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Foster Care Model of Care Workgroup (FCMCWG)
Discussion Framework and Questions

Workgroup Date: April 23, 2021

The Workgroup on April 23, 2021 will discuss key components of a model of care collected from workgroup meetings to date. DHCS and CDSS have not selected these concepts as final recommendations, nor do we know yet if all components are feasible. However, we understand that the system today does not serve our children, youth and families as well as it should and to do so will take structures and resources beyond what exists now.

The purpose of today is to understand how these components could meet the guiding principles of the workgroup, understand how they could work together, where there could be challenges, which considerations need to be addressed when recommendations are ultimately selected, and if there are critical components missing. This is our opportunity to "stress test" these components, focusing on integration, accountability, and structural changes needed for this model to be successful.

For this discussion, please envision models with potential building blocks, emerging from the following proposals reviewed in prior meetings:

1. **Streamlined access to specialty mental health services through updating medical necessity requirements** (CalAIM proposal, CWC Recommendations, Alliance Recommendations, CWDA/CBHDA Proposal): Children in child welfare are at increased risk of developing mental health conditions due to experience of trauma. Medi-Cal policy is proposed to be revised to ensure "automatic access" to a specialty mental health assessment, and then which services are needed would be based on the mental health needs of the individual child or youth.

2. **Expanded set of services for children and families** (CWC Recommendations, Alliance Recommendations):
   This proposal would incorporate some or all of the following into an expanded set of benefits for children and families in child welfare (based on federal approvals and state budget approvals):
   a. *Front-End Minimum Mandatory Scope of Behavioral Health Services* (CWDA/CBHDA proposal)*:*
      i. Trauma-informed, Resiliency-building Therapeutic Services for

Children and Families
   ii. Increasing Access to Intensive Care Coordination (ICC)
   iii. Individual Child and Family Therapy
   iv. Therapeutic Relationship-Building Services for Families
   v. Broaden Eligibility for Therapeutic Behavioral Services (TBS)
   vi. Intensive Home-Based Services (IHBS)
   vii. Substance Use Disorder (SUD) Services
   viii. Family Reunification Partnership Program (example of a potential best practice)
   ix. Peer Supports
   x. "Full-Service Partnerships" and "Wraparound Programs" for Families (including parents) in the Child Welfare Services System.

c. *Inclusion of specific Z and V Codes in Medi-Cal*
d. *Expand Crisis or Urgent-Oriented Services*
e. *For high-need youth, adopt a standardized daily bundle of minimal mental health services with standard documentation requirements for youth in an STRTP or Enhanced ISFC homes.*

3. **Prevent child welfare involvement through statewide adoption of evidence-based prevention models for pregnant women and families with young children:** examples include (but are not limited to) home visiting programs in CalWORKs, dyadic care, expansion of roles of Community Health Workers and Promotores, or Nurse Family Partnership (NFP) as a FFPSA evidence-based practice.

4. **Statewide personal health record for children in out-of-home placement** (HMA paper): this record could be hosted by a third-party entity, or by child welfare managed care plans (jointly-funded). Design to support integrated cross-agency CANS assessments.

5. **Mandated enrollment in Medi-Cal managed care plans (MCPs), with increased accountability and structural requirements**, with an exception process in place for certain beneficiaries needing to stay in fee for service (modified "option 3" from the NHELP proposal, elements of California Association of Health Plans (CAHP) Recommendations, Alliance Recommendations)**.**
   A. ***How should managed care be organized?***
      a. New regional child welfare plans OR
      b. Current county-based structure with the current number of managed care entities
   B. ***Should DHCS incentivize regional new behavioral health provider networks or regional medical networks*** ("centers of excellence" with bundled rates and special expertise?)
   C. ***Behavioral health options:***
      a. ***Carve in specialty mental health to MCPs*** (counties have first right of refusal to be contracted providers and MCPs

provide managed care functions)

b. ***Carve out all mental health and SUD services to counties*** (including nonspecialty MH)

D. **Core components in any future managed care model:**

a. Children involved in child welfare would be mandated into Medi-Cal managed care, with opt-out exemptions reviewed on a case-by-case basis.

b. The State could amend current MCP contracts to require the following:

i. Children in out-of-home placements are "special members" with no restrictions on outpatient primary care, specialty care consultations, and access to home health services for medical conditions

ii. MCPs are staffed with a foster care liaison with robust expertise in the specific needs of children in the child welfare system

iii. MCPs ensure sufficient intensity of behavioral health services to meet the additional needs of children with disrupted caregiver attachments with a focus on supporting placement in the least restrictive setting

iv. MCPs have detailed agreements with local child welfare departments and county mental health plans to ensure close coordination of care, including managed care representation at Child and Family Team meetings

v. Requirement to participate in the statewide mobile personal health record for each member, easily accessible to providers across sectors

vi. Responsibility for all medical care, with accountable to addressing identified health-related barriers to permanency and least restrictive setting.

