jointly on two separate days, talk with other members of the household, the whole foster family
- All 117 agencies must understand that just because you are licensed for therapeutic foster care doesn't mean you are going to be a TFS provider or an Intensive TFS provider
- Jordan Institute has done a study regarding training, alternatives to MAPP; looking at evidence based practice curriculum like Together Facing the Challenge. A statewide workgroup will include private, public, university partners - definitely want to switch from heavy on pre-service to heavy on in-service; develop a tool for screening parents. At the October FFTA meeting, the Diana Screen will be highlighted. Also Bob will invite Tammy Deitz with Barium Springs to speak about their screening tool. John McMahon and Lana Cook will be looking at the Center for Child and Family Health trauma-informed training and how that can be incorporated. Kevin Kelly has been working on a grant for training parents and staff.
- In the assessment and survey the Jordan Institute did, foster parents said they need skills in handling behaviors
- Also look at technology that is available; how can we make training more accessible to parents, rather than have them leave their home and come to training; had a foster parent speak to other foster parents for webinar for Jordan; going to make that webinar available for foster parents in NC (already for Wisconsin)
- Most agencies do MAPP-GPS so change won't come overnight but DSS can begin to make changes to meet the needs of the foster parents and the clinicians and agency staff

Benchmarks' Tara Fields gave an update on the pilot electronic submission of foster home licenses. Bob Hensley is working closely on this project.

Leslie Kellenberger invited anyone with comments and feedback on DSS's draft manual for licensing foster homes to stay after the meeting.

Next meeting is Friday October 14th at The Cutting Board in Burlington from 11-2.

Respectfully submitted,

Jenny Rahilly
Secretary, FFTA North Carolina Chapter