STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

February 6, 2020

SENT VIA ELECTRONIC MAIL

The Honorable Joyce Krawiec, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 308, Legislative Office Building
Raleigh, NC 27603

The Honorable Josh Dobson, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 307B, Legislative Office Building
Raleigh, NC 27603

The Honorable Donny Lambeth, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 303, Legislative Office Building
Raleigh, NC 27603

Dear Chairmen:

Session Law 2017-41, Section 7.(c) required the Department of Health and Human Services to report on the IAFT Foster Parent Pilot Program to the Joint Legislative Oversight Committee on Health and Human Services in December 2018. In the submitted report, The Department and other stakeholders recommended extending the IAFT pilot project until September 30, 2019 with a final report to the legislature on December 1, 2019, to allow for collecting additional data and adequate time to encourage more participation and to measure outcomes effectively. Pursuant to that recommendation, the Department is pleased to submit the attached report.

Should you have any questions regarding this report, please contact Tara Myers, Deputy Secretary for Human Services, at 919-855-4800.

Sincerely,

for

Mandy Cohen, MD, MPH
Secretary

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Pilot Waiver for IAFT Foster Parents

Session Law 2017-41, Part VII, Section 7.(a)(b)(c)

Report to
The Joint Legislative Oversight Committee on
Health and Human Services

By

North Carolina
Department of Health and Human Services

February 6, 2020

Background

In January 2017, the Family Focus Treatment Association (FFTA) convened a workgroup to develop a solution to the high number of disruptions in therapeutic foster care placements. The FFTA proposed the elimination of the income/financial stability requirement for Intensive Alternative Family Treatment (IAFT) families to determine if this would result in better outcomes for youth receiving IAFT services.

This advocacy resulted in a provision in Rylan's Law (Session Law 2017-41), which required the North Carolina Department of Health and Human Services (NCDHHS), Division of Social Services (DSS), to establish a pilot project that would allow DSS to waive the income/financial stability requirement for foster parents who provide IAFT services.

IAFT is a specialized family type residential service, provided to youth in a family home setting as a cost-effective intervention for youth who would have previously received care and treatment in Medicaid funded congregate care, such as a psychiatric residential treatment facility. These youth are often suspended or expelled from school or day programs and require multiple appointments on a weekly basis to address needs such as therapy, medication management, and individual education plans.

IAFT is provided by private child placing agencies with oversight by Rapid Resource for Families (RRFF) and with authorization of the local management entities/managed care organizations (LME/MCO) in North Carolina. IAFT provider families are licensed foster families and must maintain compliance with administrative rules and policies that govern foster home licensing.

Administrative rule 10A NCAC 70E .0803 (C)(7) requires that "The foster home applicants shall be assessed with respect to their financial ability to provide foster care". The foster home licensing policy manual states "To be licensed as a foster family, the applicant's home must be financially stable and secure. Income in a foster home must cover the bills. Foster care payments are not to be used for basic household expenses. Some sources of income are not stable and are temporary … The objective is to show that the household is able to meet its financial needs without providing foster care services".

In order to meet the financial stability requirement, foster parents usually maintain outside employment while providing foster care. The constant demands of meeting the needs of youth receiving IAFT services often lead to disruption in placement, as the foster parent is unable to meet those needs while maintaining employment obligations.

The pilot project was developed in a series of meetings convened by DSS throughout the spring of 2018 and early 2019. The following stakeholder organizations participated:

- Partners Behavioral Health Management
- Alliance Behavioral Health Care
- Rapid Resource for Families
- UNC – Chapel Hill
- Benchmarks
- Omni Visions
- NC Medicaid
- DHHS Division of Mental Health/Developmental Disabilities/Substance Abuse Services
- DHHS Division of Social Services

To announce the pilot project, Rapid Resource for Families provided information to private agencies explaining the project, how to report required data and additional financial incentives to be provided by the participating LME/MCO. Private agencies that provide IAFT services were asked to identify and

recruit IAFT families who already had one stay-at-home parent in the household as prospective participants.

