



CalAIM Foster Youth Model of Care Workgroup Executive Summary and Notes

Where the Workgroup has been

The CalAIM Foster Care Model of Care Workgroup (“the Workgroup”) was established to allow stakeholders to provide feedback on how children and youth involved or formerly involved in child welfare (“the child welfare-involved population”) receive health care and social services and to develop recommendations for system change. The Workgroup was charged to address: (1) how the health care delivery system for the child welfare-involved population should be organized, (2) desired outcomes for the child-welfare involved population and the measures that could be used to assess performance in achieving these outcomes, and (3) the core suite of services that should be available to the child welfare-involved population and their families and caregivers.

The Workgroup adopted a charter and set of core principles, heard from other states about how they solved similar problems, and discussed potential solutions. The Workgroup received a joint proposal from California’s County Behavioral Health Directors Association (CBHDA) and County Welfare Directors Association (CWDA), recommending a set of mandatory minimum benefits, automatic access to specialty mental health services (SMHS) services, and workforce development and training. The California Child Welfare Council’s Behavioral Health Committee also presented a comprehensive proposal, including recommendations for a set of outcomes and measurements, a core suite of services, automatic access to specialty mental health services, and other recommendations relating to Family First Prevention Services Act services, interagency collaboration, workforce development, and others. The Workgroup held a “World Café” to take a deep-dive into three topics: (1) integration and coordination of health and social services, (2) suite of core behavioral health services, and (3) data outcomes and portability.

Where the Workgroup is going

The December Workgroup will focus on potential changes to California’s managed care system and how they could address the problems discussed to date. Three papers will be presented and discussed: recommendations from the California Association of Health Plans, the National Health Law Program (NHLP), and Aurrera Health Group.

The workgroups in February will further refine the proposals discussed to date, and will also focus on potential solutions to data-sharing, including whether California should consider a portable health record for children and youth in child welfare.

By June, DHCS and CDSS expect that some recommendations will have broad-based support, and other areas may not have clear consensus; however, we should understand pros,

cons, considerations, and risks of the suite of potential proposals. DHCS and CDSS will then take this input and develop a plan of action, which could require several months of planning and preparation, including potential legislative and budget proposals.

CalAIM Foster Youth Model of Care Workgroup: Meeting Notes

The following notes summarize themes from comments shared in the June, July and August Workgroup meetings, both in the discussion and in the chat room.

Challenges in Current System

Barriers to Care

- Lack of communication and coordination between providers and services in mental health, medical care, and education: “they almost never return our calls”
- Systems are driven by what can be funded, and not by what is needed
- Difficulties following the youth’s health history due to many placement changes between providers, interrupted services
- Holes in the safety net due to gaps in coverage and systems
- High provider burnout rates
- Challenges with navigation and coordination across systems
- Payment can disincentivize cooperation – agencies compete for funding
- No funding for peer supports
- Different interpretations of HIPPA laws – afraid to share information
- Fear of liability leading to high administrative burden
- Low rates in Medi-Cal for fee-for-service providers, and underfunded children's mental health
- SUD services not available consistently in the home
- High variation between counties – difficult navigation

Need for early intervention

- Misdiagnoses lead to incorrect medications or over-medication
- System intervenes too late – missed prevention opportunities
- Diagnosis requirement can cause care avoidance due to stigma -- adverse experience and trauma doesn’t always mean a diagnosis
- Systemic racism and poverty result in additional trauma to children and their families.

Lack of Data Sharing

- Hard to get data from other systems
- Difficult to measure, track, and evaluate outcomes for outcomes you do not control
- Need data on specific populations, such as pre-detention youth or LGBTQ, to understand potential inequities in care and/or outcomes
- Hard to translate data into meaningful information, to understand outcomes and whether services are helping

- Confidentiality restrictions restricting data-sharing

What is needed in a new system?

Integrated, coordinated delivery of medical, behavioral, dental and social services

- Ensure timely, appropriate care driving equitable outcomes, standardized across state
- Administrative integration needed to support integrated and coordinated care
- “Centers of excellence” or hubs allow one-stop shopping, but could be hard to access for rural communities – consider telehealth as bridging mechanism, but ensure in-person services are an option for those who need them
- Consider bundled payment to incentivize providers to integrate at the practice level
- Need seamless system for children moving to different counties.
- Must work for broad population: under 5 (need specific measures for this population), transition-age youth, child welfare alumni, post-adoption, post-reunification
- Trauma-informed services: avoid over-assessment, ensure all providers and families trained in resilience and wellness-building programs
- Fix medical necessity – prevents early access to services
- Support resiliency: need consistent, stable and reliable adult available throughout foster care years
- Address the role each sector plays in addressing systemic racism
- Focus on quality improvement and not on compliance – get further with continuous quality improvement than with a hammer (“gotcha”) compliance approach
- Connect the education system to the health system -- need behavioral health, oral health, medical services in schools
- Youth should direct their own care – but systems are too fragmented and difficult

Core set of evidence-based services available to all children in child welfare

- Substantial support for the CBHDA/CWDA proposal – desire to see defined scope of services for the entire family (not just the child) available consistently across the state
- Need to build workforce and capacity – training and payment incentives may be needed
- Need to consider incorporating community-defined practices to address equity
- Need to better coordinate with education system
- Ensure SUD treatment needs of caregivers and children/youth are met – not enough attention to SUD needs across the system
- Focus on needs of families and caregivers siblings
- Identify and support the 760,000 youth who have experienced homelessness, including over 14,000 unaccompanied or parenting youth

Data Needs and Systems’ Interoperability

- Support data-sharing across systems with transparent outcome measures
- Need Health Education Passport to include treatment goals, medical records, to replace paper files, so youth is in charge of their own information

- Need clear and simple outcomes measures based on primary clinical and social objectives; build on DHCS's Performance Outcomes Systems – include patient-reported outcomes, not just services
- Measure and report on equity and disparities
- Need statewide or regional electronic health record system, including Presumptive Transfer Notice, JV220, Consents, Assessments, CANS, and Client plans – ensure youth voice heard (youth may not want certain people to know diagnoses)
- Data systems must be nimble (e.g., allow change of gender to reflect gender transitions)
- Need to define specific foster care outcomes measures for Managed Care Plans
- Address issues related to privacy and consent to care at the State level rather than every county defining them differently
- Need global sharing agreements and oversight
- Cross-system data sharing – need to know outcomes after a youth leaves services

Lived Experience and Constituent Voice

- Support peer services -- people with lived experiences and natural supports
- Prioritize young people's voices in making policy decisions
- Support Child Family Team process to allow youth a safe space to disagree with recommendations

Learning from other states:

- Road shows: building relationships and shared knowledge
- Team Design: coordinating medical, behavioral, social services
- Consider Zero Suicide model and protocols
- Data agreements and data sharing are critical
- Develop contract language iteratively, to align language with intent
- Over-communicate and build trust, so managed care organization becomes the helpful partner, working closely with case workers
- Clarify roles with stakeholders early and often: gain support from bipartisan legislators, child welfare, behavioral health, state agencies; offer recurrent stakeholder communication and feedback opportunities
- Consider Washington peer connection model
- Member protections are important during transitions (honoring prior auths and current providers)
- Significant need for post-implementation and transition monitoring
- Emulate Washington's rich data system: track educational and health outcomes