Children's Cabinet Directive #3
Local Care Team Protocols Effective March 1, 2021
Clarification Provided March 19, 2021

Overview

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.

The Local Care Teams (LCTs) will continue to be the point of access to services for children and youth. As of January 1, 2018, the Local Management Boards are the administrative home for the LCTs and the LCT coordinator. Parents, family members or agencies may make referrals directly to the LCT to seek assistance with: accessing services, developing plans of care for community-based services, and coordinating services from multiple agencies. Families and children at risk of out-of-home or out-of-State placement, with intensive needs and/or who are in crisis are identified as priorities for the LCT. The LCT directory is available here.

There is agreement that all Children's Cabinet agencies are critical to LCT operations and the agencies agree to hold their representatives accountable to the standards of care established herein with each responsible for its staff individually and collectively.

There is a representative from each agency identified to monitor agency compliance with protocols.

This directive provides guidance related to LCT roles and responsibilities and is applicable to all LCTs. It does not supersede information provided in previous directives issued. Questions about the material herein should be directed to: Kim Malat at kim.malat@maryland.gov or Chris Miele at christopher.miele1@maryland.gov**.**

Local Care Teams (LCTs)

Local Care Teams remain the central point for coordinated case management and access to services for children and youth.

In accordance with Maryland Statute (Human Services §8-407), a Local Care Team shall:

1. Be a forum for:
    a. Families of children with intensive needs to receive assistance with the identification of individual needs and potential resources to meet identified needs; and,
    b. Interagency discussions and problem solving for individual child and family needs and systemic needs;
2. Refer children and families to:
    a. Care management entities when appropriate; and,
    b. Available local and community resources;
3. Provide training and technical assistance to local agency and community partners;
4. 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,
5. Discuss a request for a voluntary placement agreement for a child with a developmental

disability or a mental illness under §5-525 of the Family Law Article.

LCT Membership

The Children's Cabinet continues to require that local agencies attend all LCT meetings with the agencies represented by staff who have the authority to commit appropriate and allowable agency resources at the time of the meeting to support a child's plan of care and the LCT in general. In addition to the LCT representative, the local agencies are required to ensure the attendance of the case manager(s) for the specific cases to be discussed.

As required by Human Services §8-406 each LCT shall include at least one representative from:

1. Department of Juvenile Services;
2. Developmental Disabilities Administration;
3. Local Core Service Agency;
4. Local School System;
5. Local Health Department;
6. Local Department of Social Services;
7. Local Management Board;
8. A parent or parent advocate; and,
9. A non-voting representative of the local office of the Division of Rehabilitative Services to represent individuals who are 16 years old and older.

Except as noted otherwise, each LCT will develop policies and/or procedures for its routine operations, including but not limited to:

1. Scheduling non-emergency meetings including providing 10-day notice to parents and attorneys for the children;
2. Scheduling emergency meetings including immediate notice to parents and attorneys for the children;
3. Providing training and technical assistance to local agency and community partners;
4. Identifying and sharing resource development needs and communicating with local Core Service Agencies, provider networks, Local Management Boards, and other LCTs; and,
5. Addressing a request for a Voluntary Placement Agreement for a child with a developmental disability or a mental illness under §5-525 of the Family Law Article.

LCT Chair

In accordance with its policies and procedures, the LCT should identify:

1. Which of its members will act as chair;
2. The term of the chair; and,
3. The roles and responsibilities of the chair.

LCT Coordinator

Each jurisdiction shall have a LCT coordinator that is administratively housed within the Local Management Board with funding provided by the Children's Cabinet Interagency Fund. The Children's Cabinet provides this permanent staff support to the LCTs to ensure that youth with intensive needs receive comprehensive support services.

The LCT coordinator ensures a coordinated system for LCT case referral and tracking, maintains a comprehensive resource database, collects data, and ensures follow up services as necessary. The LCT coordinator is responsible for facilitating a coordinated approach to services and ensuring parent and youth involvement in LCT meetings.

LCT Coordinator Requirements

1. The LCT coordinator must have experience with child placement systems, a clinical and/or special education background, and a Master's degree in a related field.
2. The LCT coordinator must:
    a. Serve as staff support to the LCT and any designated Statewide committee;
    b. Receive referrals to the LCT;
    c. Maintain detailed notes from each case discussion and track attendance of the LCT meetings;
    d. Ensure that the youth's plan of care has been addressed;
    e. Report on required performance measures and resource needs identified by the LCT;
    f. Maintain a directory (such as, but not limited to Maryland 2-1-1) of all community-based resources in the jurisdiction;
    g. Maintain, analyze and produce written reports from various data systems, and develop policy and procedures based on written reports, as required by the LCT and others;
    h. Work collaboratively with diverse groups of individuals;
    i. Develop and present training modules to small and large groups; and,
    j. Maintain a current and accurate list of LCT members and points of contact for the LCT.

Data and Record-Keeping

1. The Local Care Team Coordinator will maintain:
    a. Detailed notes from each case discussion that outline the plan of care and agency commitments to be reviewed and provided to the parents/guardians at the end of the meeting;
    b. A record from each LCT meeting to include:
        i. Attendance record with signatures;
        ii. List of cases discussed and the outcome of the review that specifies whether the case:
            1. Is new or a review;
            2. Was recommended for out-of-State placement, in-State placement, community services, or a Voluntary Placement Agreement;
            3. Was referred for out-of-State placement, in-State placement, community services, or a Voluntary Placement Agreement; and,
            4. Any official LCT business, including votes, recommendations or actions taken.
    c. Data on required LCT performance measures (see definitions and clarification):
        i. # of new cases referred to the LCT;
        ii. # of cases reviewed by the LCT;
        iii. # of LCT trainings provided;
        iv. # of LCT meetings;
        v. #/% of mandated LCT representatives that attend at least 75% of LCT meetings;
        vi. #/% of all LCT reviews (new, follow-up, and annual reviews) where the youth's parents (or legal guardians) attended;
        vii. #/% of new youth referred for in-State residential placement who are alternatively served through community-based services; and,
        viii. #/% of new youth referred for out-of-State placement who are alternatively served through in-state community-based services or in-State residential placements.

