Specialized Foster Care Plan (FC Plan) Workgroup

Session #6: Quality and Outcomes

July 12, 2021

3:00 pm – 4:30 pm

FC Plan Workgroup

Session #6: Quality and Outcomes

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 Sessions……3:00 – 3:10 pm
- Stakeholder Brainstorm: Quality & Outcomes……3:10 – 3:25 pm
- Deep Dive: Quality & Outcomes……3:25 – 4:20 pm
- Wrap-Up & Next Steps……4:20 – 4:30 pm

Where We Are Today: FC Plan Workgroup Session #6

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
✓	June 22, 2021 3 - 4:30pm	❑ Care Management, cont.
6	July 12, 2021 3 - 4:30pm	❑ Quality and Outcomes
7	July 26, 2021 3 - 4:30pm	❑ Provider Network
8	August 9, 2021 3 - 4:30pm	❑ Workgroup Lookback and Next Steps

Today's Goals

- ***Recap FC Plan Workgroup Care Management Feedback***
- ***Brainstorm on shared vision for FC Plan quality and outcomes design***
- ***Review proposed FC Plan quality and outcomes design***

Recap of FC Plan Workgroup Feedback and Input on Care Management Design

Care Management Recap (Sessions #3-5): Overall Plan Design

- **Family Centered.** Design family-centered care management that promotes family preservation, reunification and permanency (e.g., addresses housing, SDOH), mitigates additional trauma for children and families, and ensures support for parents/guardians (e.g., biological parents, kinship, adoptive/foster parents).
- **Preventative Approach.** Ensure a proactive, preventative approach to mitigate crises and meet the objectives of the FFPSA.
- **Local Coordination.** Engage and cultivate relationships with stakeholders in local communities (i.e., school personnel).
- **Provider-Based Care Management.** 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.
- **Quality and Outcomes.** Develop strategic metrics to improve outcomes (i.e., collective scorecard) and establish clear methods for accountability.
- **Data Sharing.** Establish clear data-sharing agreements that will facilitate information sharing and coordination between FC Plan, DSS and providers.
- **DSS Coordination.** Clearly delineate roles and responsibilities for child welfare workers and FC Plan care managers to ensure clarity on who is the designated decision maker and to ensure coordination effectively work towards reunification and permanency.
- **DSS Co-Location.** Consider lessons learned from local DSS offices that have already implemented co-location and considerations for rural DSS offices for any care manager/DSS co-location design.
- **System of Care.** Align with the state System of Care model and include family/youth supports during child and family team meetings in order to identify and prevent non-clinical crises; ensure use of Tribal System of Care when appropriate

Care Management Recap (Sessions #3-5): Services to Meet the Unique Needs of the FC Plan Population

- **Transition-Age Youth**. Provide resources and supports for successful community integration (e.g., life skills training, educational/vocational opportunities, making informed decisions about their health care, and understanding how their Medicaid enrollment works).
- **Transitions of Care.** Support unique points of transitions for children and youth (i.e., reunification, aging out of foster care) in addition to clinical transitions of care.
- **Crisis Response.** Address the needs of children and youth in crisis situations and coordinate appropriate wraparound and residential services, especially for children and youth with complex needs. Crisis response and connection to services should be immediate in cases of emergency.
- **Medication Management.** Establish clear "triggers" for care managers to coordinate with clinicians on medication review, assessment and reconciliation. Update medication management plans continually and especially following transitions and crises.
- **Health Passport.** Use the "Health Passport" to empower transition-age youth with necessary information about their health, benefits and Medicaid/health insurance options. Ensure the Health Passport is available electronically.
- **"Single Level" of Foster Care.** Consider benefits of a "single level" of foster care to limit changes in placement.

Care Management Recap (Sessions #3-5): Coordinating with the Child Welfare System

- **Coordination with Other Child Welfare Stakeholders.** Consider what coordination must occur with stakeholders and private agencies that work with licensed foster families and kinship.

- **Training/Workforce Development**. Establish clear training requirements for providers and child welfare workers, including importance of medication management and trauma-informed care/assessments; ensure child welfare staff and families can make informed decisions about their care and improve fidelity to the model (e.g., leverage family partner coordinators).

