Enhanced Emergency Care
Scope of Work

I. Background

North Carolina faces an urgent need for immediate, safe, and appropriate placements for children and youth entering foster care, particularly those with complex behavioral health needs. Many counties are unable to secure appropriate licensed placements at the point of entry, resulting in children remaining in inappropriate settings such as DSS offices or emergency departments. Statewide data indicate that an average of 16 children per week in DSS custody are boarding in county offices, often sleeping in non-residential spaces. This practice increases trauma exposure, strains county resources, and diverts staff from core casework.

To address this, the Enhanced Emergency Care (EEC) model was developed, evolving from the former *Placement First Plus* program and incorporating best practices from behavioral health crisis stabilization, therapeutic foster care, and intensive case management. EEC facilities will be licensed as Emergency Residential Child Care (group homes) under North Carolina Division of Health and Human Services, Division of Social Services (Division) and will provide 24-hour, trauma-informed, short-term placements—serving as placements of last resort—while working toward safe, permanent, family-based settings.

II. Overview and Purpose

North Carolina continues to face a critical shortage of safe, appropriate, and licensed placements for children and youth entering foster care, particularly those with complex behavioral health needs. Data from May through October 2025 reveal that **Regions 02, 05, and 03 account for more than 70% of all documented cases of children without placement statewide**, with Region 02 alone representing over 30% of the total. Link to regional map: NC CW Services Regional Map. These regions consistently experience the highest rates of placement gaps, resulting in children remaining in inappropriate settings such as county DSS offices or hospital emergency departments for extended periods. This practice not only exposes children to additional trauma but also strains local resources and diverts staff from essential casework responsibilities.

The concentration of need in these regions underscores the urgency of establishing Enhanced Emergency Care (EEC) facilities strategically located in **Regions 02, 05, and 03**. EEC facilities provide 24-hour, trauma-informed, short-term residential care for up to 90 days, designed to stabilize children and youth while permanent, family-based placements are secured. Without these facilities, counties in high-need regions lack viable options for immediate placement, perpetuating cycles of instability and increasing the risk of negative outcomes such as behavioral escalation, educational disruption, and delayed permanency planning.

Investing in EEC facilities in the top three regions is essential to achieving the Division's goals of reducing inappropriate placements, improving child well-being, and strengthening system capacity. These facilities will serve as placements of last resort, ensuring that children in crisis receive timely, therapeutic care in environments that prioritize safety and healing. By addressing the most acute regional gaps, North Carolina can significantly reduce the number of children sleeping in offices or hospitals, advance trauma-informed care practices, and align

with statewide behavioral health transformation initiatives. This targeted approach will maximize impact, promote equity across regions, and support measurable improvements in placement stability and permanency outcomes.

This initiative aligns with North Carolina's behavioral health system transformation, funded through the historic $835 million behavioral health investment, with $80 million specifically allocated to child welfare stabilization and emergency placement services. Funding is for a two-year implementation period and three facilities will be established—one in the western region, one in the eastern region, and one in the central region. Each facility will receive $1.8 million in start-up funding.

In addition, the program will leverage public-private partnerships, coordinated care planning, and evidence-based services to meet urgent needs while supporting long-term placement stability. EEC facilities will be located strategically across the state, with the long-term goal of establishing at least one facility in each of the seven regions.

III. Strategic Alignment

- Advances the NC Child and Family Services Plan by increasing placement stability and reducing the use of inappropriate placements. The NC Child and Family Services Plan emphasizes cross-system collaboration, trauma-informed service delivery, and increasing access to high-quality, family-based care for children in foster care. EEC directly supports these objectives by providing a structured, short-term placement option that prioritizes permanency planning and reduces reliance on non-family settings.
- Coordinates with Medicaid Transformation and Tailored Plan implementation to ensure behavioral health needs are addressed. Through this alignment, EEC placements can integrate behavioral health services funded by Medicaid, ensuring that children with complex needs receive timely, coordinated care while reducing system fragmentation.

IV. Eligibility and Referral Information

EEC serves children and youth who meet specific eligibility criteria and are referred through an established, standardized process to ensure timely access and appropriate placement.