Alliance Behavioral Healthcare (covering Cumberland, Durham, Johnston, and Wake counties) and Partners Behavioral Health Management (covering Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, and Yadkin counties) opted to participate in the pilot project. No other LME/MCO opted to participate. County Departments of Social Services are not participants in the provision of IAFT services; however, they can refer youth in foster care to the IAFT program in coordination with the LME/MCO. Private provider agencies that participated are Turning Point Family Services, Access Family Services, Omni-Visions, Lutheran Services of the Carolinas, and Children's Hope Alliance.

Reporting Requirements

The legislation required the LME/MCO who participated in the IAFT pilot project to provide a report on the outcomes, along with any recommendations, to DSS and that DSS would submit a report on the pilot project to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2018. In the December 1, 2018 report, DSS and other stakeholders recommended that the IAFT pilot project be continued until September 30, 2019 to allow time for collecting additional data and adequate time to encourage more participation and to measure results more effectively.

The established goals of the IAFT pilot project were:

(1) Improved placement stability with less than twenty percent (20%) of moves of youth occurring due to therapeutic foster parent request.

(2) Seventy-five percent (75%) of youth and families meeting their treatment goals within the projected time frame.

(3) No more than a ten percent (10%) increase in higher-level hospital bed days.

Summary

The provider participants chosen for the pilot project consisted of IAFT approved families who had at least one stay-at-home parent. Private agencies provided information to the DSS foster home licensing office regarding families who participated in the pilot project. Throughout the pilot project, families submitted data regarding outcomes to the RRFF. The data was analyzed to determine if waiving the employment requirement for IAFT families resulted in better outcomes for youth receiving IAFT services and if the goals of the project had been achieved.

The IAFT pilot project ended Sept 30, 2019. A total of sixteen consumers received IAFT services in the family homes identified for the project, ten were discharged during the pilot and six continue to receive services.

Regarding goal number one, placement stability, thirteen consumers, or 81 percent, remained in care or were discharged without a removal request of the treatment parent. This means that 19 percent of moves were at the request of the therapeutic foster parent, which meets the goal of less than 20 percent.

Regarding goal number two, treatment goal achievement, ten consumers, or 62.5 percent met or are still actively working on their treatment goals. Six consumers, or 37.5 percent, were discharged not having met their treatment goals; however, only four were discharged to a higher level of care and six were discharged to family or stepped down to a lower level of care. Though we did not meet the 75 percent

goal, 60 percent (6 out of 10 children) still achieved positive outcomes by stepping down to families or a lower level of care.

Regarding goal number three, avoid hospitalization, of sixteen consumers served in the pilot, four, 25 percent, were discharged to a higher level of care, twelve, 75 percent, have either maintained placement or were discharged to a lower level of care. Only one of sixteen consumers, 6.2 percent, experienced a hospital stay while receiving the service. Because this was a pilot, no baseline was available to determine if there was a decrease/increase, however, only having one hospitalization out of sixteen consumers is a positive indicator.

According to this evaluation of data, the majority of consumers who were served under the special provisions of the pilot project achieved placement stability, success in achievement of their treatment goals, and avoided hospitalization.

Recommendations

The favorable outcomes of this pilot project demonstrate that it would be prudent for DSS, the licensing authority, to consider an alternative evaluation of the employment and income/financial stability requirement for IAFT provider families. This evaluation would include consideration of the family's current, or future income from the provision of the IAFT service in determining their financial stability. It is recommended that the development of the IAFT variation to the existing financial stability evaluation for foster home licensing be developed through a coordinated effort, initiated and lead by DSS, to include the LME/MCO, Rapid Resource for Families, and IAFT provider agencies. This work would result in established parameters for evaluating the family's financial stability, as well as improved recruitment and identification of the most qualified and best suited IAFT provider families and support the LME/MCO, IAFT provider agencies and Rapid Resource for Families in assuring the highest quality of service and improved outcomes for IAFT consumers.