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## CalAIM

### Foster Care Model of Care Workgroup Charter

*July 2020*

#### **Background**

CalAIM is a multi-year DHCS initiative to implement overarching policy changes across all Medi-Cal delivery systems, with the objectives of:

- Identifying and managing member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Moving Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and

Improving quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

#### **Purpose**

The intention of this workgroup is to identify the outcomes we want for children and youth in the foster care system, what the current system does to achieve them, and what changes would be necessary to achieve better outcomes.

As a part of the larger CalAIM initiative, the Department of Health Care Services (DHCS), in collaboration with the California Department of Social Services (CDSS), will convene the Foster Care Model of Care Workgroup (Workgroup) to address the complex medical, behavioral, social, oral, and developmental health needs and challenges of current and former foster children or youth, children or youth entering or at risk of re-entering the foster system, and the families and caregivers of these children and youth. The Workgroup will be charged with helping to determine if California should develop and implement a different or new model of care or to improve an existing model for current and former foster children or youth, children or youth entering or at risk of re-entering the foster system, and the families and caregivers of these children and youth, including the Former Foster Youth (FFY) program and those individuals transitioning out of foster programs and services at age 26. Workgroup membership will be comprised of representatives from, at minimum, DHCS, CDSS, Department of Developmental Services (DDS), Department of Education, state and county child welfare associations, health plans, Tribal representation, behavioral health entities, juvenile justice and probation entities, judicial entities, foster care consumer advocates, current and/or former foster youth, and parent and caregiver representatives.

Recommendations from the Workgroup will be used to develop short- and long-term policy recommendations for California to consider for implementation of a different or new model of care, or to improve an existing model of care, with associated timelines, for improving health outcomes and delivery of health care services and supports for this vulnerable population.

## Workgroup Objectives

The CalAIM Foster Care Model of Care Workgroup is being established to provide an opportunity for stakeholders to provide feedback on opportunities to improve the current system of care, or to improve an existing model of care, for foster youth and whether or not a new system of care should be developed for current and former foster children or youth, children or youth entering or at risk of re-entering the foster system, and the families and caregivers of these children and youth. Workgroup members will be asked to participate in a series of discussions on a model of care and:

- Engage in collaborative discussions to develop policy recommendations and operationally achievable timelines for implementing a new, and/or transitioning to an existing but slightly different, model of care for current and former foster children or youth, children or youth entering or at risk of re-entering the foster system, and the families and caregivers of these children and youth, including the FFY program and transitions out of foster programs and services at age 26.
- Engage in meaningful dialogue and consensus building to ensure all keyplayers, both internal DHCS/CDSS staff and external stakeholders, have an opportunity to provide feedback and perspectives to inform a uniform and agreed upon approach to address the unique and complex health care needs of this vulnerable population.
- Develop implementation work plans and timelines.

## Scope of workgroup

The workgroup will be tasked with creating a long-term plan and model of care for how current and former foster children or youth, children or youth entering or at risk of re-entering the foster system, and the families and caregivers of these children and youth receive health care (physical health, mental health, substance use disorder treatment, social services, and oral health). The group will focus on the following three challenges:

1. What outcomes do we want for children and youth in the foster care system and what would measures would indicate success?
2. How should healthcare for current and former foster children or youth, children or youth entering or at risk of re-entering the foster system, and the families and caregivers of these children and youth (up to age 26) be organized? Options could include:
  - A single statewide integrated plan
  - Regional integrated plans, available statewide
  - Status quo (working within current Medi-Cal managed care plans, mental health plans, and DMC ODS to provide better care across transitions)
  - Other ideas brought by workgroup
3. What core suite of wrap-around services should be available for all current and former foster children or youth, children or youth entering or at risk of re-entering the foster system, and the families and caregivers of these children and youth?

It is anticipated that many challenges in the current system will arise that the group will not be able to resolve in a short series of meetings. The group will be encouraged to bucket problems and solutions into the following categories:

1. Problems that could be addressed or incorporated into the long-term plan.
2. Problems that are dependent on which plan is selected (therefore need to be in a parking lot for now).
3. Problems that are outside of the scope of the Workgroup, and could be potentially addressed in other settings (such as Agency's new Behavioral Health Task Force, AB2083 workgroup, or the Child Welfare Council).

## Deliverables

- DHCS and DSS will provide an agenda, written proposals, key questions, and relevant discussion materials for review in advance of each Workgroup meeting.
- DHCS will provide meeting notes and a summary of each Workgroup discussion to all Workgroup members and other key interested parties.
- CDSS will provide a list of short and long-term considerations/topics/issues for the Workgroup.
- Other deliverables may be identified and developed during the course of the Workgroup process, and impacted entities will be tasked with assisting with completion of those deliverables, as appropriate.
- The Workgroup will provide DHCS and CDSS with a set of recommendations on a model of care/approach for Foster Care.

