ROLES AND RESPONSIBILITES OF COMMUNITY COLLABORATIVES RELATED TO CHILDREN/FAMILIES ELIGIBLE FOR 'AT RISK' FUNDING[1]

This document was prepared by the State Collaborative for Children and Families to assist communities in the development of effective Community Collaboratives and Child and Family Teams as part of the North Carolina System of Care. It reflects the most commonly asked questions and concerns brought to the attention of the Collaborative and will become part of the Memorandum of Agreements required by the General Assembly.

1. Question: Are the Community Collaboratives (CCs) an advisory body or are they a decision making body?

Answer: The Community Collaborative serves as the local management structure for the System of Care. It's broad purposes are: (1) to promote the sharing of resources and accountability across agencies and programs on behalf of families with children who have significant mental health needs and are at risk of unnecessary out-of-home placement (foster care, state hospitals and Youth Development Centers); and, (2) to build community capacity to provide effective, community-based services to this population. In this role, the Community Collaborative has both decision-making and advisory responsibilities.

Advisory role:

a) Community Collaboratives (CC) should operate primarily as an *advisory* body regarding child specific service/treatment decisions made by a Child and Family Team. If the Child and Family Team (CFT) is unable to reach consensus regarding the planning or implementation of the service plan, the Community Collaborative should assist them, but should not assume the function of CFTs by making decisions for them. However, the CC must ensure that CFTs operate and make decisions within the parameters of policies and procedures for the target population in accordance with the Comprehensive Treatment Program Special Provision, Olmstead requirements, and related State policy.

Decision-making roles include:

a) Establishing the collaborative relationships and procedures necessary for carrying out its functions, including an efficient process for the authorization

[1] The following information is in anticipation of final passage of the House version of the Comprehensive Treatment Program Special Provision.

of At Risk Funds through CFTs, review of aggregate expenditures for the target population;

b) Identifying and coordinating existing resources across child-serving agencies and within the community to increase service/support access, divert children from unnecessary out of home placements, including foster care, and return children placed out of the community;

c) Assure that At Risk funds are utilized in a manner that promotes services that are outcome-based clinically appropriate and medically necessary to achieve the goals of preventing unnecessary use of foster care, youth academies and state hospitals;

d) Make decisions about how At Risk "service" funds are to be spent. Recognizing that each child may have multiple funding sources, the Community Collaborative should work with the Child and Family Team to expeditiously determine the available At-Risk resources. Note that area program administrators must determine if any portion of the At Risk allocation is required to support the basic System of Care infrastructure within their agency due to the absence of other allowable funding. The Community Collaborative makes decisions about how At Risk funds not needed for basic area program agency infrastructure are spent to ensure compliance with the Comprehensive Treatment Program Special Provision and related State policy;

e) Identification of training and technical assistance needs related to implementation of the System of Care and compliance with the Comprehensive Treatment Program Special Provision, Olmstead, and related State policy;

f) Determining operational logistics of the Collaborative (i.e. who will chair the CC, meeting procedures, conflict resolution, etc.);

g) Waiting list decisions when only At Risk Funds can meet a particular service need of a child/family;

h) Determining whether appropriate procedures were followed in At Risk eligibility decisions in cases of disagreements that cannot be resolved by the individuals charged with this decision;

i) Assuring the accurate and timely reporting of information to the State Collaborative;

j) Draw from the experience of the Child and Family Teams and other available information to continuously assess the need for additional resources and provide effective, collaborative leadership toward that goal.

An example of resource development decisions: the CFT has consensus about a given resource need, one that is seen as necessary to help a child remain in the community and avoid unnecessary out of home placement. However, the resource is not currently available in the community. In this case, the CC takes on a decision-making role regarding the resource needed. This brings the CC into the more programmatic and policy making arena, assessing and addressing the bigger

picture for children/families and services in the given community. Is this a resource that can be made available by modifying an existing service? Can agencies work together to establish a new resource? Are additional funds required? Are there regulatory or policy issues at the state or federal level that are barriers to establishing the needed resource? The CC should determine the scope of issues, make decisions about their course of action. Through this process, an issue related to one or more CFTs provide valuable information to the CC regarding emergent issues/needs in the local service/support system and the body makes decisions about how to improve resources consistent with CFT needs.

2. Question: When should a child-specific question be brought to the CC?

Answer: CCs need to be a strong source of support to CFTs but not do their job. Questions brought to the CCs by Child and Family Teams should routinely be those that the CFT cannot resolve at the practice level (e.g., when a next level of assistance is needed as described in the example above or if CFT members disagree with the service plan, etc.)

