CHANGING
Maryland
FOR THE BETTER

GOVERNOR'S COORDINATING OFFICES

Community Initiatives · Service & Volunteerism · Deaf & Hard of Hearing
Crime Prevention, Youth, & Victim Services · Small, Minority, & Women Business Affairs
Banneker-Douglass Museum · Volunteer Maryland

Children's Cabinet Directive #3 - Local Care Team Protocols
Question and Answer Recap #1
January 11, 2021

The Children's Cabinet is committed to strengthening the system of care for children and youth at the local level through a coordinated approach to interagency case management. The goal of this coordinated approach is to return or divert children and youth from preventable out-of-home, out-of-State, and hospital and other overstay placements through the provision of community-based services.

As part of its recent work to address hospital overstays, the Children's Cabinet has considered actionable practice strategies that are collaborative in nature and designed to strengthen families and support children in their home and community.

Below is a compilation of questions received related to the materials recently approved by the Children's Cabinet and issued to Local Care Teams (LCTs) on December 22, 2020. Subsequent questions will be compiled and the answers disseminated in the same manner.

1. **Due to the length and language, the referral form is not family friendly and may result in barriers or challenges for some of our agency partners to complete. Will a condensed or streamlined version of the form be released?**
   No, having one universal referral form is an intentional decision and there were many discussions regarding this. The form is not new, but was edited slightly from the form in use since 2018 for referral to the Interagency Placement Committee. For self referrals, the family should complete at least lines 1-5 (or as much information as possible) and the LCT coordinator should assist with completion of the form. See #7 on the instruction tab of the form.

2. **When referrals are made in the context of resource consultation, is the entire referral form required?**
   The referral form is required only for populations 1-6 as noted at the top of page 4 of the

Children's Cabinet Directive #3. For other types of requests or referrals, the LCT may elect to use the standard referral form or another form developed by the LCT.

3. **The referral form does not include tracking or follow up fields to monitor the outcome of each referral though our current referral form does. This will result in duplicative effort.**
The referral form is meant to be standard for certain populations. When the Google Forms version is released, the LCT may elect to add fields to aid with tracking as long as no standard information is deleted.

4. **Certain parts of the referral form are appropriate for various case types and not appropriate for others and will result in many N/A responses. Is this acceptable?**
The referral form is required only for populations 1-6 as noted at the top of page 4 of the Children's Cabinet Directive #3. For these youth, if the accurate response is "n/a" that should be entered.

5. **Should we add the new LCT referral form to our website using the information in the fields within the Excel spreadsheet as the use of this form should begin immediately?**
This is a local decision. We understand that that implementation is a process, but to the extent that the new referral form can be used and completed immediately, please do so. As stated in the email sent on January 11, 2021, the effective date for the new directive and form has been extended to March 1, 2021.

6. **When I try to access the referral form, it requires me to have permission to access. Please advise when it may be accessible and if we should wait for the final referral form before updating our website.**
The form that was issued on 12/22/20 is the final version and can be used now. It was sent via email as an attachment, linked on the GOC website, and also posted to the LCT Google Drive. Access issues are related to those individual users who may not have permission to view the Google Drive folder. Permission for the Google Drive folder will be granted as requested (it is no longer possible to allow open access with a link if the user is not in the Maryland.gov domain). You can access the referral form from the email attachment or on the website.

7. **Will the Google form speak only to our jurisdiction or will all data be captured by the completion of the Google form be collected in a central location that is accessible to the Office?**
The Google referral form will be specific to each jurisdiction.

8. **Am I understanding correctly that every referral needs to have an LCT meeting within 5 days? We have a system in place with 2 meeting dates per month reserved and if we have an emergency case we get together more quickly.**
The LCT coordinator should schedule and hold an LCT meeting within 5 business days of receipt of a referral for populations 1-6 as noted at the top of page 4 of the Children's Cabinet Directive #3.

9. **Are all LCTs to use the new form that was emailed to us? This new form should be**

used in place of the individual form we have been using, correct? Also, if the family is just looking for resources are we to still use the new form?
The referral form is required only for populations 1-6 as noted at the top of page 4 of the Children's Cabinet Directive #3. For other types of requests or referrals, the LCT may elect to use the standard referral form or some other - this would be the jurisdiction's preference.

