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Children's Cabinet Directive #3 - Local Care Team Protocols
Question and Answer Recap #2
January 22, 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. **Can LCT coordinators sit on the subcommittee that created the new LCT referral form, processes, etc. as either a member or liaison to assist in making decisions on LCT matters?**
   While the work specific to Directive #3 has concluded, we will consider such participation as appropriate in the future. Additionally, we are working through the LMB Association to launch a multi-disciplinary workgroup consisting of LCT representatives and State agency representatives to implement the directive.

2. **Is there a list of hospital representatives/liaisons that we can reach out to, to discuss placements, updates, etc.?**
   We do not believe such a list exists.

3. **Who is expected to complete the referral form?**

This is a local decision.

4. **Can the LCT Coordinator act as the Chair, or must it be one of the other mandated agency members?**
   It is a local decision to have a chair and/or who will chair meetings.

5. **Is the Coordinator allowed to facilitate LCT meetings or does that need to be the chairperson?**
   This is a local decision.

6. **Based on the statement "The LCT coordinator is responsible for facilitating a coordinated approach to services and ensuring parent and youth involvement in LCT meetings", is the youth now required to attend meetings? What if they are unable to attend? What age is appropriate for attendance?**
   Youth are not required to attend meetings, but should be invited and encouraged to attend if participation is age- and developmentally-appropriate.

7. **The directive makes reference to "votes" as in the LMB Manual. It's been said that the LCT does not vote, especially regarding approval or denial of placements.**
   Should the LCT vote (not related to placement or approval for such) in accordance with its local policy, then a record of that vote is appropriate. If there are no votes, then no record keeping is necessary.

8. **For youth at risk of hospital and other overstay placements or ejection from an RTC, how will the LCT coordinator be informed of this information? The hospitals/RTCs rarely, if ever, communicate with the LCT coordinator.**
   This information would generally be included on the referral form or provided by various sources during the course of the LCT meeting. Also, having a defined protocol supported by the Children's Cabinet and the Maryland Hospital Association may foster improved communication and collaboration between the hospitals and LCTs.

9. **Why would the LCT Coordinator need to contact the applicable agency, the family, or referring agency when a referral is received? Why wouldn't this occur when the LCT is notified and convened for the meeting.**
   Agencies should be notified in accordance with the protocol. The involved agencies will determine what steps should be taken internally, and what interagency collaboration should be sought on a case by case basis.

10. **Can the LCT coordinator forward a case synopsis to LCT members instead of the referral form?**
    To establish uniformity, the completed referral form should be forwarded to LCT members in accordance with the protocol. Additional materials may also be forwarded with the referral form.

11. **Are hospital referrals considered "emergent" referrals? Otherwise, they would need a 10-day notice which does not meet the 5-day meeting requirement.**
    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.

12. **If a youth has open cases with multiple LCT participating agencies, what agency would assume the lead agency role?**
In this instance, the agencies decide which will act as lead agency if a lead is necessary.

13. **The LCT does not have the expertise to review cases where youth have "complex medical needs without psychiatric features." Why are these youth included in this protocol?**
These youth have been identified as one of the populations most at-risk of preventable out-of-home, out-of-State, hospital, and other overstay placements for whom early identification and provision of community-based services is desired.

14. **What is the definition of a "youth" under this protocol? For example, DSS have committed youth to age 21. However, other agencies stop involvement at age 18.**
"Youth" refers collectively to children as defined in the Courts and Judicial Proceedings Article § 3–8A–01 of the Annotated Code of Maryland and young adults who are agency-involved, and/or those who would benefit from LCT intervention because of their developmental needs.

15. **Is consent obtained from the youth in this protocol who are age 18 and older to share information with the LCT Coordinator? If so, can this document be part of the information hospital staff are required to provide the LCT Coordinator?**
The new Directive does not impact or change current consent or release of information practices. Consents and releases should be obtained as necessary by all parties.

16. **Will parent/guardian consent be provided by hospital staff to the LCT coordinator in order for the LCT coordinator to receive confidential information from the hospital?**
Consents and releases should be obtained as necessary by all parties.

17. **In the Universal Hospital Discharge Planning Protocol, shouldn't the first point of contact for hospital staff be the DJS or DSS caseworker if a youth is currently involved with an agency and not the LCT?**
To establish uniformity, the LCT is identified as the first point of contact for certain populations.

18. **If discharge planning is resolved with DJS or DSS for youth involved with these agencies, why is the LCT being contacted for discharge planning?**
To establish uniformity, the LCT is identified as the first point of contact for certain populations.

19. **How does this protocol change the reasons for youth being stuck in the hospital that are beyond the control of the agencies and the LCT members?**
The protocol is meant to establish uniformity of response and to facilitate earlier

intervention with youth the service delivery continuum.