The CC is also the appeals body for decisions regarding initial eligibility decisions for At Risk funds. The CC should assess whether the eligibility process was appropriately followed. If the process was appropriately followed, the decision should stand. If it is determined that the process was not appropriately followed or if pertinent information was not considered, assistance should be provided to those parties to ensure that the process is properly executed.

3. Question: What is the appeal process if a family disagrees with the CC's decision regarding At Risk eligibility and waiting list decisions?

Answer: If the family disagrees with the CC's decision, regional staff from participating agencies can be asked to review the decision to assure that System of Care procedures have been followed. If disagreements remain, these should be brought to the attention of the State Collaborative. The State Collaborative will then assist regional staff and the CC to resolve the issue.

4. **Question:** How should decisions be made in Child and Family Teams as related to specific agency service/funding eligibility mandates, e.g., Medical Necessity?

Answer: Each agency maintains ultimate responsibility for its respective legal mandates. However, these responsibilities should be clearly explained to all parties

and made within the context of needs being discussed, in the open, and with a spirit of collaboration.

For example, federal Medicaid policies require the determination of medical necessity to be performed by qualified mental health professionals. The Comprehensive Treatment Program Special Provision requires that At Risk funds are used for clinically appropriate and medically necessary services. The System of Care approach further guides Child and Family Teams as to how and when this determination is made:

- Within the context of the Child and Family Team, the first order of business is to identify the strengths and needs of the child and family through an initial strengths and needs assessment lead by the family and the case manager or team facilitator. The strengths and needs drive the development of the service plan. This is to assure that the planning process and service plan truly reflects the mix of services and supports needed by the child/family;
- The CFT then examines the availability of resources to meet each need, including resources through entitlements, 'informal' community supports, existing behavioral health and other agency/organization services;
- Once there is agreement of a 'fit' between strengths, needs, and potential resources, eligibility factors are examined as appropriate for each service or resource/support. In the case of behavioral health services, a determination of medical necessity must now occur. Qualified area program staff should lead a discussion with the Child and Family Team about medical necessity, utilizing the Division's Level of Care document, for each mental health service included in the plan. In other words, area program staff have the responsibility to assure that medical necessity criteria are met before Medicaid or At Risk funds are authorized, but this determination must be done in the context of the Child and Family Team and be subject to discussion by the Team members.
- If medical necessity criteria are not met for a particular service, the Team should discuss the possibility of providing the service with other funding, supports, or revising the plan in order to meet the identified need;
- A similar process should occur regarding eligibility for other services and funds, e.g., Title IV-E (through DSS), educational resources (through the Local Education Agency), etc.

Any disagreements regarding medical necessity determinations that cannot be resolved within the CFT can be appealed to the state Division of Mental Health, Developmental Disabilities and Substance Abuse Services (i.e., *not* to the Community Collaborative).

5. Question: Is the intention for the CC's to make *all decisions* re: spending ARC funds?

Answer: No.

a) The CCs should make decisions regarding how At Risk *"service"* (UCR) funds are expended. This response recognizes that each area program agency must have a basic infrastructure of staff positions and administrative supports to implement the System of Care. The area program Director should inform the Community Collaborative of the amount of the At Risk allocation that is required for this purpose. The Collaborative makes decisions, shares responsibility and accountability, about how At Risk funds *not* required for the basic infrastructure are expended to ensure the most timely delivery of clinically appropriate and medically necessary services.

- The CC should monitor aggregate expenditures of ARC funds through Child and Family Teams;
- They should pay close attention to 'outlier' expenditures (e.g., if children are being served out of state[2] at considerable cost, the CC should be expected to examine what it would take to meet the needs of these children in state, etc.);
- The CC should monitor ARC expenditures to determine how these funds, in the context of the array of funds available/needed by local children/families, can be used most appropriately and efficiently to maximize local resources to meet the requirements of the Comprehensive Treatment Program Special Provision.

The CC should also make decisions (within guidelines provided by the State) regarding how Non-UCR categories are expended: 1) System of Care Coordination funds - to ensure effective management, integration, and coordination activities required for cross-agency service planning and delivery, and 2) Family Participation funds - to ensure family involvement, e.g., participation in Community Collaboratives, training regarding shifts in practice necessary to increase family involvement.