10. **Are we to continue using our consent to release information form?**
The new Directive does not impact or change current release of information practices.

11. **While I think use of the referral form would make sense for youth who are currently hospitalized or working with an agency for a placement, I am concerned that the criteria seems to make it necessary for all youth who are being referred to the LCT.**
The referral form is required only for populations 1-6 as noted at the top of page 4 of the Children's Cabinet Directive #3. For other types of requests or referrals, the LCT may elect to use the standard referral form or some other.

12. **Regarding the requirement of a meeting chair, originally we were told that we were not required to have a chair for the LCT. Has that changed?**
No. The Children's Cabinet Directive #3 notes that the LCT should select a chair, specify term length, and roles and responsibilities of the chair in accordance with its policies and procedures. If it's local policy not to have a chair, then no action is necessary.

13. **Regarding the requirement to conduct an LCT meeting within 5 days of referral, this is new and not always possible. VPA meetings are usually held within this timeframe because of the 7 day requirement, but traditional meetings are not. We meet twice per month and if we need to change that, I know that our reps. would need their agencies to discuss this directive and plan.**
The mandated agency members of the LCT should support the LCT process including scheduling, holding, and attending a meeting within 5 business days of receipt of the referral for populations 1-6 as noted at the top of page 4 of the Children's Cabinet Directive #3. The agencies are aware of the LCT protocols and were involved in their development and assisted in the recommendations made to and approved by the Children's Cabinet. This information has been shared by the agencies with affected staff.

14. **Have the local hospital teams been given the Universal Hospital Discharge Planning Protocol? We have struggled with all hospitals at some point about protocol and what the LCT does and I am not confident that we would be able to implement the protocol without their collaboration.**
The Hospital Discharge Planning Protocol was developed in conjunction with the Maryland Hospital Association and the final protocol has been shared with the Association for distribution. We are reaching out to the hospital association in the District of Columbia and seeking contact with similar associations in Delaware and Pennsylvania as well. The Protocol outlines the responsibility for hospital personnel to make a referral to the LCT. The LCT coordinator's role is to ensure that hospital staff making a referral for a youth identified in number 1-6 as noted at the top of page 4 of the Children's Cabinet Directive #3 are invited to the LCT meeting.

15. **On page 4 of the directive under action steps, our LCT members will be unable to meet the expectation of a meeting within 5 business days for ALL of the 6 referral types. Or is this expediting meant to be applied for cases with the most extreme need (overstays, etc).**
The LCT coordinator should schedule and hold a meeting within 5 business days of receipt of the referral for populations 1-6 as noted at the top of page 4 of the Children's Cabinet Directive #3.

16. **According to the protocols, essentially all cases will be scheduled for an LCT review within 5 days. Is this intentional/by design?**
Yes, it is intentional. A meeting should be scheduled and held within 5 business days of receipt of the referral for populations 1-6 as noted at the top of page 4 of the Children's Cabinet Directive #3.

17. **According to the protocols, all cases where any agency involvement is reported must result in communication up the chain. Is this by intentional/by design?**
Yes, it is intentional. The involved agencies will determine what steps should be taken internally, and what interagency collaboration should be sought on a case by case basis.

18. **Please define 'current involvement' with the agencies. Is this meant to include axillary involvement/non-committed youth, i.e., youth in kinship navigation, youth receiving post-adoptive services, temporary cash assistance, youth receiving alternative response, other youth who are receiving DSS supported care but not formally assigned?**
Current involvement means receiving services from the agency. It does not include instances of youth and/or families receiving only financial assistance. Identifying involvement with agencies and the requisite notification will ensure interagency collaboration in a timely manner.

19. **What is the goal of the new directive?**
The goal is to return or divert children and youth from preventable out-of-home, out-of-State, and hospital and other overstay placements through the provision of community-based services and to intervene with youth sooner in the service delivery continuum.