Eligible:

- Be ages 9–17 at the time of referral.
- Be in the legal custody of a County DSS.
- Lack a safe and appropriate family-like placement at the time of referral.
- Have experienced placement instability or be at imminent risk of placement disruption.
- Present with behavioral, emotional, or mental health needs that require short-term stabilization in a structured, trauma-informed environment.

Not Eligible**:**

- Youth under age 9 or over age 17 at the time of referral.
- Youth whose needs require immediate psychiatric hospitalization or a higher level of care than EEC can provide.
- Youth with acute medical needs that cannot be met in a residential care setting.

<u>Referral Information</u>:

It is the responsibility of the Grantee to obtain the following information, including but not limited to, in order to make an informed decision regarding acceptance:

1. **Completed EEC Referral Form**
    - Grantee-approved or Division-approved template.
    - The referral form must contain space to detail the efforts made to seek alternative placement.

2. **Placement History**
    - Including reasons for prior placement disruptions.
3. **Current Behavioral Health Assessments**, including:
    - Comprehensive Clinical Assessment (CCA).
    - Psychological or psychiatric evaluations, if available.
    - Standard Trauma-Informed Assessment (if available).
4. **Education Records**
    - Including current school placement, IEP/504 Plan (if applicable).
5. **Medical Information**
    - including current medications, allergies, and primary care Grantee(s).
6. **Court Orders**
    - legal documents impacting placement, visitation, or services.

The Grantee must document the reason(s) for not accepting a child or youth into the facility and submit this information on a monthly basis to the Division.

V. Services Provided

Stabilization Phase:
Within the first 30 days, a comprehensive assessment will be completed to determine the needs of the child or youth. Once the appropriate services are identified, referrals will be made promptly to initiate service delivery.

It is essential that each EEC facility is in an area with a sufficient number of qualified behavioral health providers to ensure services can begin as quickly as possible. Services may include, but are not limited to:

Mental Health Services
- Services will be individualized to address the specific needs of the child or youth.
- Clinical assessment of mental health needs, as necessary.
    - The Standard Trauma-Informed Assessment will be utilized when available.
    - A copy of the current Comprehensive Clinical Assessment (CCA) will be required to determine whether any additional assessments are needed.
- Care Management services.
- Behavioral health services.
    - If the child or youth has an established provider(s), virtual service delivery to maintain this therapeutic relationship is acceptable and encouraged.
- Evidence-based behavioral health therapies.
- Crisis intervention services, including mobile crisis team response.
- Medication management services.

Educational Supports
- Strategies will be prioritized to maintain the child or youth's school of origin. The Grantee is required to follow the provisions established under Every Student Succeeds Act.
    - Virtual options with the child or youth's current school should be considered to prevent additional disruption.
- Coordination of educational testing and/or educational support services, as necessary.

Transitional Phase:

Transition planning begins on the first day of placement. These services are designed to facilitate a successful move to a lower level of care, such as the home of a relative, a foster family, a therapeutic or adoptive family, an independent living arrangement, or another community-based setting.

- To support transition planning, Child and Family Team (CFT) meetings will be held weekly. The team will include the child or youth, DSS caseworker, EEC caseworker, previous or potential placement provider (kinship, family, therapeutic), Care Manager, and any additional identified supports.
- Services to assist in the transition may include, but are not limited to:
    - Family Finding services.
    - Permanency Support services.
    - Services designed to support the child or youth's adjustment and integration into the family and community.
- All services implemented are intended to promote the stability of the placement following discharge from the EEC program.

VI. Outcomes

The implementation of Enhanced Emergency Care services will support measurable improvements across multiple child welfare performance domains, including:

- Reduced inappropriate placements, ensuring fewer children sleep in DSS offices, emergency departments, or other non-residential sites.
- Increased transition to family-like settings, including kinship, foster, therapeutic, or adoptive care, which promotes emotional security and resilience.
- Improved behavioral and emotional well-being, reflecting successful therapeutic engagement and evidence-based care.
- Enhanced permanency planning, with earlier connection to permanent placements and reduced time to permanency.
- Preserved family continuity, including sibling unity and frequent quality visits between children, parents, and siblings.
- Better physical, mental health, and educational outcomes.
- Greater system coordination, strengthening collaboration across child welfare, behavioral health, and education systems, while embedding trauma-informed practices across teams.

