Enhanced Care Management (ECM) for Children and Youth (C/Y): Child Welfare

February 13, 2024

Health Plans We Support

Welcome and Housekeeping

- This webinar is being recorded
- Attendance will be tracked via log-in
- Send a message to the host if you cannot hear or see the slides
- After the webinar you will get a copy of the PowerPoint and recording link
- Participants are automatically MUTED. Please communicate via the chat
- If we are unable to address your questions in today's webinar, we will address your questions in an upcoming forum

Agenda

- Welcome and Introductions
- Learning Objectives
- Review the Child Welfare Population of Focus for ECM
- Tools to Support Coordination between Child Welfare and ECM
- Provider Spotlight
- What's on the Horizon
- Q&A

Welcome and Introductions

Nancy Wongvipat Kalev, MPH, Health Net
Senior Director, Systems of Care

Today's Presenters

Liz Arjun, MSW, MPH
Health Management Associates

Christina Altmayer
Health Management Associates

Learning Objectives

- Understand ECM eligibility for Children and Youth being served in the Child Welfare system.
- Discuss how ECM complements Child Welfare programs.
- Hear from providers who have experience aligning their child welfare and ECM work.
- Connect with other Child and Youth Providers to learn to navigate multi-sector systems.

Getting to Know You!

The Child Welfare Population of Focus

Children & Youth Involved in Child Welfare

Children & Youth who meet one or more of the following conditions:

(1) Are under age 21 and are currently receiving foster care in California;

(2) Are under age 21 and previously received foster care in California or another state within the last 12 months;

(3) Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state;

(4) Are under age 18 and are eligible for and/or in California's Adoption Assistance Program;

(5) Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months.

Notes on the Definition:

- Foster care is defined in California by WIC 11400(f).
- California's Adoption Assistance Program is defined by WIC 16120.
- California's Family Maintenance program is defined by WIC 16506 and designed to support a child or youth remaining in a safe, secure, stable home.

Key Child Welfare Programs

California Wraparound

- *Optional county-run program that provides wraparound team focused on building and implementing a care team from when a child enters the system through transition*
- *Four core services:*
  - *Engagement*
  - *Care planning*
  - *Implementation*
  - *Transition*
- *Child Family (CFT) care team*
- *Wraparound Plan*

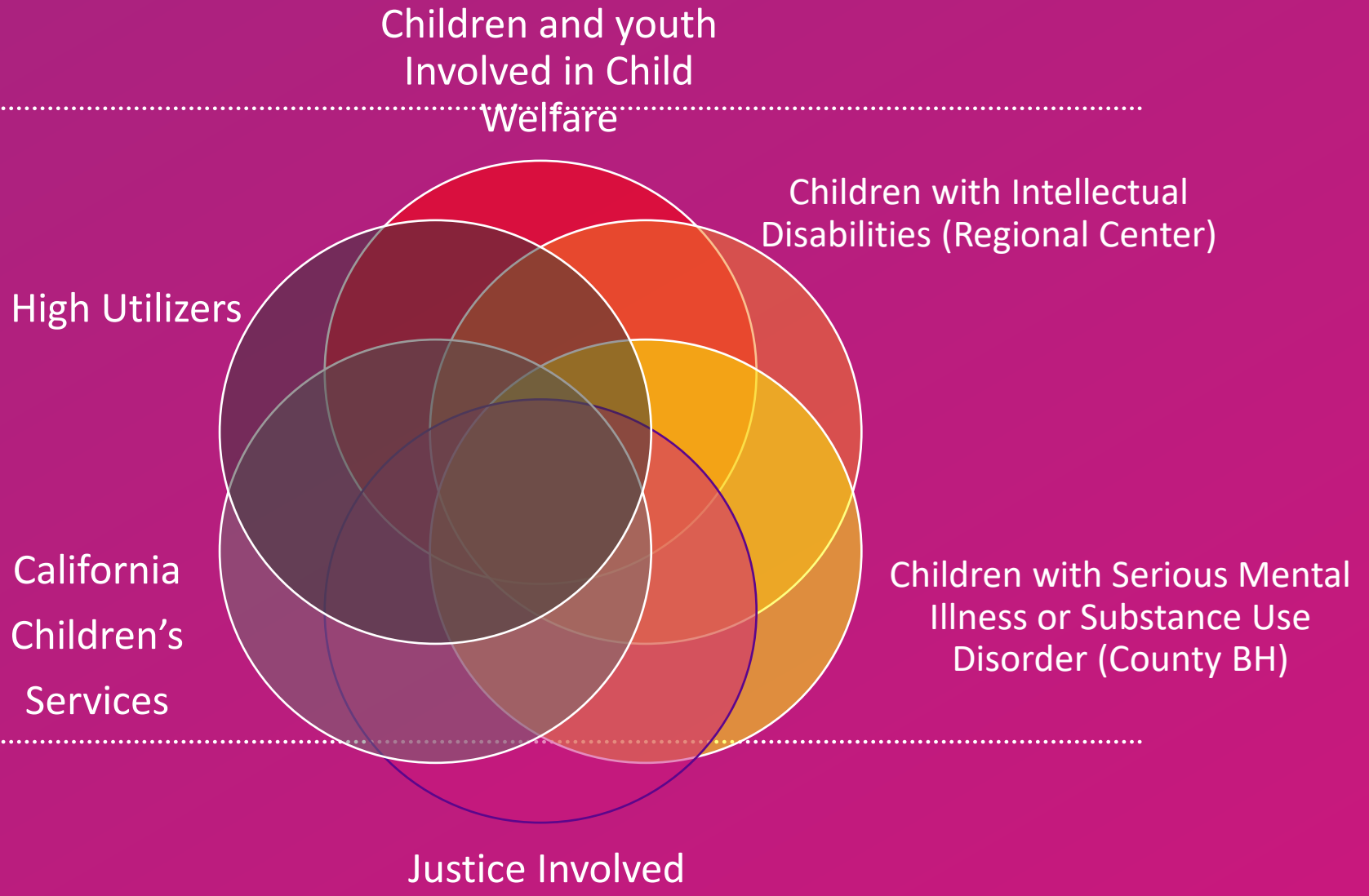
Health Care Program for Children in Foster Care (HCPCFC)