20. **Does this shift the focus of LCT to direct its efforts toward the types of referrals outlined in the Directive?**
No. Youth with intensive needs have always been a priority of LCTs, but there is a need to ensure that certain populations of youth are being reviewed by all LCTs Statewide.

21. **Are LCTs also still responsible for referrals that do not meet the criteria above and where the family is in need of community supports as a preventive measure for a youth to remain safe in the home, school and community?**
LCTs must consider referrals for populations 1-6 as noted at the top of page 4 of the Children's Cabinet Directive #3. LCTs may elect to accept referrals for other purposes as well.

22. **How will this impact LCT performance measures?**
There are no changes to the existing performance measures.

23. **How does the requirement to hold an LCT meeting within 5 business days for certain youth correlate to the 10-day waiver?**
Human Services Article §8-408(b) requires that at least 10 days notice is provided to the parent or guardian of the child and the child's attorney of the date, time, and location of any meeting the [Local Coordinating] Council or the LCT plans to hold to discuss the child's out-of-State placement. If out-of-State placement is not being discussed, the 10-day notice/waiver is not necessary. If the 10-day notice is applicable to the situation, notice should either be given or a waiver secured from the parent/guardian.

24. **Currently, even with meetings only occurring 1-2 times per month and on a regular schedule, it can be difficult for mandated members to manage their workload and attend multiple LCT meetings. How will this affect performance measures related to member agency representation at meetings?**
The LCT's mandated agency members should support the LCT process including scheduling, holding, and attending a meeting within 5 business days of receipt of the referral for populations 1-6 as noted at the top of page 4 of the Children's Cabinet Directive #3. The agencies are aware of the LCT protocols and were involved in their development and assisted in the recommendations made to and approved by the Children's Cabinet. There are no changes to the existing performance measures, but the data reported may be affected if required members do not attend scheduled meetings.

25. **It has been stated that LCT coordinators are not case managers; however the changes outlined in the directive points to responsibilities that seem like case coordination/management. Can this be clarified?**
The LCT coordinator facilitates and coordinates the work of the LCT. They manage LCT intake, ensure the necessary information is received, and administratively document the LCT's service planning. This is not case management. LCT member agencies retain their agency-specific case management and care coordination roles.

26. **Much of the directive is related to hospital overstays and discharge planning. Why is the LCT the first point of contact for these cases? If youth have a lead agency, shouldn't both of these issues be addressed by the lead agency and/or brought to the LCT by the lead agency?**
Because the Children's Cabinet previously designated the LCTs to be the central point for coordinated case management and as a point of access to services for children and youth, enhancing the role of the LCTs to be the first point of contact for the youth populations 1-6 as noted at the top of page 4 of the Children's Cabinet Directive #3 makes sense vs. implementing a separate structure.

27. **What entities are considered a hospital for the purpose of these referrals? Does this include local general hospitals/emergency rooms, acute psychiatric facilities and residential treatment centers?**
This includes private and public local general hospitals, acute care facilities (both general and psychiatric), and emergency rooms. It DOES NOT include residential treatment centers.

28. **How are hospitals being notified and trained on this process? On the Shore, youth are often sent to acute care facilities in Delaware. How will out-of-State acute and longer-term residential facilities be educated about this process? Does the LCT coordinator play a role in this notification/training process?**
The Hospital Discharge Planning Protocol was developed in conjunction with the Maryland Hospital Association and the final protocol has been shared with the Association for distribution. We are reaching out to the hospital association in the District of Columbia and seeking contact with similar associations in Delaware and Pennsylvania as well. A training plan for this group is under development. The LCT coordinator is not specifically responsible for training and/or notifying hospital personnel, but may elect to do so if there is an established relationship with a local hospital.

29. **When will LCT coordinators receive the Google Form?**
The referral form currently in Excel format will be created as a Google Form and sent to each LCT coordinator shortly.

30. **Is it the role of the LCT coordinator to document that 818 packets have been sent to facilities and monitor and follow up on the status of these referral packets?**
No. The 818 Form is specific to the Department of Human Services. There is no requirement for LCT coordinators to use this form.