20. **Was a capacity analysis performed regarding the number of youth for which this protocol is required?**
Information from the interviews with LCT coordinators was considered along with data provided by various agencies including performance measure data for LCTs.

21. **The directive implies that the role of the LCT and Core Service Agency are direct service providers and held accountable as such. Community and treatment providers come to the LCT and CSA for consultation. Some tasks are unrealistic and would apply to the service provider case managers; for example, "ensure parent and child involvement." Please clarify.**
The LCT coordinator facilitates and coordinates the work of the LCT. They manage LCT intake, ensure the necessary information is received, administratively document the LCT's service planning, and ensure parent and child involvement with the LCT as appropriate (e.g. through meeting invitations, contact to obtain information for the referral form, etc.). This is not direct service or case management. LCT member agencies retain their agency-specific roles, as applicable.

22. **Would the Children's Cabinet consider the following change to support a "no wrong door" approach? Current: LCTs will continue to be *the* point of access to services for children and youth. Suggested: LCTs will continue to be *a* point of access to services for children and youth.**
This request is currently under review.

23. **Care Management Entities discontinued operation with the creation of Care Coordination Organizations, so should this be reflected in the following?**
> ***Care management entities when appropriate; and, Identify and share resource development needs and communicate with the care management entity, local core service agencies, provider networks, local management boards, and other local care teams in surrounding jurisdictions;***

This is a direct quote from the existing Statute. Changes would require legislative action.

24. **Could "Local Core Service Agencies" be updated in the following to note LBHAs/CSAs/LAAs?**
    - ***Identify and share resource development needs and communicate with the care management entity, local core service agencies, provider networks, local management boards, and other local care teams in surrounding jurisdictions; and,***
    - ***Identify and share resource development needs and communicating with local Core Service Agencies, provider networks, Local Management Boards, and other LCTs...***

This is a direct quote from the existing Statute. Changes would require legislative action.

25. **It is difficult to get parents to attend LCT meetings without giving 10 days to 2 weeks' notice as they often are not available. How will parents not attending affect this performance measure?**
The data reported may be affected if parents do not attend scheduled meetings.

However, every effort should be made to schedule meetings to accommodate parents. It is more important to hold a meeting on day 5 or 6, than to not hold a meeting. Exceptions to the timeline can be made when the meeting timeline benefits the youth/family.

26. **On page 4 of the directive, #2 states "at risk of ejection from a community/ Residential Treatment Center placement." Does this include foster home, group home, therapeutic group home, etc., or is this only for ejection from RTC? For other than RTC placements, there are processes in place to address these ejections such as the Family Team Decision Meeting for DSS youth and the Central Review Committee for DJS youth.**
The protocol is not only for ejection from RTC, but also includes ejection from community-based (group home settings or higher) residential child care programs. The protocol is not meant to supersede existing processes and/or agency-specific responsibilities.

27. **Clarify #4, "whose needs cannot be met by one agency." If a youth is working with two agencies and the needs are met, why is this listed?**
If the youth's needs are met, no referral is necessary.

28. **Action Steps 1-4 for the LCT coordinator are not practical for the position as currently funded in most jurisdictions, especially ours. It is not realistic to expect an LCT coordinator to contact the family, complete the intake within 72 hours (including document those attempts, gathering and clarifying information from the referral [treatment history, treatment recommendation, agency involvement, insurance information, etc.] as well as simultaneously perform other functions. Will administrative funds be provided if these additional duties require more staff, additional hours, etc.?**
Funding for LCT coordinators is requested by the Local Management Board consistent with local needs. Requests for additional funding will be considered on a case by case basis subject to availability and other factors.

29. **Can "72 hours" be changed to "ASAP"?**
This request is currently under review.

30. **LCT Coordinators do not have backup in times of absence from work. What can the LMB do if there is a job vacancy, illness, or vacation by the LCT coordinator to continue the LCT coordinator function?**
This is a local decision. However, as "mission critical" employees/functions, Local Care Team coordinators and Local Care Team operations should continue.

31. **May the LCTs include a local-specific "addendum" to the referral form if there are jurisdictional requests for additional information not already included on the standard form?**
The LCT may add fields to the referral form as long as no standard information is deleted.

32. **Could consideration be given to update Human Services Article §8-406 and shift**

the language for “Local Core Service Agency” to “Local Behavioral Health Authority or Local Core Service Agency and Local Addictions Authority”?
This request is currently under review.

33. **When there are conflicts between agencies, which is ultimately responsible for the referral - especially when a child falls between agency requirements?**
There is no one agency that is specifically responsible to make the referral.

34. **In the State, there are varying challenges and/or types of cases seen. Is it possible to combine part of the new referral form with our own form?**
The referral form is meant to be standard for certain populations. When the Google Forms version is released, the LCT may add fields to the referral form as long as no standard information is deleted.