- **Justice-Involved Population.** Consider what support is needed for children/youth who are involved with the juvenile justice system as well as those who have parents that are incarcerated or justice-involved.

How Stakeholder Engagement Is Informing FC Plan Design

- ***DHHS is cataloguing all input provided on FC Plan design by stakeholders through written comments, verbal comments, and chat comments.***
- ***DHHS is compiling input and identifying open design decisions and any additional stakeholder engagement that is needed.***
- ***In the fall 2021, DHHS will consider all input to determine necessary changes to the policy and operational design and facilitate a stakeholder engagement session to review updated FC Plan design.***
- ***After incorporating stakeholder input, DHHS will release a revised Concept Paper to share changes made to the FC Plan design.***

Stakeholder Brainstorm: Quality & Outcomes

Feedback Received on FC Plan Quality and Outcomes

Feedback Under Review

Public comments on quality and outcomes largely focused on the following areas:

- Support for stratifying quality measures around demographics (e.g., race, ethnicity, geography, gender, primary language, ability/disability) and incorporating additional criteria (e.g., sexual orientation/gender identity)
- Recommendation to make quality data publicly available (e.g., via an online dashboard)
- Recommendation to track long-term outcomes for children/youth (e.g., % exiting custody to permanency, # of placements)

Discussion: Quality & Outcomes

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 outcomes are we trying to achieve?

Based on what we are trying to achieve, what indicators should we measure?

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

Deep Dive: Quality & Outcomes Proposed Design

Approach to FC Plan Quality Design

The FC Plan will be required to report on a robust set of quality measures that capture the physical health, behavioral health, and SDOH outcomes of the FC Plan population. The Department intends to promote collaboration between the providers and systems that serve children and families involved in the child welfare system to achieve the highest quality of care.

To develop quality requirements that meet the unique needs of the FC population, the Department:

- ✓ Used measures that align with the **State's Quality Strategy** as a base*
- ✓ **Added indicators** that focus on needs prevalent among the FC Plan population
- ✓ Developed **Performance Improvement Projects** that seek to address significant needs or gaps in outcomes **priority areas** for the FC population

The quality design for the FC Plan emphasizes outcomes for children and youth over process.

*Where possible, the Department has aligned the measure set with existing SP and BH I/DD TP quality measures.

Proposed FC Plan Quality Measures for Children and Youth

The FC Plan will be required to report on a robust set of quality measures that capture the physical health, behavioral health, and SDOH needs of the FC Plan population.

Also a required measure for BH I/DD Tailored Plans

Also a required measure for Standard Plans

FC Plan Pediatric Quality Measures
1. Percentage of Eligibles Who Received Preventive Dental Services
2. Follow-up for Children Prescribed ADHD Medication
3. Use of Multiple Concurrent Antipsychotics in Children and Adolescents
4. Metabolic Monitoring for Children and Adolescents on Antipsychotics
5. Child and Adolescent Well-Care Visit
6. Childhood Immunization Status (Combo 10)
7. Immunizations for Adolescents (Combo 2)
8. Well-Child Visits in the First 30 Months of Life
9. Total Eligibles Receiving at least One Initial or Periodic Screen (EPSDT)
10. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
11. Rate of Other Relevant Screenings*

DHHS may continue to iterate or modify quality measures as needed

*Technical specifications are under development

Proposed FC Plan Quality Adult Measures for Former Foster Care Youth

Also a required measure for BH I/DD Tailored Plans

Also a required measure for Standard Plans

Quality measures will be monitored on a rolling quarterly basis and assessed annually

FC Plan Adult Quality Measures for Former Foster Care Youth
1. Antidepressant Medication Management
2. Continuation of Pharmacotherapy for Opioid Use Disorder
3. Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications
4. Cervical Cancer Screening
5. Chlamydia Screening in Women
6. HbA1c Poor Control (>9.0%)
7. Concurrent use of Prescription Opioids and Benzodiazepines
8. Controlling High Blood Pressure
9. Flu Vaccinations for Adults
10. Follow-up After Hospitalization for Mental Illness
11. Medical Assistance with Smoking and Tobacco Use Cessation
12. Plan All Cause Readmissions
13. Screening for Depression and Follow-up Plan
14. Use of Opioids at High Dosage in-Persons Without Cancer
15. Use of Opioids from Multiple Providers in-Persons Without Cancer
16. Total Cost of Care*
17. Rate of Screening for Unmet Resource Needs
18. Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence
19. Rate of Other Relevant Screenings*

*Technical specifications are under development

FC Plan Performance Improvement Projects (PIPs)

The FC Plan will develop and execute at least one performance improvement project (PIP) annually that falls under each of three proposed categories that focus on priority needs for the FC population: non-clinical needs, clinical needs, and transitions and continuity of care needs.