VIII. Grantee Submission Requirements

Potential Grantees must submit a complete application package containing all required documentation and supporting evidence. Incomplete submissions will not be considered for selection. All application materials must be submitted by the deadline indicated in the solicitation and must include:

- Licensure and Accreditation Documentation:
    - Proof of the current NC DHHS residential child care (group home) (group home) license.
    - If not currently licensed, a signed Accreditation Attestation Statement acknowledging the requirement to obtain licensure within the specified timeframe and to operate in compliance with all applicable NC Administrative Rules and child welfare policy.
- Program and Service Description
    - A detailed narrative describing the proposed Enhanced Emergency Care program, including service philosophy, use of evidence-based practices (e.g., The Sanctuary Model, Ukeru®), and approaches to trauma-informed care.
- Description of stabilization and transition services, including coordination with county DSS, care coordination teams, and behavioral health Grantees.
- Staffing Plan and Qualifications
    - Organizational chart and job descriptions for all positions assigned to the EEC program.
    - Documentation of staff qualifications, licenses, certifications, and training in required evidence-based models.

    - Plan for maintaining required staffing ratios (minimum 2:6 during wake hours and 1:6 during sleep hours) and ensuring 24-hour supervision.
- Facility Information
    - Physical address, description, and layout of the facility, including safety features, accessibility, and compliance with fire, health, and safety codes.
    - Capacity and bedroom configurations to ensure compliance with NC Administrative Code.
- Policies and Procedures
    - Copies of the agency's policies and procedures manual
- Process for working with County DSS and Care Coordination to facilitate stabilization, service delivery, and discharge planning.
    - Description of how the Grantee will coordinate Medicaid-covered services under Tailored Plans.
- Performance and Quality Assurance
    - Plan for collecting and reporting data on program performance, including length of stay, discharge outcomes, and child/family satisfaction.
    - Process for implementing Continuous Quality Improvement (CQI) measures in response to DHHS or County DSS feedback.
- Financial Documentation
    - Evidence of financial stability, such as audited financial statements for the last two years or equivalent documentation.
    - Budget proposal showing anticipated expenses and alignment with the cost-model rate structure.
- References
    - Contact information for at least two agencies or organizations for which similar services have been provided, including a description of services delivered and outcomes achieved.

IX. Grantee Selection

- Grantees must hold a current NC DHHS license for residential child care (group home) issued through the Division of Social Services (DSS).
- If a Grantee is not licensed to provide residential services in North Carolina, the Grantee must be eligible to meet licensure requirements as indicated in NC Administrative Rule and go through the licensure process.
- If the Grantee has not been accredited for three years or longer from either the Council on Accreditation (COA), The Joint Commission (TJC), The Commission on Accreditation of Rehabilitation Facilities (CARF), or The Council on Quality and Leadership (CQL), an Accreditation Attestation Statement must be signed indicating that accreditation will be achieved within three (3) years of licensure. Failure to achieve accreditation in three years (3) will result in revocation of license.
- Selection will prioritize Grantees with demonstrated capacity to deliver trauma-informed, clinically supported care, and the evidence-based practices.
- Geographic distribution will be considered to meet the goal of having at least one EEC facility in each region.

X. Funding Source

EEC is funded through the $835 million statewide behavioral health investment, with $80 million dedicated to child welfare stabilization and emergency services. The Division of Social Services has been appropriated $5,575,000 in non-recurring funds to develop the EEC. Funding is for a two-year period.

<u>Rate Structures & Reimbursement Methodologies</u>:
Three facilities will be established—one in the western region, one in the eastern region, and one in the central region. Each facility will receive $1.8 million in start-up funding.

Grantees delivering Enhanced Emergency Care will also receive the Cost-Modeled Residential Rate, which significantly exceeds the standard board rate:

- Ages 9–12: $4,598/month
- Ages 13 and up: $4,692/month

This Cost-Modeled Rate is set through a structured annual cost-finding and rate-setting process and communicated directly to counties through the Dear County Director Letter.

The Grantee shall submit one signed DSS-1571 III (Administrative Costs Report) via email to nc.privateagency.notifications@dhhs.nc.gov by the 20th of each month for services provided in the preceding month. The email subject line must read: *Enhanced Emergency Care – [Name of Agency] – [Month]*.

