This document contains answers to questions received after the July 2017 CC4C webinar. You can register for this webinar by clicking on this link: <https://www.surveygizmo.com/s3/3679915/July-2017-CC4C-Webinar-Registration>. Once you register, an email will be sent to you with the link to the recorded webinar.

**Identification/Referral**

1. **How do I receive a referral?**

CC4C staff should work out the referral process with the local DSS; one option is that the referrals could be sent to the CC4C referral contacts found in the CC4C referral directory.

1. **If DSS does not do a CPS investigation will the child still be referred to CC4C?**

DSS sends the referral to CC4C prior to making the decision as to whether the infant is screened in or screened out. So yes, the referral to CC4C will still be made regardless of an investigation.

1. **Will DSS be referring only those infants identified by the hospitals with exposure to parental substance abuse or will they be referring all children 0-5 with an exposure to parental substance abuse?**

The purpose of the Plan of Safe Care initiative is to address the effects on substance use disorders on infants and their families. DSS can continue to refer children in the CC4C target population ages 0-5 years, as they did prior to the implementation of the POSC initiative.

1. **The slides indicate DSS will immediately refer this population prior to their screening and will not be able to share if the family screened out and why. Will DSS be able to share that the family screened in, so that we can continue collaboration?**

DSS has authority to share information during the context of providing protective services, which includes the period before the screen in or screen out decision is made, as well as when they have screened in a case and started an investigation.

1. **Since the CC4C referral will be completed and faxed before any CPS screening decision is made, what should be the action on the CC4C referral if the CPS report is screened out/unsubstantiated?**

The POSC is developed and sent to the CC4C care manager prior to any determination by CPS of screened in/screened out. The CC4C CM should serve the child the same regardless of the status of any referral by CPS.

1. **Are we still required to share the outcome of the CC4C referral within 30 days? Because if families are screened out will DSS be concerned documenting the results of the CC4C assessment?**

Yes, the requirement to share the outcome of the referral with the referral source is part of the CC4C Standardized Plan and should be followed with all referrals. This is a great way to show collaboration and improve communication with the referral source.

1. **Are ALL newborns screened for drugs at the hospital at birth, or just those with mothers with risk factors?**

Hospitals will evaluate all newborns based on the following definitions to determine if a notification to DSS is needed. This information was also provided on slides 20 & 21 during the July 2017 CC4C webinar.

**Affected by Substance Abuse:**

Infants who have a positive urine, meconium or cord segment drug screen with confirmatory testing in the context of other clinical concerns as identified by current evaluation and management standards.

OR

Medical evaluation, including history and physical of mother, or behavioral health assessment of mother, indicative of an active substance use disorder, during the pregnancy or at time of birth.

**Affected by Withdrawal Symptoms:**

The infant manifests clinically relevant drug or alcohol withdrawal.

**Affected by FASD:**

Infants diagnosed with one of the following:

* Fetal Alcohol Syndrome (FAS)
* Partial FAS (PFAS)
* Neurobehavioral Disorder associated with Prenatal Alcohol Exposure (NDPAE)
* Alcohol-Related Birth Defects (ARBD)
* Alcohol-Related Neurodevelopmental Disorder (ARND) \*

OR

Infants with known prenatal alcohol exposure when there are clinical concerns for the infant according to current evaluation and management standards.

1. **If the hospital happens to skip DSS and sends the info directly to the CC4C department how should we proceed?**

Proceed on with the referral. But, also notify DSS of the situation, since birthing hospitals are required to notify DSS.

1. **Will this target population be considered highest priority in relation to other previously noted populations? For example, the CCNC priority children?**

As described in section B. Pre-Assessment Phase, on page 8 of the CC4C Standardized Plan, real-time referrals take priority. Since these children are real-time referrals, they are considered priority.

1. **How will this process work with infants that stay in the hospital longer which may require transitional care from the networks?**

In most cases these infants will not meet the Transition Care Priority definition used by CCNC. And for many of these children, their Medicaid application will still be in process when discharged from the hospital. However, it does not mean that some of the children will not be identified for transition care. If the child is being served by the primary care manager for transition care the CC4C CM can continue to work with the family during that 30-day period if the two programs are addressing different goals and needs. The CC4C CM and the PCM should have a joint discussion regarding the child and determine how the child is best served. In some cases, it may be that the CC4C CM should begin to serve the child at the end of the 30-day transition care period and in others it may be best to have a joint approach.

1. **If we get a referral from DSS for POSC and the parent refuses or is unable to contact, will it go into our measures like it normally does already?**

The work done with this population will be part of the data as with any other client.

1. **What if the child is born in a hospital outside of NC? Will the referral still be made to CC4C and DSS?**

The POSC process applies only to NC hospitals. But, collaboration with bordering states is being discussed and more information will be forth coming.

1. **How will DSS and hospitals access the CC4C Directory? Right now it is only located in CMIS and neither have access to it.**

Each update of the CC4C Referral Directory will be shared with state DSS leadership.

