Nebraska System Flow Chart: How Substance Abuse is Assessed/Treated in Parents in Child Welfare System

Codes: DCFS; Court; DMLTC; DBH; Law enforcement
Square= action; Diamond = decision

DCFS Hotline phone call. Reporter is asked if SA is involved. If yes, it is noted.

Safety Assessment: 14 Safety Factors assessed across 6 Domains + 5 safety threshold criteria
1. Maltreatment; 2. Nature; 3. Child Functioning; 4. Parenting - Discipline; 5. Parenting – General (excl. discip);
6. Adult General Functioning
14 Safety factors in 6 domains + all 5 threshold criteria
Priority 1 = 0-24 hrs: life threatening;
Priority 2 = 0-5 days;
Priority 3 = 0-10 days

If child is safe, a case is not opened; community services may be recommended but are at the family's choice.

DCFS has no authority to remove child/ren, so if emergency removal is needed, it must be done by Law Enforcement (LE). LE must be involved in all criminal cases: sexual/physical abuse, serious SA including meth/meth labs. If child removed must appt Guardian Ad litem for best interest of child & child's legal best interest

If child is unsafe, a case is opened & safety plan is developed.
Decide if removal is necessary.

Safety plan can be:
In home services,
Combination of in home/out of home, or
Out of home

Emergency removal/48 hour hold period until court order (generally, ex parte order) must be issued

DCFS requests filing in Juv Ct.
County Attny may or may not file
(Mandatory request to County Attorney for filing for meth)

No file/Non court involved but could still follow process.

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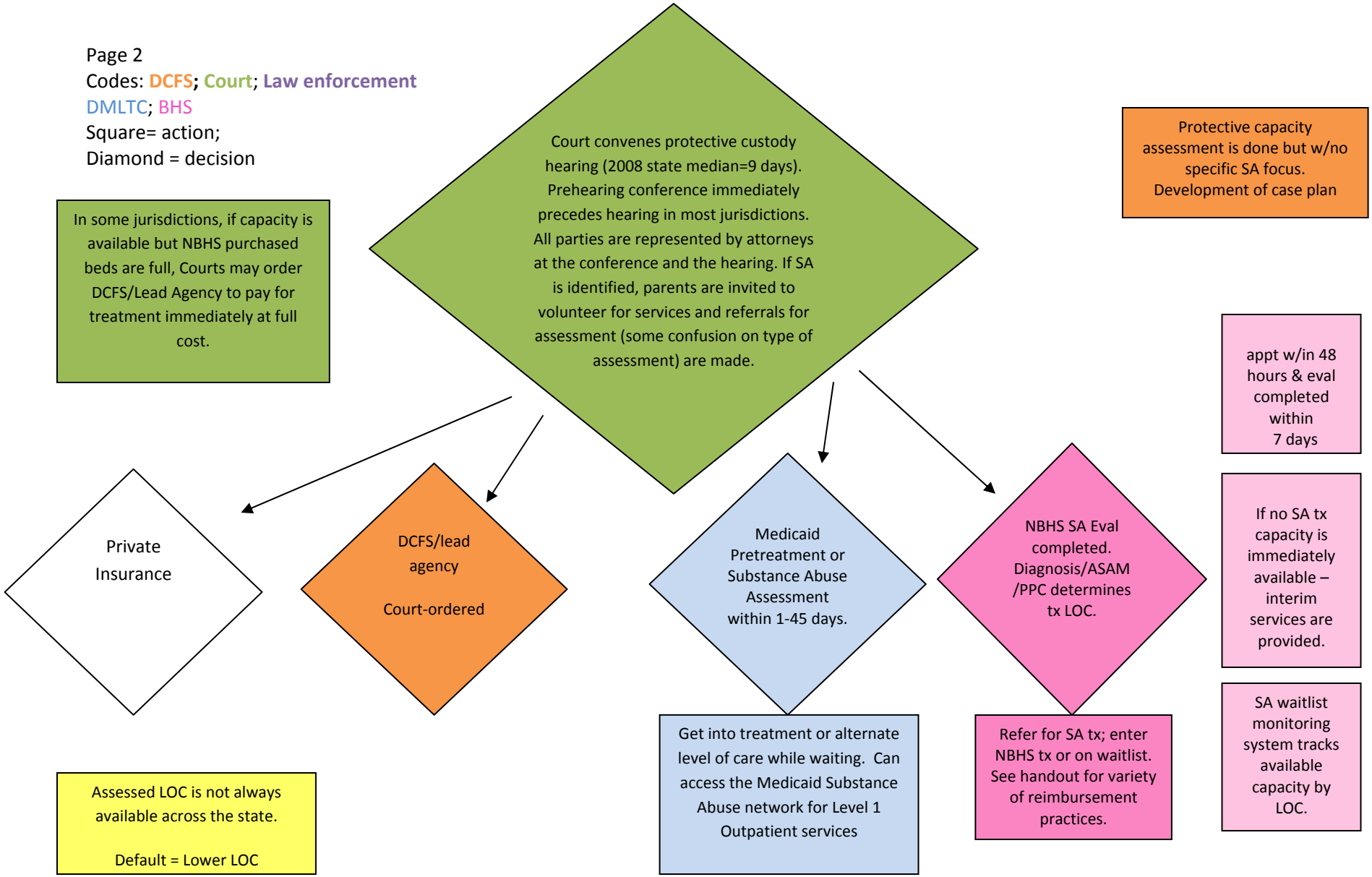

*- An informal survey of judges reflected significant delays in getting assessments (average 30 days) and tx (45 days).

