



# **Specialized Foster Care Plan (FC Plan) Workgroup**

***Session #4: Care Management,  
cont.***

***June 7, 2021 3:00 pm – 4:30 pm***

## **FC Plan Workgroup**

*Session #4: Care Management, cont.*




**Before we begin, please:**

**Note today's Workgroup session will be recorded**

**Display your name and organization in your Zoom display**

- **Recap of FC Plan Workgroup Session #3.....3:00 – 3:05pm**
- **Review Revised Enrollment Approach.....3:05 – 3:10 pm**
- **Stakeholder Brainstorm.....3:10 – 3:55 pm**
- **Session Topic: Care Management, cont.....3:55 – 4:25 pm**
- **Wrap-Up & Next Steps.....4:25 – 4:30 pm**

# Where We Are Today: FC Plan Workgroup Session #4

Session #	Dates	Proposed Topic(s)
	April 19, 2021 3 - 4:30pm	<input type="checkbox"/> Introduction to FC Plan Workgroup and Approach <input type="checkbox"/> FC Plan Overview <input type="checkbox"/> Statewide Design
	May 3, 2021 3 - 4:30pm	<input type="checkbox"/> Eligibility & Enrollment <input type="checkbox"/> Benefits/Services
	May 17, 2021 3 - 4:30pm	<input type="checkbox"/> Care Management
4	June 7, 2021 3 - 4:30pm	<input type="checkbox"/> Care Management, cont.
5	June 21, 2021 3 - 4:30pm	<input type="checkbox"/> Provider Network <input type="checkbox"/> Quality
6	July 12, 2021 3 - 4:30pm	<input type="checkbox"/> Interim Plan for Children in Foster Care 2021- 2023
7-8	July/August 2021	<input type="checkbox"/> <i>To permit more time for discussion and feedback, we will add additional Workgroup sessions this summer</i>

\* 'Spillover' topics or additional topics to be determined based on discussion

# Today's Goals

- Recap FC Plan Workgroup Session #3*
- Review revised approach to FC Plan enrollment during interim period*
- Listen to stakeholder priorities on FC Plan care management*
- Review proposed FC Plan care management design*

## **Recap of FC Plan Workgroup Session #3**

# Session #3 Recap: Care Management

## Stakeholder Feedback Under Consideration

### Overall Care Management Design

- Design care management in a family-centered approach to promote family preservation, reunification and permanency
- Allow flexibility for delegation of care management to community-based provider entities
- Ensure care management addresses the needs of children in crisis situations and coordinates appropriate wraparound and residential services, especially for children with complex needs;
  - Consider that families may experience crises that differ from clinical crises
  - Ensure model takes a proactive, preventative approach to prevent crises
- Establish clear accountability and ensure sufficient resources are directed to rural areas