vii. Have value-based payment models in place that encourage integrated care (e.g., bundled payments for hubs or certified community behavioral health clinics)

viii. Quality improvement and accountability framework:

- Accountability for a set of outcomes measures specific to the child welfare population
- New foster care metrics and an easy-to-read dashboard based on integrated and shared data sources.
- Development of a continuous quality improvement framework based on identified metrics (modeled on Cal-OAR and/or the California Child and Family Services Review).
- Financial incentives and sanctions based on key performance targets, applied to MCPs, county BH, and county welfare

ix. Focused outcome measures for children with specialized health care needs.

x. Enhanced care management:

- Managed Care Plans required to contract with one of the following to provide a single point of contact:
  - Public health nurse
  - County BH case manager (e.g., targeted case management or full service partnership)
  - County child welfare case manager
- Key roles of case manager (in addition to ECM duties described in CalAIM proposal)
  - Key point of contact for bio parents, resource families, youth, and the child and family team, including the child's social worker or probation officer
  - Responsible to support coordination of MCP with all medical, behavioral, dental, and social services and for intensive engagement when these needs lead to placement stability challenges.
  - Gathering initial/essential health information from bio parents and foster youth
  - Provide reproductive health education where needed, and coordinate to sensitive services
  - Monthly home visits with medically fragile youth and their caregiver(s), young children with developmental concerns, or other high-needs youth.

6. **Enhanced relationships and stronger collaboration between managed care plans, local systems, providers, and the youth and families** (modified components from the CAHP proposal). Opportunity for enhanced relationships and stronger collaboration, which is key to improving health and ensuring the needs of children and youth in foster care, are being met. Components include:
   A. Participate in staffing and multidisciplinary team meetings such as Child and Family team meetings;
   B. Provide health education and support to families of origin, foster parents, caregivers, youth, and providers;
   C. Be an active part of the system of care for children and youth in foster care, developing relationships with county-based child welfare services and other locally-based child welfare service providers;
   D. Designated Foster Care Liaison Coordinator as the key point of contact.

With elements of the above proposals combined, what do we need to consider to know what we need to ensure is in place going forward? The following questions can guide our discussion.

Discussion Questions:

1. What is the role of the model of care in addressing the inequities that disproportionately bring children of color into child welfare? Which prevention strategies have the most promise?

2. What does oversight and accountability look like, and how do we create a model where we have one set of expected outcomes across managed care, behavioral health, and social services? How would this look with the current managed care structure or with a regional structure? What results should the model be expected to deliver? (Deeper dive questions into accountability below)

3. How should we support the use of data to improve outcomes for foster youth? Are there economies of scale that are needed to effectively implement Continuous Quality Improvement strategies for this population?

4. Which model best supports continuity of care and a stable provider network that has needed expertise and is responsive to the needs of foster youth?

5. How could new expectations for managed care plans allow for better coordination and integration of social services? (e.g., participation in Child and Family Team meetings, work to find alternatives to residential care)

6. What are the keys to success for this model? What key policies would need to be in place for this model to deliver better access and better outcomes?

Deeper Dive into Accountability: additional questions

1. How are each of the system's partners currently held accountable for meeting the needs of children and families? Are we reliably able to identify when and why each system is not meeting the needs of our children and families? What is working and what are some of the gaps?
   - Do system partners have performance and outcome measures that drive or support concrete actions that improve outcomes?
   - Do Cal-OAR, California Child and Family Services Review, or EQRO provide useful models?
   - How should we manage accountability for transitions or hand-offs between systems?

2. What joint accountability framework exists or should exist to identify whether each system is providing appropriate interventions necessary to accomplish the ultimate goals of the health, safety, wellbeing, and permanency of children, youth, and families?

- Does each system partner understand each of their roles in impacting shared outcomes that are collectively important for children and families involved in the foster care system?
- Is there a need for new or different financial incentives and sanctions applied to MCPs, county BH, and placing agencies based on key performance targets?

3. What are the key components of a joint accountability and quality improvement framework?
    - Consider the need for inter-system continuous quality improvement teams, shared data sources, braided funding, new foster care metrics, easy-to-use dashboard, technical assistance, corrective action, etc.
    - What are the barriers for you to do the right thing for children and youth?

4. What changes at the local and state level may be needed to leverage and add to existing system mandates to create a joint system of care approach for accountability and continuous quality improvement?
    - Consider opportunities for changes/alignment in CFSR and EQRO processes, changes to state plans, waivers, or statutes.
    - How can managed care and FFS providers become integrated into the System of Care efforts?

5. What approach or process should be used to design and implement the accountability framework, including the development of specific measures and shared outcomes?
    - Considerations: stakeholder engagement processes, resources, subject matter expertise, timeframes, etc.