Developed by: IDTA Substance Abuse & Child Welfare Project Core Team

Last revised: 6.21.10

Current Practices by RBHA Region Network Providers

R1

At this point I'm responding with the Panhandle Mental Health Center practice but will ask other providers at our meeting on Thursday.

PMHC enters into a Letter of Agreement with BGH to provide services to a CFS involved parent. The Letter of Agreement is for the amount determined on the sliding fee schedule. We have a couple of non-discountable services and then the LOA is for the full amount. We haven't established any written policy that guides the payment for CFS parents but admissions understands the need for the LOA before scheduling the parent. We haven't had a court order directed at us for treatment. If there is court ordered treatment it is going through BGH at this time.

I'm not aware if BGH is utilizing any private providers for services. I would doubt that a private provider would agree to a reduced fee and BGH isn't going to want to pay full rate if they can help it.

I hope this is helpful.

R2

Answers to the best of our ability!

1. If client is being billed for services in our outpatient services, sliding fee is charged based on eligibility. If a second or third party payer is billed, contracted amount is paid or full fee. Our contracted residential and IOP have not talked with us about this being a problem.
2. not that we know of
3. We do not have policies specific to parents with CFS involved youth.

R3

Region 3 providers are handling this differently. I've listed the various billing/payment practices below:

A parent may pay their portion of the sliding fee scale, and the Region/DBH pays units billed by the provider;
CFS pays the sliding fee portion, and the Region/DBH has paid for the units billed by provider;
CFS pays entire amount charged by provider via a Service Authorization;

No provider reports that the Lead Contractor (Boys and Girls Home for Central Service Area) has paid for any service.
One provider reports that they have not had anyone identify themselves as a parent of a stateward.

R4

I have had a couple providers respond to your questions below. Their responses are copied below:

Provider 1:

I guess we have handled it various ways. When we used to get a referral from HHS it always stated that they are always to be the payer of last resort. Therefore, if the client is eligible for Medicaid, Magellan, etc. we must bill them first. If the client is sent with a case plan and there is no medicaid or magellan involvement then we bill to the address on the (case plan). If a client calls in and is in need of substance abuse treatment for treatment purposes only we offer a sliding fee scale. However, that evaluation is to

either help them get placed in residential care or in treatment in our facility. If HHS is involved, etc. we refer to a case plan for payment. When the State of Nebraska discontinued the contracts and Boys & Girls Home and a few other providers took over we have had limited referrals. Basically the only referrals that I am aware of have been to our youth IOP program and these individuals have been Medicaid and/or Magellan.

Provider 2:

We have not had CFS or B&GH pay for anyone's (child or adult) substance abuse care (or sliding fee payment) at BHS. We have followed what had been sent out by DHHS many many months ago--which identified that adult care runs through DBH. We haven't been asked/approached or been offered payment by CFS/B&GH.

R5

-Apply financial aid policy – payor of last resort
-Court Order or cond. of custody
Apply sliding fee scale (client pays) and then report rest of money to be paid by Lead Agency/Child Welfare
-Payment mechanisms – not aware of any
-Policies? – not to her knowledge

R6

Here's the information that Beth Sparks received from Region 6 SA providers:

I have contacted all of our Network Agencies that provide outpatient or inpatient Substance Abuse treatment for adults and specifically the parents of children in the Child Welfare system. There are some differences for sure but there didn't seem to be any 'guiding principle" that influenced what funding source was tapped in many cases. All of these agencies seem to start with Insurance and Medicaid; if there is no insurance, then they have sub-contracts or do LOA's with the Child Welfare providers (KVC and NFC) and get reimbursed from them (one agency said they were told that LOA's would no longer be used, but clearly not all providers have gotten that message). One agency delineated between "Court Ordered" and "Referred"; if it was the former, then the Child Welfare agency paid, if the latter, then they would assess for Region funding. One agency automatically assesses for Region funding, whether Ct. Ordered or just referred by the Child Welfare agency. Another agency always treats the Region funding as the "payer of last resort". Several have allowed the Child Welfare agencies to pay the co-pay for parents and then bill for Region funding. Almost all of them would like clarification of who is the "payer of last resort". There is even a difference from Case Manager to Case Manager in the Child Welfare system as to when they authorize payment and when they refer for sliding fee assessment. One of the Child Welfare agencies is instructing their case managers to refer parents to the Region sliding fee agencies and sees themselves as the payer of last resort for parents.

In summary, Region 6 providers are somewhat confused by the "funder" issue when it comes to the parents of kids in the Child Welfare system. They all would welcome a specific protocol that could be applied in such situations. Many quoted their contracts with Region 6 which they state says the Region is the payer of last resort and so have followed that…?? Similar issues come up for those agencies that provide MH services to parents also.