Implementing PIPs

To implement PIPs, the FC Plan should:

- Report on and analyze performance based on the Plan's quality measure set
- Participate in discussions with the State regarding performance improvement areas identified through the State's quality measurement activities
- Perform additional assessments and data collection at the plan and practice level, as appropriate
- Coordinate closely with DSS to share information and implement needed processes and supports for enrollees

See appendix for full list of proposed PIPs.

FC Plan Accountability for Quality Improvement

The FC Plan will be accountable for continuous quality improvement to ensure accountability for delivering appropriate health services and improving the outcomes for FC Plan members.

Design Feature	Proposed Approach

Continuous Monitoring	• The FC Plan must have a dedicated **Quality Director** responsible for quality management and quality of care. The Quality Director must be a licensed clinician and will participate in **monthly** meetings with the Department to discuss opportunities for performance improvement.
	• The FC Plan must report **quarterly** updates to the Department on its quality activities, including progress on performance improvement projects.
	• The FC Plan shall develop an annual **Quality Assurance and Performance Improvement (QAPI) Plan** outlining quality activities.
	• The QAPI must contain mechanisms to detect **underutilization, overutilization, and timely utilization of services**, including:
	  ◦ Use of EDs for behavioral crises (e.g., lengths of stay)
	  ◦ Lengths of stay in inappropriate settings while awaiting access to needed services
	  ◦ County-by-county use of congregate care settings (both FC Plan-funded and DSS-funded)
	  ◦ Use of community/home-based services for youth residing in foster care settings who have behavioral health diagnoses
	  ◦ Out of home placements away from a member's home (including out of state placements)*

** Greater than 30 miles/30 minutes (urban) or 60 miles/60 minutes (rural)*

FC Plan Accountability for Health Equity in Quality Outcomes

The FC Plan will be required to develop a continuous, outcomes-based quality improvement process that promotes equity through a reduction or elimination of health disparities for children and youth.

Design Feature	Proposed Approach

Health Equity	• The FC Plan will report **stratified quality measures*** by:
	  • Race and ethnicity
	  • Geography
	  • Age
	  • Gender
	  • Ability/disability
	• Performance on stratified measures will be reviewed by the Department and the FC Plan to identify and **implement interventions to reduce observed disparities** in health and quality outcomes.
	• As part of the annual Quality Assurance and Performance Improvement (QAPI) Plan, the FC Plan must also **assess and identify interventions** to reduce disparities based on:
	  • Key population group (e.g., those with physical/cognitive disabilities or those with behavioral health conditions)
	  • Member's primary language

*Statistical significance for sub-stratified measures (E.g., race by age, or geography) may be limited

Discussion on FC Plan Quality Improvement

For Discussion

- After reviewing the contract requirements for quality improvement, are there any other requirements the State should consider?
- How can quality requirements be used to support the whole family?
- What additional considerations should the Department take into account as it finalizes the quality requirements?

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 #7: July 26, 2021 (3-4:30pm)**
- **Provider Network**

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

Proposed Pediatric Quality Measures

Table 1: Survey Measures and General Measures: Pediatric*		
NQF #	**Measure Name**	**Steward**
NA	Child and Adolescent Well-Care Visit	NCQA
NA	Percentage of Eligibles Who Received Preventive Dental Services	CMS
0038	Childhood Immunization Status (Combo 10)	NCQA
0108	Follow-up for Children Prescribed ADHD Medication	NCQA
9999	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	NCQA
1407	Immunizations for Adolescents (Combo 2)	NCQA
2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA
NA	Well-Child Visits in the First 30 Months of Life	NCQA
TBD	Total Eligibles Receiving at least One Initial or Periodic Screen	TBD
2801	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA
NA	Rate of Other Relevant Screenings*	NA