Protocol for Referrals to the Local Care Team

The LCT shall utilize a universal referral form for referrals for the following youth for which this protocol is applicable:

1. Currently in or at risk of an extended hospital stay. Defined as youth who are hospitalized at an inpatient psychiatric facility and are in need of placement or treatment in a higher level of care (e.g., Residential Treatment Center, Diagnostic Center, Therapeutic Group Home, etc.) that may be unavailable or difficult to secure. Youth may be eligible for discharge from an inpatient psychiatric hospital but parents/caregivers decline to return the youth home due to various concerns (e.g., safety, etc.). The inpatient psychiatric hospital must contact the local Department of Social Services in these instances.;
2. At risk of ejection from a community placement or higher level of care (e.g., Residential Treatment Center, Diagnostic Center, Therapeutic Group Home, etc). Defined as youth with intensive needs who are already in placement/accessing treatment through a higher level of care, are facing ejection, or are in need of further placement/treatment access in a higher level of care where none is available. For youth in this category whose needs are being addressed by existing internal agency policies and procedures (such as the local Department of Social Services' Family Team Decision Meetings/Family Involvement Meetings), an LCT referral is not required.;
3. Known/referred to the LCT and are/are not formally involved with an agency who are at risk of a community/RTC/psychiatric/out-of-State placement or treatment access. Defined as youth known to the LCT, though they may or may not be formally involved with a member agency. Current involvement means receiving services from an LCT member agency (e.g., local Department of Social Services, local Department of Juvenile Services, etc.). Current involvement does not include instances of youth and/or families receiving only financial assistance from an LCT member agency. These youth have intensive needs and are in need of placement/treatment access in a higher level of care (e.g., RTC, Diagnostic Center, Therapeutic Group Home, etc.), though a coordinated effort or plan has not yet begun.;
4. Whose needs cannot be addressed by one agency. Defined as youth with intensive needs who are multi-system involved, i.e., engaged with the local Behavioral Health Authority/Core Service Agency and the local Department of Social Services or local Department of Juvenile Services. Agency involvement does not include youth/families receiving only financial assistance from an LCT member agency, or youth conventionally engaged with the local school system;
5. Who are referred by hospital personnel in accordance with the Universal Hospital Discharge Planning Protocol. Defined as referrals sent by hospitals for youth with intensive needs who are at risk of an overstay.; and/or,
6. Who are referred by self or family. Defined as youth who are in need of an intervention that entails more than a warm handoff or information and referral and/or are identified in categories 1-4 above.

Action Steps

1. When a referral is received for a youth identified above, the LCT coordinator should attempt to contact the family and complete the intake within 72 hours (and document those attempts) and gather/clarify information from the referral (i.e. symptoms, treatment history, treatment recommendation, agency involvement, insurance information, etc).
2. Simultaneously, the LCT coordinator contacts the applicable agencies below:
    a. The regional office staff of the Developmental Disabilities Administration (DDA) if the family reports that DDA services are needed or the youth is currently involved with the agency.
        i. The DDA Regional Director will contact Janet Furman, Director of Children's Services at janet.furman@maryland.gov or 410-767-5929.

b. The Child and Adolescent Coordinator at the local Behavioral Health Authority (BHA)/ Core Service Agency (CSA) if the family reports no agency involvement and the person has behavioral health and/or substance use needs or is currently involved with the agency.
    i. The local BHA/CSA is the authority in each jurisdiction for public mental health services. The Child and Adolescent Coordinator will work closely with the parent and youth by reviewing and discussing the mental health services that are available in their jurisdiction.
    ii. If the youth is not insured by Maryland Medicaid, the youth may be referred to services available for privately insured youth.
    iii. Medicaid billable services
c. The local Department of Social Services (DSS) caseworker if the family reports it is currently involved with the department.
    i. The DSS caseworker will contact Sheila Garrett (Sheila.garrett2@maryland.gov), Placement Specialist Liaison at the Department of Human Services' Social Services Administration.
d. The contact is made with the Department of Juvenile Services Regional Director if the family reports the youth is currently involved with the department.
    i. The Regional Director will contact Kara Aanenson, Director, Resource Office at the Department of Juvenile Services.

3. Simultaneously, the LCT coordinator forwards the referral to LCT members in accordance with State and local confidentiality requirements.
4. The LCT coordinator should schedule and hold a meeting within 5 business days of receipt of the referral.
    a. If the referral is received from hospital personnel, that staff should be invited to the meeting.
5. If the youth has an open case with an LCT participating agency, that agency will assume the lead agency role in coordinating services and care for the youth.

Notes:

1. See Universal Hospital Discharge Planning Protocol for an explanation of the youth who will be referred by hospital personnel to the LCT.
2. Confidentiality must be maintained at all times. No waiver of the Health Insurance Portability and Accountability Act (HIPAA), Family Educational Rights and Privacy Act (FERPA), or other statutory requirements is implied.