### Coordination and co-location with DSS

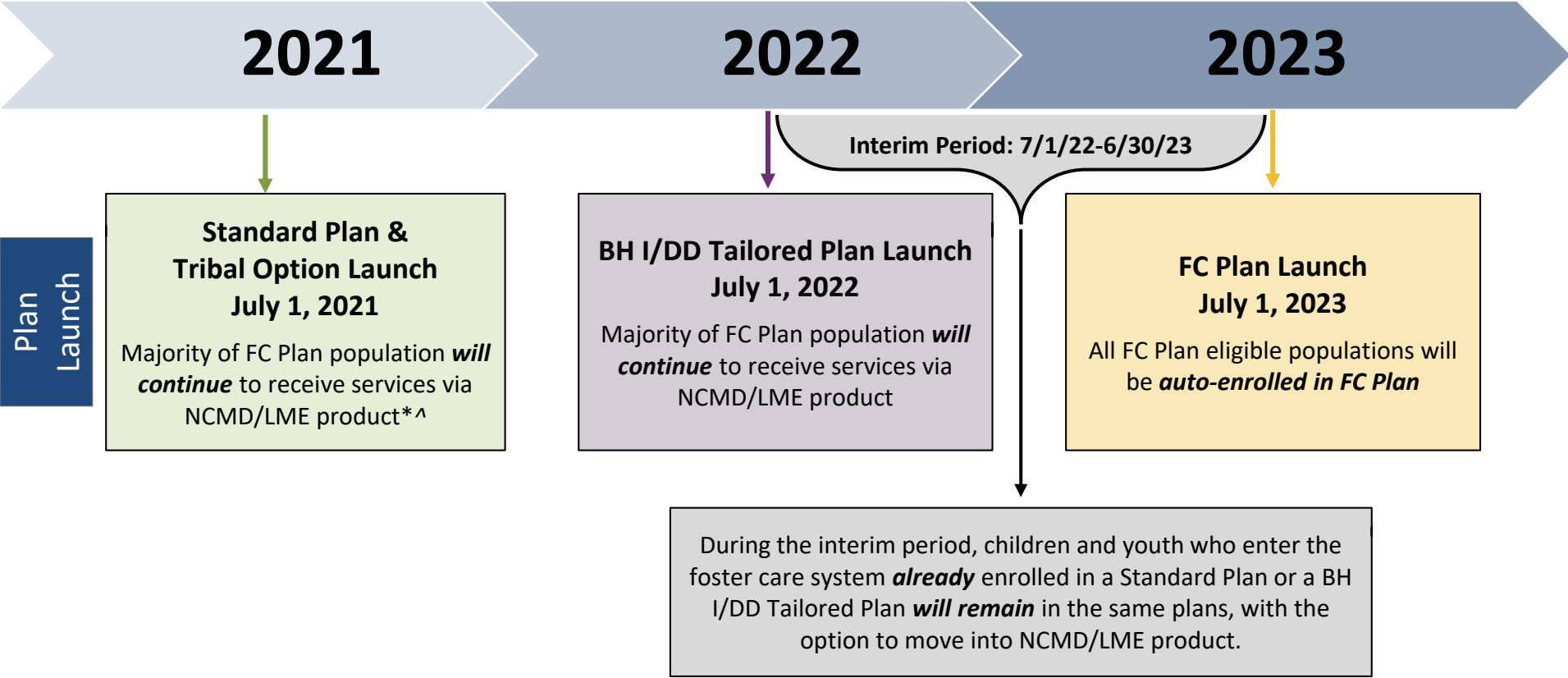
- Ensure clear delineation of roles and responsibilities and training for child welfare workers and care managers
- Consider lessons learned from local DSS offices that have implemented co-location already

# **Revised Enrollment Approach**



# Revised Interim Period Enrollment Approach

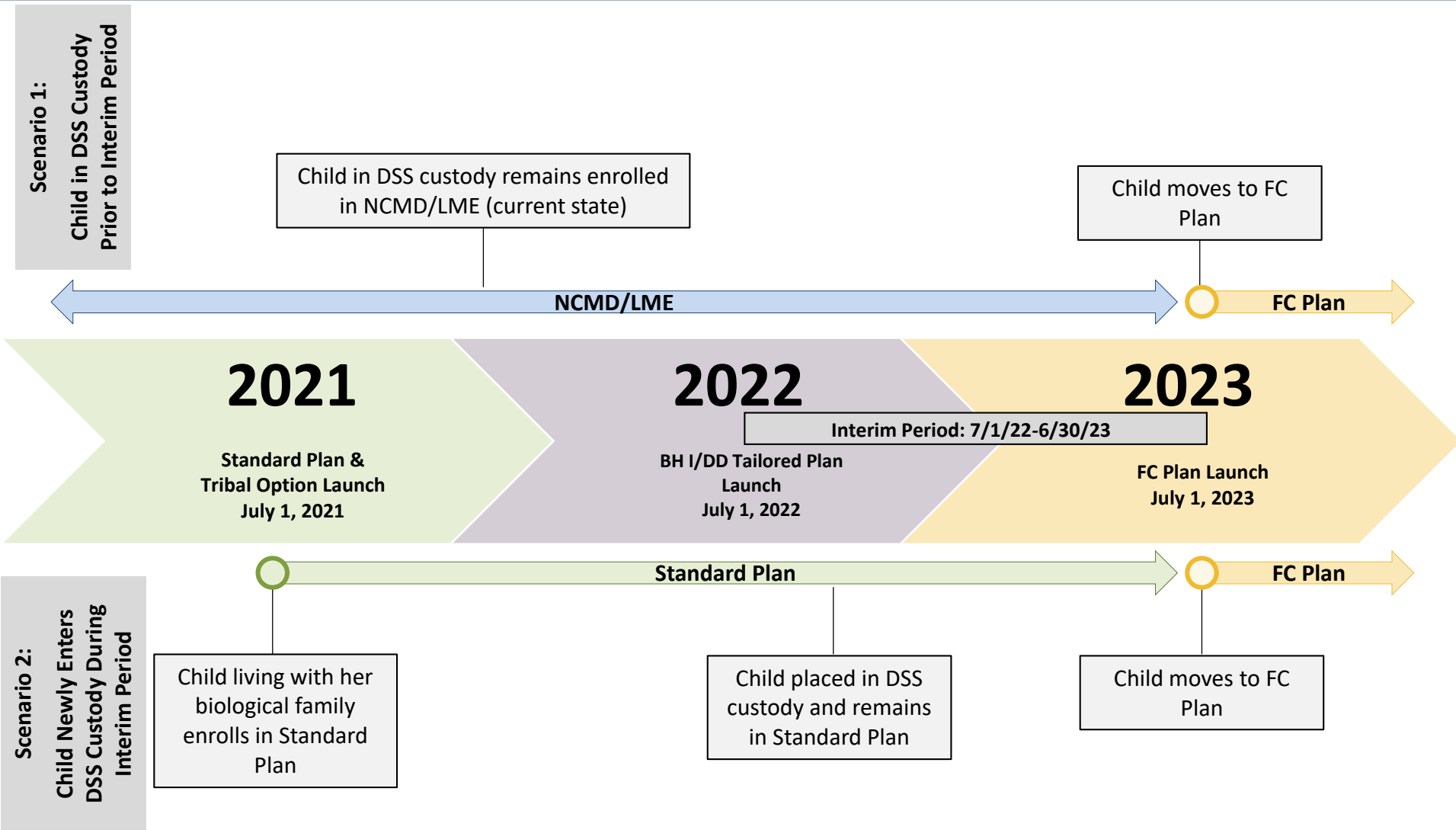
Based on stakeholder feedback, the Department has revised the policy for enrollment of FC Plan eligible groups in managed care during the interim period to reduce transition points and complexity for children, youth, and stakeholders in the child welfare system.