Please note that the person preparing the invoice shall be different from the person authorized to sign it. Failure to submit monthly reports may delay receipt of reimbursement. The Division will have no obligation for payments based on expenditure reports submitted later than 30 days after termination or expiration of the contract period. All payments are contingent upon fund availability.

XI. Contract Deliverables with Performance Standards

- Maintain an active residential child-care license under **10A NCAC 70I**.
- Comply with all applicable North Carolina Administrative Code provisions, including but not limited to:
  - **10A NCAC 69** – Confidentiality of Social Services Records
  - **10A NCAC 70E** – Minimum Licensing Standards for Residential Child Care Facilities
  - **10A NCAC 70F** – Additional Licensing Standards for Residential Child Care Facilities
  - **10A NCAC 70J** – Shelter Care, Emergency Care, and Specialized Populations
  - Any other applicable rules as issued or amended by NCDHHS DSS.
- Remain current on all North Carolina child welfare policies, including those issued through policy manuals, Dear County Director letters, official NCDHHS DSS guidance, and any changes or amendments to applicable administrative rules.
- Operate in accordance with all current and updated NC child welfare policies and procedures. Non-compliance may be considered a breach of contract and subject to corrective action or termination.

Performance Standard: Maintain 100% compliance with licensing/accreditation standards, NC Administrative Rules, and NC child welfare policy during the contract term, verified through DHHS monitoring and inspection reports.

- Provide 24/7 staffed, trauma-informed residential care for children referred by County DSS, in a safe and nurturing home environment supervised by staff 24 hours per day. This includes maintaining a minimum staffing ratio of 2:6 staff-to-child during waking hours and 1:6 staff-to-child during sleeping hours.

Performance Standard: Maintain required staffing ratios 100% of the time, documented through staff schedules and verified during onsite reviews.

- Ensure that at least one EEC facility site is staffed by personnel trained in Ukeru® and that all EEC facility staff are trained in at least one evidence-based, trauma-informed care model such as *The Sanctuary Model*.

Performance Standard: 100% of designated site staff complete Ukeru training prior to providing care and maintain annual recertification; all staff complete initial training in an approved evidence-based model (e.g., The Sanctuary Model) within six months of hire and participate in required ongoing professional development.

- Conduct initial behavioral health and medical assessments within 72 hours of placement.

Performance Standard: Complete assessments for 95% or more of children within the 72-hour timeframe, verified through case file review.

- Extended Timeframe Allowance: If the 72-hour standard cannot be met due to factors beyond the Grantee's control (e.g., child illness, delayed access to qualified professionals, natural disasters), assessments must be completed as soon as possible, but no longer than thirty (30) calendar days from the date of placement.
- All exceptions must be documented in the child's case record, including the reason(s) for delay and the date the assessment was completed.

- Develop an individualized service plan within 10 calendar days of placement and update it weekly.

Performance Standard: Achieve a 95% compliance rate for timely service plan creation and updates, verified through file audits.

- Submit monthly performance and utilization reports to DHHS, including data on length of stay, discharge outcomes, service utilization, and incidents.

Performance Standard: Submit 100% of required reports by the 10th calendar day of the following month; reports must be complete, accurate, and use the DHHS-approved format.

- Maintain a discharge planning process that begins within the first 10 days of placement and results in transition to a family-based or lower-level setting within 90 days unless an exception is granted by DHHS.

Performance Standard: 85% or more of children transition within 90 days; exceptions must be documented and approved in writing by the Division

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- Participate in quarterly onsite quality assurance reviews and implement CQI plans as required.

Performance Standard: Attend 100% of scheduled reviews; submit CQI plans within 15 business days when required, and complete corrective actions within the DHHS-approved timeframe.

- Maintain financial and service delivery documentation for audit purposes for at least five years after contract close-out.

Performance Standard: 100% of requested documentation must be provided within 10 business days of DHHS request; records must meet State and Federal audit standards.