## Workgroup Requirements and Expectations

- Workgroup members must commit to attending scheduled virtual meetings;
- The workgroups will be a solution-focused, collegial environment for respectfully expressing different points of view;
- The Workgroup meetings will be a mechanism for direct communication and problem solving with DHCS and CDSS;
- Members may be asked to provide and/or present information to the Workgroup;
- Neither DHCS nor CDSS will pay a per diem or compensate Workgroup members for expenses, including travel and related costs to attend meetings;
- All meetings will be held in the spirit of the Bagley-Keene Open Meeting Act whenever possible.

## Meeting Schedule

The CalAIM Model of Care workgroup will establish a schedule to achieve the goals. All meetings will be virtual. Meetings will not start before 9:30 a.m. or end past 4:30 p.m. Agendas and times for each meeting will be finalized closer to the meeting date.

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## Guiding Principles for a Foster Care Model of Care For July 24, 2020 Meeting

Children, youth, and families served by the foster system will be healthy in mind and body and connected through a reimagined, improved, and responsive model of care created through the workgroup process. When we speak of children, youth, and families served by the foster system, we envision the diversity that reflects California, including diverse cultures, races, LGBTQ+, tribal, behavioral and/or physical challenges, and more. This workgroup is intended to explore ways to improve the physical, behavioral, and oral health services in support of positive social services outcomes.

### The Foster Care Model of Care:

1. **Builds upon existing foster care reform efforts**, such as the [Integrated Core Practice Model](#) and [AB 2083 Model of care](#), and the [Continuum of Care Reform](#). It uses family-centered care planning and service delivery to provide trauma-informed and coordinated physical, behavioral, and oral health care services along with the social services supports. Supportive services and treatment should be based on the individual needs of the child or youth, their families, and their caregivers. While the group appreciates the risk of all children entering the child welfare system, the focus of this workgroup will be primarily on those children and youth already involved with the foster system or at risk of returning.
2. **Provides timely and appropriate access** to care for children and youth in out-of-home placements and former foster youth, up to age 26 years. Coordination across child-serving systems should be increased and appropriate services should be available to meet the needs of this vulnerable population.
3. **Ensures that children and youth have continuity of care** through maintaining trusted relationships and preserving connection to family, community and culture. Multi-system collaboration and integrated planning must facilitate effective linkages between systems of care. This includes the provision of electronic health records, telehealth, and personal health information between systems where appropriate and within relevant privacy laws, which should reduce disruptions in care and increase efficacy of ongoing treatments and services.
4. **Meets the needs of diverse children, families, caregivers, and youth** through a trauma-informed health delivery system that focuses on recovery and resiliency. The model of care must have flexibility to appropriately mitigate barriers to care, and include culturally appropriate services and supports. Children should be able to receive services in the communities in which they reside to support their connection to family, community, and culture.
5. **Identifies and reduces disparities** and ensures that identified needs are addressed and supportive services are provided in a culturally responsive manner, including race, ethnicity, language, sexual orientation, and gender identity perspectives.
6. **Values youth/family voice and choice** in preserving and furthering California's investment in a child- and family-centered approach to care planning and decision-making
7. **Identifies needs as early as possible**. The needs of children, youth, and families in the-foster system and of those entering or at risk of re-entering the child welfare services system must be addressed and met comprehensively and expeditiously.

8. **Assesses and treats the health needs of children and families entering or at risk of re-entering the foster system.** This includes enhancing direct access to public health nurses, and provision of services for, behavioral, physical, and oral health needs as well as substance use disorders and those with developmental delays and involvement in the juvenile justice system. Ensures services and treatment for parents or guardians available, to prevent re-entry into the foster system.
9. **Children and youth receive services in the least restrictive environment.** The participants of Child and Family Teams (CFTs), including the placing agency, county behavioral health representatives, as well as other health providers, must base placement and services recommendations on the specific needs of children/youth and families with a goal of supporting children and families in the least restrictive and most family like setting possible.
10. **Ensures children and families receive services provided by knowledgeable providers** who are apprised of the proper resources available to address their needs. Providers should be trained in collaboration across child-serving systems, including county and contracted provider networks, and should recognize the specific needs a child in the foster system and their family may have. Additionally, the child-serving systems should receive training to understand the role each sector plays in addressing attachment, permanency, and trauma-related needs of children and their families/caregivers, which aligns with the intent of the AB 2083 Model of care.
11. **Establishes streamlined and standardized processes** to unify (or at least closely coordinate) systems, to prevent duplication and eliminate complexity of reporting.
12. **Ensures accountability,** and that processes and tools are in place to monitor and be adapted as needed, based on outcomes and child, family, and community engagement.