\*Exception for children of individuals eligible for FC Plan enrollment who will be auto-enrolled in SP, as eligible, at launch.

^Individuals eligible for EBCI Tribal Option will be auto-enrolled in the Tribal Option effective 7/1/21 and are exempt from auto-enrollment into the FC Plan.

# Scenarios for Revised Interim Period Enrollment Approach



# **Stakeholder Brainstorm: Care Management**

# Discussion

**The Department is committed to developing a shared vision for the FC Plan to strengthen collaboration and improve outcomes for children, youth, and families.**



What are we trying to solve for when we design the FC Plan care management requirements?



Based on what we are trying to solve for, what requirements would you like to see put into place with respect to FC Plan care management?



What role does your organization/agency play in ensuring the success of the FC Plan's care management model?

## **Deep Dive: Care Management**

# Key Design Features to Support Care Management Goals

Following today's discussion on stakeholder priorities and responsibilities, the Department encourages additional feedback on how key design features for FC Plan care management can align to stakeholder priorities and where additional gaps in design may exist.

- 1 Plan-based care management
- 2 Coordination and co-location with DSS
- 3 Continuity of care & coordination during transitions
- 4 Support for transition-age youth aging out of the child welfare system and transitioning to adulthood
- 5 Medication management services
- 6 Ensuring a System of Care approach

## 3. Continuity of Care & Coordination during Transitions

Care managers will provide care management when members transition between plans or treatment settings to ensure stability and continuity of care

Design Feature	Proposed Approach	Rationale
<b>Continuity of Care</b>	<ul style="list-style-type: none"> <li>Manage members in treatment for a chronic/acute medical or behavioral health condition when transitioning into or out of FC Plan</li> </ul>	<ul style="list-style-type: none"> <li>Ensure members have the appropriate support needed when they experience transitions between plans or treatment settings</li> <li>Minimize disruptions in care that may occur when members experience transitions</li> <li>Help ensure members receive care in the most appropriate setting available</li> </ul>
<b>Health Plan/PCP Selection</b>	<ul style="list-style-type: none"> <li>Notify DSS Child Welfare worker, foster parent(s), and biological parents of a change in health plan; assist in selecting a new PCP when necessary</li> </ul>	
<b>Discharge Planning</b>	<ul style="list-style-type: none"> <li>Conduct discharge planning and arrange for medication management when members leave a hospital or institutional setting</li> </ul>	
<b>Institutional Care Settings</b>	<ul style="list-style-type: none"> <li>Provide diversion interventions for members at risk of admission to an institutional setting</li> <li>Engage with members in institutional settings who may be able to have their needs met in the community</li> </ul>	

## 3. Discussion on Continuity of Care & Coordination during Transitions

- What additional considerations should the Department take into account to ensure robust continuity of care and coordination during transitions?
- From a consumer perspective, what other supports are integral to ensuring members have continuity of care during transitions?
- Are there potential unintended consequences for members with the proposed design that the Department should consider?