Similarly, local DSS, DJJDP and other participants covered in the Comprehensive Treatment Program Special Provision must provide information regarding the resources available in their agencies, including all relevant services and any "service" funds. This is necessary to ensure that the CC has a comprehensive picture of service resources within the local

[2] Children should receive clinically appropriate and medically necessary behavioral health services in their home communities to avoid out of home placements. Children currently place out of home should be targeted to come back into their communities and resources developed to assure necessary capacity. Communities must adhere to the CFS Section/Division's Out of State Placement protocol when considering *any* potential out of state placement.

community, to promote cost-sharing and eliminate cost shifting as required in the Special Provision.

The above answer is based on the following set of premises:

(a) Children with serious mental health needs and their families typically utilize/require the services of more than one agency;

(b) Every agency receives funds to provide services to families, and there is considerable opportunity to improve services to children and families through the sharing of resources;

(c) The General Assembly has made it clear that child-serving agencies should share and maximize resources, and stop cost shifting as it relates to these children:

- ARC funds are dedicated to meeting the mental health needs of eligible children and families and it is critical that CCs know the level of ARC funding available in a given community/catchment area since there is a finite amount of funds available;
- **ARC funds must not be viewed as the only source of funds and support available to meet the various needs of these children and their families.**

6. Question: "If the Community Collaborative is making decisions regarding 'denial' of funding for specific service requests, will the members at the CC making the decision be held liable? If so, what is the plan for liability insurance for the members who are not covered by their Agencies liability insurance?"

Answer:

We assume that this question concerns liability related primarily to waiting list decisions, i.e., if services needed for a particular child/family can only be funded through At Risk funds and those funds are exhausted. The fact that At Risk funds are not an entitlement does not increase the risk of liability, as resource limitations have always been a reality. Because the System of Care emphasizes the importance of collaborative planning and the essential involvement of the family, we believe the risk of such liability is significantly decreased. Service plans should not be implemented without the approval of the parents and caretakers of the child. A Child and Family Team should be organized and charged with the development and implementation of a service plan on behalf of each family that includes a child eligible for At Risk funds, whether At Risk funds are available to support the plan or not. When children/families need services for which At Risk funds are needed but are not available; it is critical to document (via the Waiting List) that this circumstance is due to insufficient funds and not capricious decision-making by a CC. This is not denial of service; it is a matter of meeting the priority population requirements within available resources as required in legislation. We

are researching the need for liability coverage for non-agency participants and will issue an update on this issue in the near future.

7. Question: "Can each Community Collaborative decide what they should decide or will the state give a range of decision-making authority?"

Answer: Legislation provides the broad parameters of decision-making authority and information distributed by the State Collaborative provides greater detail where necessary to implement the System of Care. To accomplish their purposes (see #1), CCs must broaden their scope beyond the management of At Risk funds to build a strong foundation of community-based support for families of children with significant mental health needs.

8. Question: Should Community Collaboratives include representatives beyond public child-serving agencies?

Answer: *Yes*. Community Collaboratives *must* include required partners as described in legislation, e.g., decision-makers from mental health, developmental disabilities, substance abuse, DJJDP, and DSS. Family members must also be represented (i.e., parents of children currently served by the local system). DPI/Local Education Agency decision-makers are expected to become mandated partners per the Comprehensive Treatment Program Special Provision.

In order for a CC to be successful, it is critical that other representatives be fully included as well, i.e., private providers, advocates, community leaders and resource 'brokers'. Ideally, representation in a CC should be comprised of 1/3 public agencies, 1/3 family members and 1/3 other community and private provider representatives. Remember that the purposes of the Community Collaborative are to maximize exiting resources and build community capacity. Membership in the Collaborative must clearly reflect those purposes.

9. Question: Can Area Program representatives continue to chair their Community Collaborative after July 1, 2001?

Answer: No. To promote shared responsibility and accountability across child-serving agencies, families, and the community, Community Collaboratives should not be chaired by Area Program representatives after the initial start-up period (i.e. July 1,2001).

10. Question: Do family members have an automatic 50% 'vote' in CC decisions?

Answer: No. The State does not currently require a given formula for family involvement in CC decisions. However, CCs must ensure that family members are full partners in decisions and should strive for consensus on this important issue. CCs may chose to give family members weighted decision-making capacity if there are not sufficient family members represented on the CC to ensure that their 'voice' is heard in decisions. Community Collaboratives should actively engage local families and their advocacy/support organizations to address these issues.

11. Question: Do members of the State Collaborative agree with these answers?

Answer: Yes. This document has been discussed, reviewed and endorsed by the State Collaborative.