XII. Performance Monitoring & Quality Assurance

The Division will monitor program performance, including but not limited to:

- Number of referrals and County who made referral
- Number admissions, discharges, length of stay
- Demographic information (age, gender, race/ethnicity, part of sibling group,
  - Full Name (as listed in DSS case file)
  - Date of Birth (and age at admission)
  - Gender (as identified in the case record; may also include gender identity if reported)
  - Race and Ethnicity (as reported by child/family or in case file)
  - County of Custody (responsible County DSS)
  - Date of Admission to EEC

    - Date of Discharge and reason
    - Placement type upon discharge (family foster home, kinship care, residential, etc.)
- Mental health diagnosis upon admission and discharge
- Medication upon admission and discharge
- Number and age of child/youth denied placement and reason(s) for denial
- Services utilized (during stay and discharge)
- Rate of successful transition to family-based placements.
- Incident reports, including use of de-escalation strategies, and critical incidents
- Staffing levels and turnover
- Immediate notification of any significant events affecting child safety or facility operations.

Quality assurance reviews will occur quarterly and will include onsite visits, case reviews, and Grantee performance scorecards. Continuous Quality Improvement (CQI) plans will be required for any Grantee not meeting performance benchmarks.

XIII. Definitions

The following definitions apply specifically to this contract and are intended to provide clarity for all parties.

- **Acute Medical Needs** – Immediate and significant health conditions requiring urgent medical attention, continuous monitoring, or specialized care that cannot be safely provided in a standard foster home setting.
- **Care Coordination** – A collaborative process that links children, families, county DSS, Grantees, and other stakeholders to necessary services and supports to ensure continuity of care.
- **Child and Family Team (CFT)** – A collaborative, family-centered meeting that brings together the child or youth, their family, DSS caseworkers, service providers, and other identified supports to develop, monitor, and update service and transition plans.
- **Comprehensive Clinical Assessment (CCA)** – A standardized, in-depth evaluation of a child or youth's mental health, behavioral health, and functional needs conducted by a qualified behavioral health professional to inform treatment planning.
- **Cost-Modeled Residential Rate** – The reimbursement rate determined through NC DHHS' structured cost model process for residential child care (group home), reflecting actual Grantee costs.
- **Enhanced Emergency Care (EEC**) – An Enhanced Emergency Care (EEC) is a 24-hour residential placement for up to 90 days to provide an integrated program of stabilization and transitional services and support for children and youth in DSS custody. An EEC is a placement of last resort.
- **Evidence-Based Practice** – Service models and interventions supported by rigorous research demonstrating positive outcomes for children and youth.
- **Family Finding Services** – Specialized services designed to identify, locate, and engage biological relatives and other significant connections for children and youth in foster care to promote family-based placement options and permanency.
- **Inappropriate Placement** – Any temporary placement that does not meet licensure requirements for residential or foster care, such as DSS offices, hotels, or hospital emergency departments.
- **Last Resort Placement** – Placement option used only after documented exhaustion of all family-based, kinship, and licensed foster home options.
- **Permanency Support Services** – Services and activities that help ensure children and youth transition successfully into permanent family-based placements, including adoption, guardianship, or reunification with parents or relatives, and remain stable after placement.
- **Placement History** – A documented record of all prior placements for a child or youth, including the type of setting, length of stay, and reasons for disruption or discharge.

- **Sanctuary Model, The** – An evidence-based, trauma-informed organizational change model that promotes safety, emotional intelligence, open communication, social responsibility, and growth to support healing for individuals and organizations exposed to trauma.
- **Stabilization** – The process of addressing immediate safety, behavioral, emotional, medical, and educational needs of a child or youth to enable transition to a less restrictive, family-based placement.
- **Standard Trauma-Informed Assessment** – A structured evaluation tool used to identify the impact of trauma on a child or youth's functioning and to inform the development of trauma-responsive services and supports.
- **Tailored Plan** – A North Carolina Medicaid plan that integrates physical health, behavioral health, intellectual/developmental disability, and pharmacy services for beneficiaries with complex needs, designed to ensure coordinated care.
- **Trauma-Informed Care** – An organizational framework that recognizes and responds to the impact of trauma on children, guiding policies, procedures, and practices.
- **Ukeru** – A trauma-informed, restraint-free crisis management program focused on proactive de-escalation strategies, relationship building, and maintaining the dignity and safety of all individuals.
- **Grantee** – An organization or agency contracted with NC DHHS DSS to provide Enhanced Emergency Care services in accordance with all applicable laws, administrative rules, policies, and contract provisions.