1. **Some counties border with other states. What are the CC4C responsibilities when a baby lives in NC but is born in another state or vice versa?**

CC4C is a program for children who reside in NC so all children who reside in NC should receive the same services. Discussions with out-of-state hospitals regarding the identification of substance-affected infants could occur in the future.

**Contacting Families, Completing Assessments & Implementing POSC**

1. **Can we be provided a specific scripted message that can be used to offer an explanation to families upon making our cold call on why we are calling and whom referred them for care management services?**

Guidance, scripting and talking points are available in the CC4C Key Messages and Script document that is found in Section 04 of the CC4C toolkit may assist you in developing a message to be delivered during cold calls.

1. **How do I develop a POSC?**

The Infant Plan of Safe Care is developed by DSS. Specific focuses on CC4C services identified are identified by DSS and marked on the back page of the referral form. CC4C care managers implement the Infant Plan of Safe Care following the CC4C Standardize Plan.

1. **Will other tools be available for CC4C to identify strengths and needs of the child/ family?**

The CC4C program will continue to make programmatic changes and improvements to be able to better serve the child and family. These tools will be posted in the Informatics Center.

1. **Since the identified referral reason is considered a toxic stress condition, won't the LSP be required which means at least 6-month involvement?**

The provision of CC4C services should be based on the needs and concerns of the family. If it is determined that a child referred by DSS as a substance-affected infant could benefit from CC4C services, then CC4C services should be provided per program guidelines. The LSP is required for children identified with toxic stress. Since this is a toxic stress condition, yes, the LSP is program requirement. The CC4C CM should follow the guidance regarding the LSP as found in the March 2014 Questions and Answers-LSP Toxic Stress and ASQ-3 document located in section 05 of the CC4C toolkit.

1. **How do we identify strengths? Will other tools be added to the program other than the LSP?**

Family strengths can be identified through the available tools that are used for CC4C such as the LSP. You can also identify strengths through discussion with the family. The program will continue to add new elements beyond the LSP to assist in identifying needs of families and children.

1. **How long do I have to follow these children?**

Children referred by the POSC initiative will be served just as the other children you are serving. You should serve the child as long as there are goals and needs that are being addressed.

**Confidentiality & Documentation**

1. **Will we receive any additional guidance about documentation regarding substance abuse in the child's chart?**

The confidentiality guidance found in the CMIS under the Resources tab and in section 07 in the CC4C toolkit still applies and should be followed. Further support will be considered and provided as available. Also remember that the Infant Plan of Safe Care is in response to substance exposure rather than substance abuse.

**Collaboration with POSC Partners**

1. **When is the implementation date?**

The implementation date for this effort is 7/31/2017.

1. **A bulletin explaining the Federal Laws/CC4C service delivery regarding POSC needs to accompany the updated referral form for the DSS staff with instructions on how to complete. Who is responsible for informing DSS of the process and referral form?**

DSS is providing education and training for their staff from the state and local level including bulletins and written information and is responsible for informing the local agencies. However, CC4C can reach out their local DSS contacts to facilitate the collaboration.

1. **Is it encouraged for DSS and CC4C to have monthly meetings to discuss any changes/questions related to this initiative?**

This is a state-level DSS plan and it is a DSS initiative. CC4C is a referral source for DSS and this population. CC4C staff may want to reach out to their local DSS to improve collaboration and communication but this is not a CC4C-led initiative, but a DSS-led initiative. However, regular communication between the local DSS and CC4C staff is encouraged to assure a smooth and efficient implementation process.

1. **We have had a lot of challenges with collaboration with our DSS staff, if we continue to have challenges after implementing Plan of Safe Care, will there be anyone (from the state or network) available to assist us?**

DSS and DPH and other partners are very invested in this initiative and the state and regional staff are available to assist with collaboration at the local level. If you have difficulties in collaborating with the local DSS around this program, please reach out to your regional child health nurse consultant who will assist you or contact CC4C state-level staff for intervention.

In addition, a new collaborative has been formed, the Plan of Safe Care Interagency Collaborative (POSCIC), to address issues during implementation.

1. **How is the education about the POSC being shared to OB-GYN offices, hospitals, and other facilities other than CC4C?**

The state-level multiagency Plan of Safe Care Interagency Collaborative, is overseeing education of community partners. These include families, hospitals, NC Hospital Association, DSS regional consultants, local DSS CPS staff, OBCM care managers, CCNC, CC4C care managers, birthing centers, local health directors and local DSS directors, and other partners to provide education for their area of interest.

**Funding**

1. **Will there be a new A/A or contract to cover the expansion of the CC4C program and will it include additional funding on the county level?**

There are no plans or resources to increase funding, either through the contract with the local network or through the DPH Agreement Addenda. The implementation of the POSC initiative is not an expansion of the CC4C program, as substance-affected infants have been a CC4C target population since the program began. Last year the CC4C Program served over 1,600 neonates affected by substance use. The number of referrals may increase, and state program staff will work with local staff in to develop strategies to manage the workload.