*Technical specifications under development

Proposed Adult Quality Measures

Table 2: Survey Measures and General Measures: Adult*		
NQF #	**Measure Name**	**Steward**
0105	Antidepressant Medication Management	NCQA
0032	Cervical Cancer Screening	NCQA
0033	Chlamydia Screening in Women	NCQA
0059	HbA1c Poor Control (>9.0%)	NCQA
3389	Concurrent use of Prescription Opioids and Benzodiazepines	PQA
3175	Continuation of Pharmacotherapy for Opioid Use Disorder	USC
0018	Controlling High Blood Pressure	NCQA
1932	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	NCQA
0039	Flu Vaccinations for Adults	NCQA
0576	Follow-up After Hospitalization for Mental Illness	NCQA
3488	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation	NCQA
1768	Plan All Cause Readmissions	NCQA
0418/0418e	Screening for Depression and Follow-up Plan	NCQA
2940	Use of Opioids at High Dosage in-Persons Without Cancer	PQA
2950	Use of Opioids from Multiple Providers in-Persons Without Cancer	PQA
TBD	Total Cost of Care^	TBD
NA	Rate of Screening for Unmet Resource Needs	DHHS
NA	Rate of Other Relevant Screenings*	NA

*Technical specifications under development
^Total cost of care method will be finalized prior to go-live.

Other Proposed Quality Measures

Table 3: Survey Measures and General Measures: Maternal*		
NQF #	**Measure Name**	**Steward**
NA	Low Birth Weight^*	NC DHHS
NA	Percentage of Pregnant Smokers Receiving Appropriate Screening/Treatment for Smoking*	NA
1517	Prenatal and Postpartum Care (PPC)	NCQA
NA	Rate of Screening for Pregnancy Risk	DHHS

Table 4: Survey Measures and General Measures: Patient and Provider Satisfaction*		
NQF #	**Measure Name**	**Steward**
Patient Satisfaction		
0006	CAHPS Survey	AHRQ
Provider Satisfaction		
NA	Provider Survey	DHHS

^The Department will work jointly with the plans to report this measure.
*The Department may ask the Plan to conduct supplemental analyses to further refine measure specifications.

Performance Improvement Projects

The FC Plan will be required to complete at least three annual performance improvement projects (PIPs). PIPs will be focused on promoting the use of innovative measures unique to the FC Plan to achieve improved outcomes.

Non-Clinical PIPs

1. Improving timeliness of health assessment completion and care plan development
2. Improving supports to promote diversion, in-reach and/or transition
3. Improving the adequacy of behavioral health network with regards to geographic and virtual accessibility and representation of historically underrepresented groups among network providers
4. Improving educational outcomes and addressing underlying health needs/learning disabilities that contribute to poor school performance

Clinical PIPs*

1. Prevention and management of acute and chronic conditions**
2. Identification and management of psychotropic medication prescribing
3. Identification of and treatment for primary diagnosis of PTSD and underlying diagnoses
4. Identification of and care for children with special health care needs
5. Incorporation of trauma-informed competence and services, particularly for children/young adults who have a history of abuse/neglect and children/young adults who are at risk for juvenile justice involvement

Transitions and Continuity of Care PIPs

In Placements

1. Measures taken to conduct regular medical team care conferences that engage all appropriate representatives for the enrollee
2. Coordination with DSS to provide all necessary supports required to enable an enrollee to remain in a placement, provided the placement is safe and suitable
3. Measures taken to mitigate law enforcement involvement in behavioral health crises

Between Placements

4. Development of transitional care plans to ensure continuity across placements and institutional settings
5. Processes implemented to conduct regular monitoring and timely face-to-face interactions with enrollees who are temporarily in out-of-county or out-of-state placements
6. Mechanisms to involve family and DSS in care plan development and transitional care

Transitions Out of Foster Care

7. Measures taken prior to enrollee exiting foster care to reduce risk of adverse outcomes, including justice system involvement and homelessness
8. Measures taken prior to enrollee exiting foster care to ensure successful community integration

*The FC plan must consider how innovative use of care management can contribute to clinical performance improvement in their selected area(s).

**Focus areas may include, but are not limited to, the following: asthma; early childhood health and development, including well visits, immunizations, and developmental screenings; tobacco screening and cessation; behavioral-physical health integration; birth outcomes; and maternal health

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*