## 4. Support for Transition-Age Youth

Care manager will support transition planning for members aging out of the child welfare system, as well as members aging out of Medicaid coverage at age 26

Design Feature	Proposed Approach	Rationale
<b>Transition Planning</b>	<ul style="list-style-type: none"> <li>Participate in the 90-Day transition planning* led by DSS Child Welfare Workers to identify health-related supports, as appropriate</li> </ul>	<ul style="list-style-type: none"> <li>Help facilitate a successful transition to self-sufficiency for members</li> <li>Provide specialized supports for health-related aspects of transition out of foster care and/or out of Medicaid coverage eligibility</li> </ul>
<b>Health Passport</b>	<ul style="list-style-type: none"> <li>Supplement DSS 90-Day Transition Plan with a “Health Passport” that contains critical health care-related information for each member (e.g., list of medication, copies of medical records)</li> </ul>	
<b>FFY Aging out of Medicaid Coverage Eligibility</b>	<ul style="list-style-type: none"> <li>Discuss health insurance options and make plans for transitioning ongoing health care services/medications</li> </ul>	

## 4. Discussion on Support for Transition-Age Youth

- What additional considerations should the Department take into account to ensure support for transition-age youth?
- From a consumer perspective, what other supports are integral to ensuring members have adequate support when they either age out of the child welfare system or age out of Medicaid?
- Are there additional areas where Care Managers and Child Welfare Workers can coordinate to support transition-age youth?

## 5. Medication Management Services

FC Plan Care Manager will be responsible for coordinating with providers to ensure appropriate use and monitoring of psychotropic medications

Design Feature	Proposed Approach	Rationale
<b>Best Practices</b>	<ul style="list-style-type: none"> <li>Follow “Best Practices for Medication Management for Children &amp; Adolescents in Foster Care” from the North Carolina Pediatric Society/Fostering Health NC* (<i>or other best practices for medication management</i>)</li> </ul>	<ul style="list-style-type: none"> <li>Ensure adequate medication management to prevent overmedication or dangerous medication interactions, which is particular concern for children and youth in the child welfare system</li> <li>Ensure members have access to their medications and that medication usage is coordinated across providers</li> <li>Identify potential overuse of psychotropic medication</li> <li>Integrate medication management best practices</li> </ul>
<b>Medication Review</b>	<ul style="list-style-type: none"> <li>Review member’s medications with a qualified clinician within 72 hours of enrollment</li> <li>Ensure adequate supply of essential medications</li> </ul>	
<b>Psychotropic Medication Monitoring</b>	<ul style="list-style-type: none"> <li>Coordinate with qualified clinician to assess and identify potentially harmful aspects of the medication regimen for members prescribed <b>psychotropic medications</b> and adjust prescriptions, as necessary</li> <li>Ensure members prescribed <b>antipsychotic medications</b> receive clinically appropriate metabolic monitoring (e.g. monitoring of glucose and lipids)</li> </ul>	
<b>Coordinate with Clinical Experts</b>	<ul style="list-style-type: none"> <li>Coordinate closely with members’ clinicians</li> <li>Leverage FC Plan psychiatrist/pharmacist expertise, as necessary</li> </ul>	

## 5. Feedback on Medication Management Services

### Feedback

**Public comment on medication management services clustered around the following areas:**

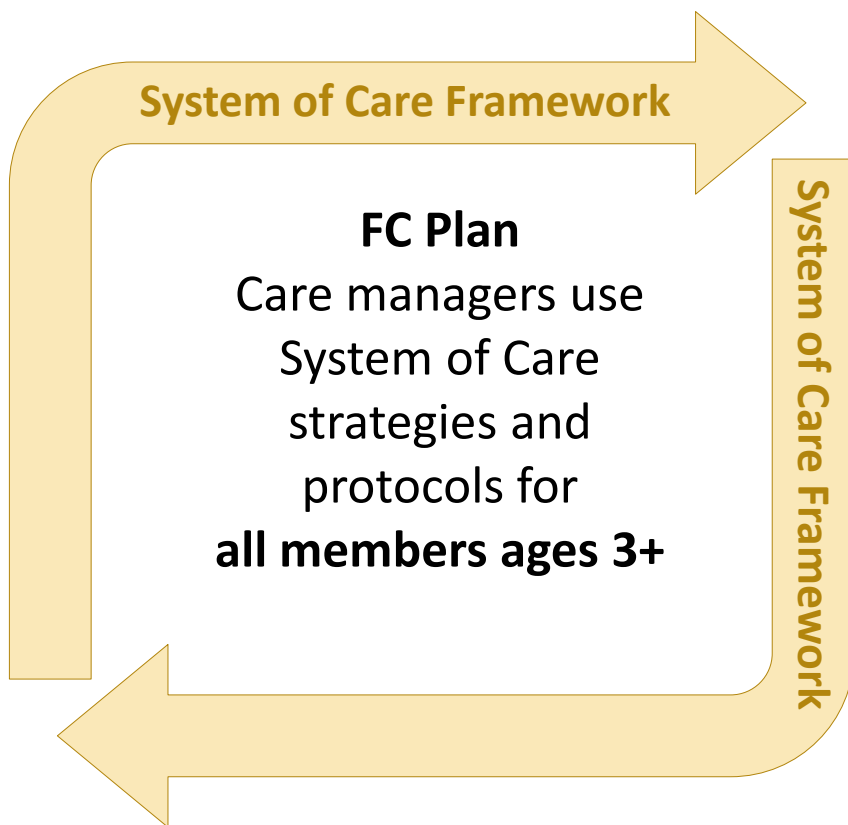
- Clarify whether Care Managers or providers will be making recommendations on medication management
- Recommend using best practices for medication management requirements

### For Discussion

- What additional considerations should the Department take into account for design of medication management services?
- To the extent that Workgroup members have concerns about medication management services, what are those concerns and how do you recommend the FC Plan address them?
- What does this design area look like through the lens of the people who will be using the program and are there potential unintended consequences with the proposed design for the Department to consider?

## 6. System of Care

The FC Plan will align with the NC System of Care framework designed to meet the needs of families who are involved with multiple child service agencies (e.g. child welfare, juvenile justice). The FC Plan will address members' needs through evidence-based, trauma-informed, resiliency-oriented approach to behavioral health care



### System of Care Policy

- FC Plan will develop a **System of Care Policy**, to be approved by the Department
- FC Plan will have a **System of Care Manager** responsible for statewide implementation of the FC Plan's System of Care Policy, and **Outreach Coordinators** responsible for local implementation of the policy, including:
  - Working with community agencies to identify and respond to members' needs
  - Participating in local Community Collaboratives that work to address service barriers
  - Participating in state-level interagency groups (i.e. Child Welfare State groups)

### Rationale

- Ensure coordination between FC Plan Care Manager, child service agencies, and community-based services that support the needs of children and youth

## 6. Discussion on System of Care Integration

- What additional considerations should the Department take into account to ensure the FC Plan aligns with the state's System of Care framework?
- Are there any areas of further clarification on System of Care requirements for the FC Plan that would be helpful?

## **Wrap-Up & Next Steps**

# Looking Ahead

The Department values input and feedback from stakeholders and welcomes stakeholder to join the upcoming FC Plan Workgroup sessions and/or submit additional comments and questions to the Department.

## Upcoming FC Plan Workgroup Sessions

- Session #5: Provider Network and Quality
- Monday, June 21, 2021 (3 - 4:30pm)
- Pre-read materials will be shared in advance



## Additional Comments & Question

- Comments, questions, and feedback are all welcome at [Medicaid.NCEngagement@dhhs.nc.gov](mailto:Medicaid.NCEngagement@dhhs.nc.gov)

*The Department will also continue to provide regular updates at:*  
<https://medicaid.ncdhhs.gov/transformation/specialized-foster-care-plan>

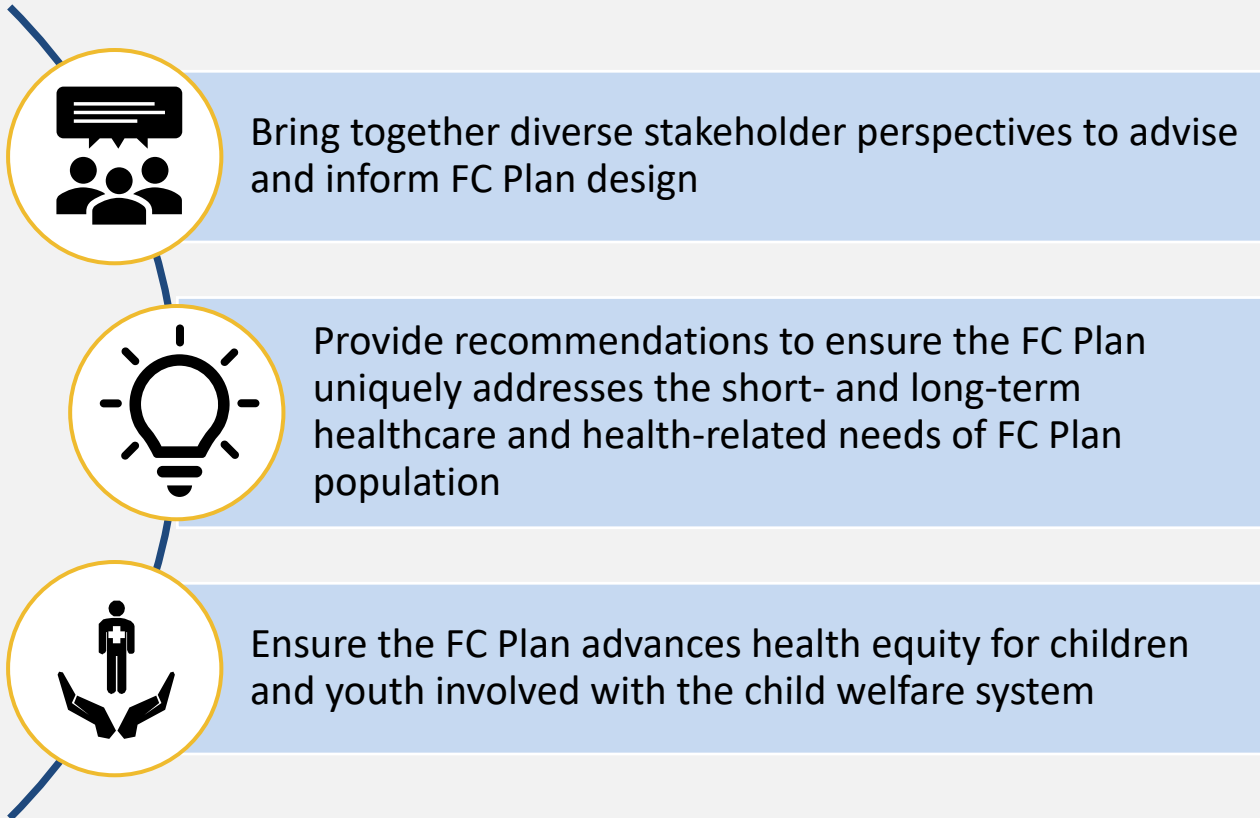


# Appendix

# Reminder: Objective & Goals of the FC Plan Workgroup

Provide feedback to the NC Department of Health and Human Services on key aspects of Specialized Foster Care Plan (FC Plan) design to ensure it effectively meets the unique needs of the State's children and youth currently and formerly involved in the child welfare system

## Workgroup Goals



# Guiding Principles for FC Plan Design

The FC Plan seeks to support the health care needs of children and youth who are currently or were formerly involved in the child welfare system. Following Session #1 feedback, the principles below were modified to further emphasize a family focus, particularly related to reunification and achieving permanency for children with better outcomes.

- Provide **integrated and coordinated physical and behavioral health services** to address the whole person.
- Deliver **person-centered trauma-informed care** focused on promoting long-term well-being for children and youth, with a specialized focus on **addressing the population's Adverse Childhood Experiences** and family's specialized needs.
- Provide necessary health care services and supports that **improve health outcomes and advance the permanency goals** of the child/youth and their families.
- Ensure the provision of physical and behavioral health care services in order to **prevent family disruptions and support keeping families safely together**, as appropriate.
- Establish a **single point of care management accountability** that is responsible for coordinating with the Department of Social Services to ensure the child or youth's health care goals are met.
- Provide **intensive care management support during high-risk transition points including:** (1) child welfare transitions (e.g., when aging out, moving from one foster care setting to another, or during and after family reunification); and (2) health care setting transitions (e.g., when moving from a hospital back into the community).



# FC Plan Workgroup Participants

Name	Organization	Stakeholder
<b>Teka Dempsey</b>	Child Welfare Advisory Council	Advocacy Group
<b>Tiffany Munday</b>	Guardian ad Litem	Advocacy Group
<b>Kaylan Szafranski</b>	NC Child	Advocacy Group
<b>Fredrick Douglas</b>	NC Families United	Advocacy Group
<b>Nicole Dozier</b>	NC Justice Center	Advocacy Group
<b>Ms. Shanita</b>	SaySo	Advocacy Group
<b>Tara Larson</b>	EBCI Public Health and Human Services	EBCI
<b>Christy Street</b>	NC Pediatric Society/Fostering Health	Provider
<b>Dr. Molly Berkoff</b>	UNC Child Medical Evaluation Program	Provider
<b>Karen McLeod</b>	Benchmarks	Provider
<b>Peter Kuhns</b>	Department of Juvenile Justice (DJJ)	State/Local Agency
<b>Lisa Cauley</b>	Division of Social Services (DSS)	State/Local Agency
<b>John Eller</b> (Mecklenburg County DSS) <b>Brenda Jackson</b> (Cumberland County DSS) <b>Lizzi Shimer</b> (Buncombe County DSS )	NC Association of County Directors of Social Services	Local Agency

# FC Plan Workgroup Participants

Name	Organization	Stakeholder
<b>Sean Kenny</b> (Trillium) <b>Rhonda Cox</b> (Vaya) <b>Lynn Grey</b> (Partners Health)	Representatives from*: <ul style="list-style-type: none"> <li>• Alliance Health</li> <li>• Cardinal</li> <li>• Eastpointe</li> <li>• Partners Health</li> <li>• Sandhills</li> <li>• Trillium</li> <li>• Vaya Health</li> </ul>	LME/MCOs
<b>Julie Ghurtskaia</b> (CCH) <b>Sarah Goscha</b> (UHC) <b>Matt Oettinger</b> (WellCare)	Representatives from*: <ul style="list-style-type: none"> <li>• AmeriHealth</li> <li>• Healthy Blue</li> <li>• Carolina Complete Health</li> <li>• UnitedHealthcare</li> <li>• WellCare</li> </ul>	Standard Plans
<b>Kimberly Deberry</b>	CCNC	Other Stakeholder(s)

\*Representatives may rotate per session

# 1. Plan-based Care Management

All members enrolled in the FC Plan will have access to a robust care management model administered by the FC Plan

Design Feature	Proposed Approach	Rationale
<b>Available to All Members</b>	<ul style="list-style-type: none"> <li>All members are assigned a FC Plan-based Care Manager</li> <li>Care management provided to members:               <ul style="list-style-type: none"> <li>For the duration of their time in the Plan</li> <li>Regardless of geographic location</li> <li>Regardless of member's placement (e.g., residing with foster care family, PRTF)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Position care managers to proactively address trauma and other Adverse Childhood Events (ACEs) experienced by children and youth in the child welfare system that increases risk of behavioral health and physical health needs</li> </ul>
<b>Whole-Person Integrated Care Approach</b>	<ul style="list-style-type: none"> <li>Comprehensive management of each member's healthcare needs, including physical health, behavioral health, LTSS, and pharmacy needs</li> <li>Led by care manager in concert with multidisciplinary care team, including DSS Child Welfare Worker, family members/guardians, and PCP/providers, among others</li> </ul>	<ul style="list-style-type: none"> <li>Ensure coordination across all health and health-related services and across all stakeholders involved in a member's care</li> </ul>
<b>Delivered by FC Plan Care Managers</b>	<ul style="list-style-type: none"> <li>Administered primarily by plan-based care managers</li> <li>Working in close partnership with members' providers (with additional provider reimbursement for care team meeting participation)</li> </ul>	<ul style="list-style-type: none"> <li>Creates single point of accountability and oversight</li> <li>Promote continuity when members change placements or move across geographic areas in the state</li> <li>Promote clear delineation of roles/responsibilities and streamline coordination across individuals involved in member's care, including DSS and providers, among others</li> </ul>

# 1. Feedback on Plan-based Care Management

## Feedback

### Public comment on plan-based care management design clustered around the following areas:

- Concern about the centralized approach to care management given local care management model in SPs and TPs
- Support for local providers to be able to offer care management
- Recommend setting caseload standards for care managers

## For Discussion

- What additional considerations should the Department take into account for the proposed care management design?
- From a consumer perspective, what are some ways that provider-based care management could benefit members?
- Are there potential unintended consequences for members with the proposed design that the Department should consider?

## 2. Coordination & Co-location with DSS

Care managers will coordinate closely with each member's assigned County Child Welfare Worker. Some care managers will co-locate in local DSS offices to facilitate coordination

Design Feature	Proposed Approach	Rationale
<b>Clear Division of Roles</b>	<ul style="list-style-type: none"> <li>• <b>FC Plan Care Managers:</b> Lead FC Plan core care management functions (e.g., care plan development, medication management)</li> <li>• <b>Child Welfare Workers:</b> Retain intake and assessment, placement, and permanency planning responsibilities (e.g., 7-day and 30-day health assessments)</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure clear delineation of roles and responsibilities between Care Managers and Child Welfare Workers to avoid duplicating work</li> </ul>
<b>Coordination</b>	<ul style="list-style-type: none"> <li>• Timely initial meeting following member enrollment</li> <li>• Ongoing monthly meetings</li> <li>• Timely notification of unexpected/crisis events (e.g., member visits an ED)</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure bidirectional sharing of information that is critical to facilitate health care services/reunification/permanency planning efforts</li> </ul>
<b>Co-location</b>	<ul style="list-style-type: none"> <li>• Co-location of 50% of Care Managers in local DSS offices             <ul style="list-style-type: none"> <li>• A minimum share of care managers will be co-located in rural offices</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Embed care management in the community and facilitate ongoing coordination</li> </ul>

***FC Plan Care Managers will not assume any existing DSS responsibilities***



## 2. Feedback on Coordination & Co-location with DSS

### Feedback

**Public comment on coordination with DSS clustered around the following areas:**

- Clarify timeframe and approach to co-location with DSS
- Clarify roles between FC Plan Care Manager and DSS County Child Welfare Worker
- Clarify how data sharing will work among the FC Plan and DSS
- Recommend standardizing policies, forms, and how information is shared

### For Discussion

- What additional considerations should the Department take into account to ensure robust coordination and co-location with DSS?
- What does care management design look like through the lens of the people who will be using the program and are there potential unintended consequences with the proposed design for the Department to consider?
- What other operational considerations should the Department take into account?

# Care Management Timeframes

Requirement	Recommended Timeframe
Share FC Plan enrollment packet with Member, including information on Care Manager assignment	<ul style="list-style-type: none"> <li>At initial FC plan launch: 30 days prior to FC Plan launch</li> <li>After plan launch: within 14 days of enrollment</li> </ul>
Conduct initial meeting between Care Manager and DSS Child Welfare Worker	<ul style="list-style-type: none"> <li>At Initial FC Plan launch: Within 60 days of enrollment, or earlier, if necessary to appropriately to manage the member's healthcare needs (meeting may be telephonic, if necessary)</li> <li>Ongoing: Within 72 hours of enrollment, or earlier, if necessary to appropriately to manage the member's healthcare needs (meeting may be telephonic, if necessary)</li> </ul>
Initiate contact with Member to start the Comprehensive Assessment	Within 7 days of FC Plan enrollment, or earlier, if necessary to appropriately to manage the member's healthcare needs
Complete Comprehensive Assessment	<ul style="list-style-type: none"> <li>High-risk members: Within 14 days of FC Plan enrollment</li> <li>Other members: Within 30 days of FC Plan enrollment</li> </ul>
Complete initial Care Plan/ISP (note: the FC Plan must not withhold services pending completion of the Care Plan/ISP)	<ul style="list-style-type: none"> <li>High-risk members: Within 7 days of the completion of the comprehensive assessment</li> <li>Other members: Within 14 days of the completion of the comprehensive assessment</li> </ul>
Update Care Plan/ISP	<ul style="list-style-type: none"> <li>At minimum every 12 months</li> <li>Within 14 days of re-assessment</li> </ul>
Document/store and make Care Plan/ISP available to Member	Within 24 hours of completion
Convene Child and Family Team (for children with a mental health disorder/SUD who are receiving MH/SUD services)	At least once every 30 days
Ensure post-partum visit with physician	Within 56 days of delivery
Follow up with Member after inpatient/ED discharge	Within 48 hours
Arrange outpatient follow-up visit after inpatient/ED discharge	Within 7 days, unless a shorter timeframe is required
Comprehensive Assessment/reassessment following inpatient/ED discharge	Within 14 days
Update Care Plan/ISP following inpatient/ED discharge	Within 14 days of Comprehensive Assessment/reassessment
Reassessment for Members leaving the Child Welfare System but remaining enrolled in the FC Plan (i.e., former foster youth)	Within 90 days of member leaving the Child Welfare System
Discuss health insurance options for individuals aging out of Medicaid at age 26	90 days prior to the member's 26 <sup>th</sup> birthday
Outreach related to high-risk ADT alert	Same-day or next-day for all members
Care Needs Screening for Members who have opted out of care management	Within 45 calendar days of FC Plan enrollment