## Health Care Program for Children in Foster Care

The Health Care Program for Children in Foster Care (HCPCFC) is a public health nursing (PHN) program, located within county child welfare service agencies and probation departments, which provides PHN expertise to meet the medical, dental, mental and developmental needs of children and youth in foster care and non-minor dependents. The enabling legislation for the HCPCFC was Assembly Bill 1111, which defined the components of the program and added Section 16501.3 (a) through (e) to the Welfare and Institutions Code. HCPCFC was implemented in 1999 through a General Fund appropriation in the State Budget Act to the California Department of Social Services (CDSS). CDSS entered into an Interagency Agreement with the Department of Health Care Services (DHCS) in order to draw down federal financial participation.

Local Child Health and Disability Prevention (CHDP) programs are responsible for administering the HCPCFC. This includes the hiring and supervision of PHNs and the management of the required interdepartmental Memorandum of Understanding with the local child welfare service agency, probation and health departments.

The goals and objectives of the HCPCFC are common to the health, welfare, and probation departments and are implemented through close collaboration and cooperation among this multi-disciplinary, interdepartmental team. The program has established a process through which PHNs consult and collaborate with the foster care team to promote access to comprehensive preventive, primary, and specialty health services.

Through the HCPCFC, PHNs under the supervision of a supervising public health nurse provide the following services in consultation and collaboration with social workers and probation officers:

- Medical and health care case planning;
- Help foster caregivers to obtain timely comprehensive health assessments and dental examinations;
- Expedite referrals for medical, dental, mental health and developmental services;
- Coordinate health services for children in out-of-county and out-of-state placements;
- Provide medical education through the interpretation of medical reports and training for foster team members on the special health care needs of children and youth in foster care; and
- Participate in the creation and updating of the Health and Education Passport for every child as required by law.

The CHDP program, under the direction of DHCS, works with community programs and agencies to identify the major obstacles children in foster care face in gaining access to coordinated, multidimensional services.

The HCPCFC currently serves a statewide caseload of foster children/youth of approximately 70,000. In Fiscal Year (FY) 2016-17, State funding (matched with federal funds) augmented the HCPCFC to increase PHN staffing levels to enhance care coordination for foster children/youth treated with psychotropic medications. Additional State funds (matched with federal funds) were allocated in FY 2017-18 to increase PHN staffing levels in order to reduce PHN caseloads and enhance the coordination of needed services and supports.

## California Children's Services Program

The California Children's Services (CCS) program was established in 1927 and is one of the nation's oldest public health programs. It was originally created to address the growing polio epidemic. CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides physical and occupational therapy services that are delivered at public schools.

The enabling legislation of the CCS program [Health and Safety Code, Section 123800 et seq.](#) is the enabling statute for the program. The explicit legislative intent of the CCS Program is to provide necessary medical services for children with CCS medically eligible conditions whose parent are unable to pay for these services, wholly or in part.

The CCS program is mandated by the Welfare and Institutions Code and the California Code of Regulations, [Title 22, Section 51013](#), to act as an agent of Medi-Cal for Medi-Cal beneficiaries with CCS medically eligible conditions. Medi-Cal is required to refer all CCS-eligible clients to CCS for case management services and authorization for treatment. The statute also requires all CCS applicants who may be eligible for the Medi-Cal program to apply for Medi-Cal.

The CCS program is administered as a partnership between county health departments and DHCS. Currently, approximately 80 percent of CCS-eligible children are also Medi-Cal eligible. The cost of care for the other 20 percent of children is divided between CCS Only at 7 percent and Optional Targeted Low Income Children's Program (OTLICP) with 13 percent. The cost of CCS Only is funded equally between the State and counties. The cost of care for OTLICP is funded 76.5 percent federal Title XXI, 11.75 percent State, and 11.75 percent county funds.

Classic CCS uses a fee-for-service delivery model – “carved out” of managed care in most counties. Children with CCS eligible conditions generally receive specialty care through CCS providers paid by the state, and primary care through providers contracted with Medi-Cal managed care plans. County CCS programs provide medical and financial eligibility determination, care coordination, and Medical Therapy Program.

Current CCS caseload (June 2020)

- Total CCS Population – 181,576
  - Classic CCS – 150,737
  - Whole Child Model (WCM) – 30,539
  - Foster Children – 6,585

### Whole Child Model Program

Senate Bill 586 (Stats. of 2016) authorized DHCS to establish the Whole Child Model (WCM) program in designated County Organized Health System (COHS) or Regional Health Authority counties. The Whole Child Model (WCM) implemented in 21 specified counties and 5 health plans, starting in July 2018, with the last of the counties completing implementation July 2019. The WCM carves in CCS covered services to Medi-Cal managed care plan (MCP) contracts. The MCPs perform utilization management and care coordination, and the counties determine CCS program eligibility. The desired results are improved care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions.