Specialized Foster Care Plan (FC Plan) Workgroup

Session #5: Care Management, cont.

June 22, 2021 3:00 pm – 4:30 pm

FC Plan Workgroup

Session #5: Care Management, cont.

Before we begin, please:

Note today's Workgroup session will be recorded

Display your name and organization in your Zoom display

Agenda

- Today's Goals and Recap of Previous Session……3:00 – 3:10 pm
- High Level Vision for Coordination Across DSS and FC Plan…..3:10 – 3:15 pm
- Deep Dive: Care Management……3:15 – 4:20 pm
- Wrap-Up & Next Steps……4:20 – 4:30 pm

Where We Are Today: FC Plan Workgroup Session #4

Session #	Dates	Proposed Topic(s)
✓	April 19, 2021 3 - 4:30pm	❑ Introduction to FC Plan Workgroup and Approach ❑ FC Plan Overview ❑ Statewide Design
✓	May 3, 2021 3 - 4:30pm	❑ Eligibility & Enrollment ❑ Benefits/Services
✓	May 17, 2021 3 - 4:30pm	❑ Care Management
✓	June 7, 2021 3 - 4:30pm	❑ Stakeholder Brainstorm on Care Management
5	June 22, 2021 3 - 4:30pm	❑ Care Management, cont.
6	July 12, 2021 3 - 4:30pm	❑ Provider Network ❑ Quality
7-8	*July/August 2021*	❑ *To permit more time for discussion and feedback, we will add additional Workgroup sessions this summer*

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

Today's Goals

- ***Recap FC Plan Workgroup Session #4***
- ***Review proposed FC Plan care management design***

Recap of FC Plan Workgroup Session #4

Session #4 Recap: Stakeholder Brainstorm on Care Management

Stakeholder Feedback

- **Family Centered.** Design care management in a family-centered approach to promote family preservation, reunification and permanency and prevent additional trauma for children and families
- **Transitions of Care.** Ensure care management supports unique points of transitions for children and youth (i.e. reunification, aging out of foster care) in addition to clinical transitions of care
- **Local Coordination.**
  - Ensure care management can engage and cultivate relationships with stakeholders in local communities (i.e. school personnel)
  - Consider the role local providers can play in care management and allow sufficient time for providers to prepare for roles/responsibilities in the FC Plan
- **Communication and Training**. Establish clear training and communication on care management to ensure child welfare staff and families can make informed decisions about their care and improve fidelity to the model (i.e., leverage family partner coordinators)
- **Clear Measures for Improving Outcomes.** Develop strategic metrics to evaluate care management outcomes (i.e. collective scorecard)
- **Roles and Responsibilities.** Establish clear delineation of roles and responsibilities for child welfare workers and care managers to ensure clarity on who is the designated decision maker

High Level Vision for Coordination Across DSS and FC Plan

DHHS is in discussion with DSS to ensure alignment on core responsibilities and vision for coordination.

Core Responsibilities for Supporting Families Involved in the Child Welfare System

DSS

- Responding to cases of child abuse and neglect
- Determining if child maltreatment has occurred
- Developing case plans, completing referrals, and implementing preventive services in the home that can ensure families can safely stay together
- Determining if out of home placement is necessary to protect the child (ren) from harm
- Conducting ongoing risk assessments, strengths and needs assessments, participating in child and family team meetings, and implementing visitation plan for children in foster care
- Working with children and families on a permanency plan (including reunification, adoption or independent living), monitoring progress, and making recommendations to court

Medicaid & FC Plan

- Ensuring children and parents who are enrolled in Medicaid have access and are connected to comprehensive Medicaid State Plan and waiver physical and behavioral health services. This includes:
  - Coordinating and providing referrals, information, and assistance in obtaining and maintaining health services
  - Arranging coverage for services, treatment for emergency medical conditions (including behavioral health crisis), and ensuring care in appropriate settings 24 hours per day/7 days per week
  - Ensuring robust and timely care management is provided to support members during period of life and clinical transitions

Permanency Planning

DSS

Bi-directional information sharing and coordination

Medicaid & FC Plan

- A core component of supporting reunification and permanency planning is conducting **strengths and needs assessments**, within a prescribed period of time, to inform needed interventions and **referrals to physical and behavioral health services**

- FC Plan is the delivery system of the Medicaid services and is responsible for **managing the health care** of individuals enrolled in the Plan
- FC Plan care managers will coordinate with DSS to make sure children receive the **physical and behavioral health services** outlined in their permanency plans and are supported throughout their coverage and during all transitions of care

Deep Dive: Care Management

Key Design Features to Support Care Management Goals

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

DHHS is meeting with DSS to review proposed approach. Updates will be shared with stakeholders at a later time.

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

Today's focus

3. Continuity of Care & Coordination During Transitions

FC Plan Care Managers will develop a comprehensive Care Plan or Individual Support Plan to guide ongoing care management and proactively plan to support members during periods of transition.

Design Feature	Proposed Approach

Care Plan/Individual Support Plan (ISP)	• Ensure each member has a Care Plan or Individual Support Plan developed in collaboration with the member, foster parents/biological parents (as appropriate), care team and other supports
	• Develop a life transitions plan as part of the member's Care Plan/ISP to address instances including:
	  • When a member changes schools,
	  • When a member experiences a change in caregiver/natural supports
	• Ensure regular comprehensive updates to the member's Care Plan/ISP, including
	  • Every 12 months, at minimum
	  • When a member changes foster care placement (e.g. moves to out-of-home placement, is adopted)
	  • When a member transitions out of an institutional/congregate setting

3. Continuity of Care & Coordination During Transitions

FC Plan Care Managers will be responsible for performing required care management activities to support members during both life transitions (e.g. changes in placements) and clinical transitions ensure stability member stability and continuity of care.

Design Feature	Proposed Approach

Transitional Care Management Requirements	• As part of care management during transitions, FC Plan Care Managers must:
	  • Ensure continuity of care for beneficiaries in an active course of treatment during transitions between plans, clinical treatment settings and/or foster care placements
	  • Conduct discharge planning and facilitate clinical handoffs
	  • Arrange for medication management and conduct outreach to member's providers
	  • Assist members in accessing needed social services and supports as part of their transition (e.g. access to housing)
	  • Proactively develop a crisis plan for members

3. Discussion on Continuity of Care & Coordination During Transitions

- After reviewing the contract requirements for supporting continuity of care and coordination during transitions, are there any other requirements the State should consider?
- From a consumer perspective, what other supports are integral to ensuring members have continuity of care during transitions?

4. Support for Transition-Age Youth

FC Plan Care Managers 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, to provide specialized supports for health-related aspects of transition.

Design Feature	Proposed Approach

Transition Planning in Coordination with DSS	• Child Welfare Workers may request FC Plan Care Managers assist with the development of the DSS-administered Transitional Living Plan and 90-Day Transition Plan for transition-age youth. FC Plan Care Managers may assist with:
	  • Identifying key health-related goals, resources, and necessary supports in partnership with the member and their providers
	  • Ensuring accurate contact information for member's providers
	  • Identifying current medications
	  • Attending 90-Day Transition Plan meetings with the members, Child Welfare Workers and the Child and Family Team, as needed

Support for FFY Aging out of Medicaid Coverage	• FC Plan Care Managers must proactively meet with members who will age out of Medicaid coverage to discuss options for health insurance coverage and plan for transitioning all current healthcare services and medications

4. Support for Transition-Age Youth (cont.)

FC Plan Care Manager will be required to develop a "Health Passport" for members aging out of the child welfare system, as well as members aging out of Medicaid coverage at age 26, to ensure members receive critical health care-related information, guidance, and support to navigate their health needs.

Design Feature	Proposed Approach

Health Passport	• The "Health Passport" will supplement the DSS 90-Day Transition Plan and provide each member with critical health care-related information, including:
	  • Copy of the Member's full Care Plan/ISP
	  • Summary of scheduled medical visits and recommended schedule of future visits
	  • List of prescribed medications, including clear guidance on when medication should be taken
	  • Copies of all known medical records
	  • Clear guidance on how members can achieve their healthcare goals as they leave the child welfare system
	  • Information on healthcare resources that may be available to the members regardless of insurance status (e.g. State-funded mental health and substance abuse treatment programs)

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?

*Refers to the DSS administered "Transitional Living Plan – 90 Day Transition Plan for Youth in Foster Care (DSS-5096b)" comleted prior to youth's 18th birthday

5. Medication Management Services

FC Plan Care Manager will be responsible for coordinating with providers to ensure appropriate use and monitoring of psychotropic medications and prevent overmedication or dangerous medication interactions.

Design Feature	Proposed Approach
Best Practices	• Follow "Best Practices for Medication Management for Children & Adolescents in Foster Care" from the North Carolina Pediatric Society/Fostering Health NC* *(or other best practices for medication management)*
Medication Review	• Review member's medications with a qualified clinician within 72 hours of enrollment • Ensure adequate supply of essential medications
Psychotropic Medication Monitoring	• Coordinate with qualified clinician to assess and identify potentially harmful aspects of the medication regimen for members prescribed **psychotropic medications** and adjust prescriptions, as necessary • Ensure members prescribed **antipsychotic medications** receive clinically appropriate metabolic monitoring (e.g. monitoring of glucose and lipids)
Coordinate with Clinical Experts	• Coordinate closely with members' clinicians • Leverage FC Plan psychiatrist/pharmacist expertise, as necessary

*Available at: www.ncpeds.org/resource/collection/715AED5E-6572-4109-AD5E-1F064520FD69/BP_for_Medication_Management_July_2020.pdf

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

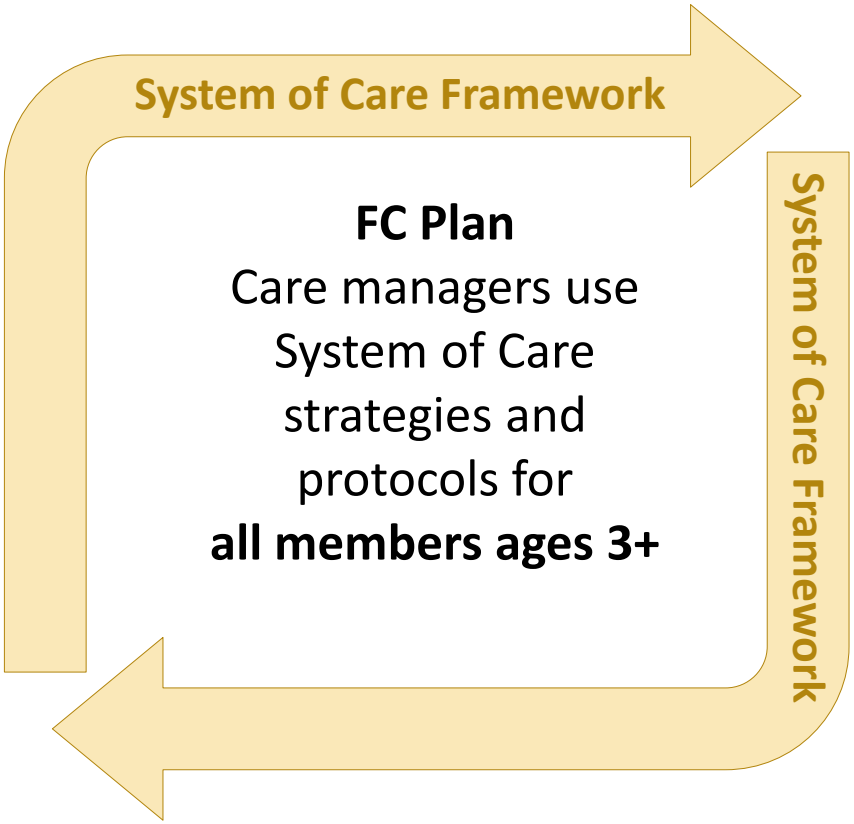
For Discussion

- 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?

*Available at: www.ncpeds.org/resource/collection/715AED5E-6572-4109-AD5E-1F064520FD69/BP_for_Medication_Management_July_2020.pdf

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)

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 #6: Provider Network and Quality**
- **Monday, July 12, 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

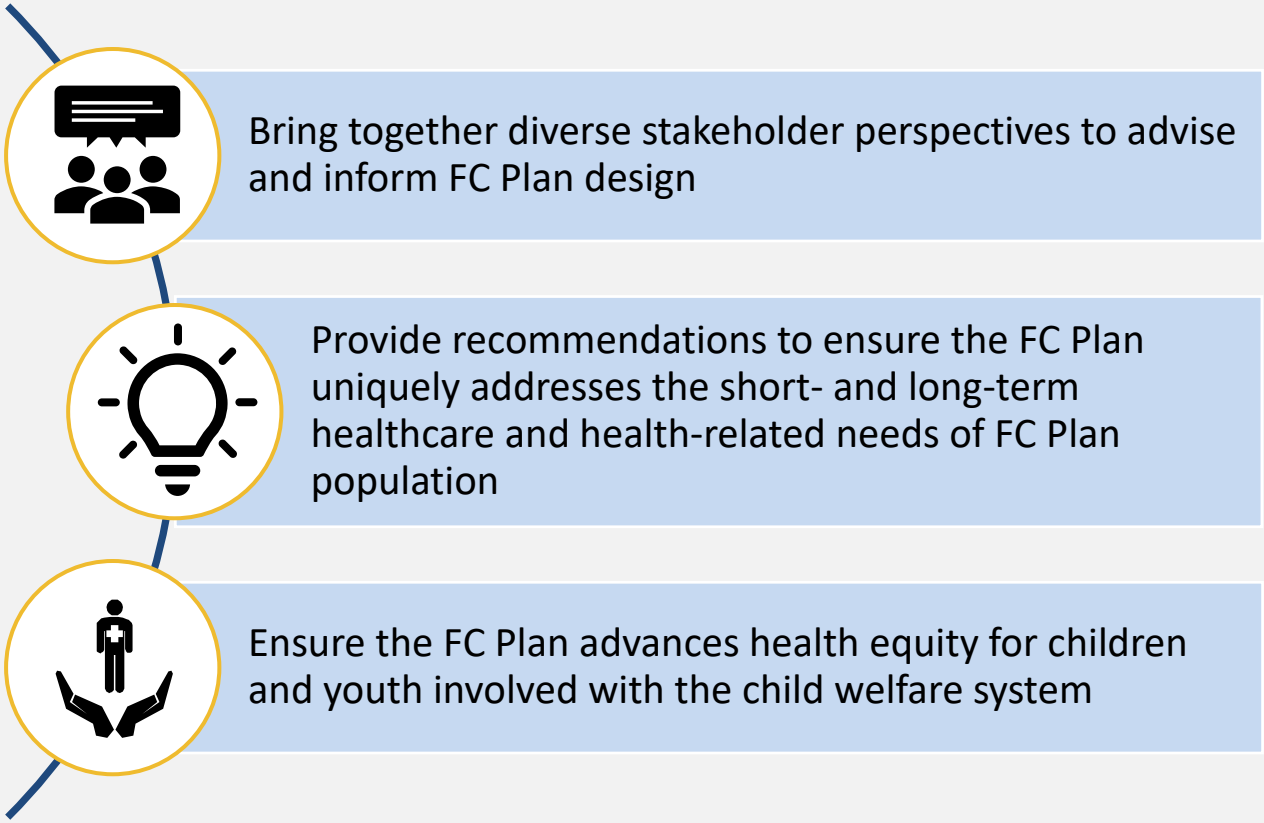
The Department will also continue to provide regular updates at:
https://medicaid.ncdhhs.gov/transformation/specialized-foster-care-plan

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

FC Plan Workgroup Participants

Name	Organization	Stakeholder
Sean Kenny (Trillium) **Rhonda Cox** (Vaya) **Lynn Grey** (Partners Health)	Representatives from*: • Alliance Health • Cardinal • Eastpointe • Partners Health • Sandhills • Trillium • Vaya Health	LME/MCOs
Julie Ghurtskaia (CCH) **Sarah Goscha (UHC)** **Matt Oettinger (WellCare)**	Representatives from*: • AmeriHealth • Healthy Blue • Carolina Complete Health • UnitedHealthcare • WellCare	Standard Plans
Kimberly Deberry	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

Available to All Members	• All members are assigned a FC Plan-based Care Manager
	• Care management provided to members:
	  • For the duration of their time in the Plan
	  • Regardless of geographic location
	  • Regardless of member's placement (e.g., residing with foster care family, PRTF)
		• 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

Whole-Person Integrated Care Approach	• Comprehensive management of each member's healthcare needs, including physical health, behavioral health, LTSS, and pharmacy needs • Led by care manager in concert with multidisciplinary care team, including DSS Child Welfare Worker, family members/guardians, and PCP/providers, among others	• Ensure coordination across all health and health-related services and across all stakeholders involved in a member's care
Delivered by FC Plan Care Managers	• Administered primarily by plan-based care managers • Working in close partnership with members' providers (with additional provider reimbursement for care team meeting participation)	• Creates single point of accountability and oversight • Promote continuity when members change placements or move across geographic areas in the state • Promote clear delineation of roles/responsibilities and streamline coordination across individuals involved in member's care, including DSS and providers, among others

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
Clear Division of Roles	• **FC Plan Care Managers:** Lead FC Plan core care management functions (e.g., care plan development, medication management) • **Child Welfare Workers:** Retain intake and assessment, placement, and permanency planning responsibilities (e.g., 7-day and 30-day health assessments)	• Ensure clear delineation of roles and responsibilities between Care Managers and Child Welfare Workers to avoid duplicating work
Coordination	• Timely initial meeting following member enrollment • Ongoing monthly meetings • Timely notification of unexpected/crisis events (e.g., member visits an ED)	• Ensure bidirectional sharing of information that is critical to facilitate health care services/reunification/permanency planning efforts
Co-location	• Co-location of 50% of Care Managers in local DSS offices • A minimum share of care managers will be co-located in rural offices	• Embed care management in the community and facilitate ongoing coordination

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	• At initial FC plan launch: 30 days prior to FC Plan launch • After plan launch: within 14 days of enrollment
Conduct initial meeting between Care Manager and DSS Child Welfare Worker	• 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) • 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)
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	• High-risk members: Within 14 days of FC Plan enrollment • Other members: Within 30 days of FC Plan enrollment
Complete initial Care Plan/ISP (note: the FC Plan must not withhold services pending completion of the Care Plan/ISP)	• High-risk members: Within 7 days of the completion of the comprehensive assessment • Other members: Within 14 days of the completion of the comprehensive assessment
Update Care Plan/ISP	• At minimum every 12 months • Within 14 days of re-assessment
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 26th 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