- *County child welfare agency contracts with county public health agency to provide public health nurse that is part of a multi-disciplinary care team to meet the health, social emotional needs for children in foster care*
- *Collaborative, interdisciplinary care team established through health, welfare and probation departments in the county.*
- *Care Plan and Health Education Passport*

The Child and Adolescent Needs and Strengths (CANS) is the main assessment tool in child welfare

Children and Youth are often engaged with multiple systems of care

ECM is intended to provide a **single point of accountability** to ensure care management across multiple systems/programs — the "air traffic control" role



Unique challenges in engaging children and youth in ECM

BENEFIT CHALLENGES

- ECM is likely to be **one** of several programs and care coordination services that the child/youth is receiving.
- Potential for longer ECM enrollment
- Multiple assessments exist from other systems requiring coordination
- Service utilization and related costs likely not visible to MCP.
- Community referrals critically important

PROVIDER AND NETWORK CHALLENGES

- In-person and family engagement critical to assessing child/youth needs
- Point of contact may not be member and subject to change
- Engagement and training for non-traditional providers — Providers working closely with the families may not have Medi-Cal experience and may require significant infrastructure investments.

Child Welfare Programs and ECM

ECM should include addressing other needs that are not already being met by California Wraparound or HCPCFC. Examples of applicable ECM services for this population include (but are not limited to):

- Facilitating enrollment in SNAP
- Supporting enrollment in educational opportunities and grants, such as Cal Grant B for Foster Youth and Chafee Foster Youth Grant Program
- Assisting the Member with scheduling appointments with their PCP and coordinating referrals to specialists
- Ensuring the Member's foster parents have the resources and knowledge to monitor the Member's medication-assisted treatment to address a SUD

DHCS Policy Guide

Community Supports Services: Overview

The Health Plan provides all 14 Community Supports Services

Community Support	Description
Medically Tailored Meals	Help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Meals are tailored to each member's needs based on their medical conditions. Results from providing this service include: Improved member health outcomes. • Lower hospital readmission rates. • A well-maintained nutritional health status. • Increased member satisfaction.
Sobering Centers	• Alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. • Provides services primarily to those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.
Recuperative Care	Short-term residential care for individuals who: • Do not need to be in the hospital, but still need to heal from an injury or illness (including behavioral health conditions). • Are in a condition that would be exacerbated by an unstable living environment.

Community Supports Services: Overview

The Health Plan provides all 14 Community Supports Services

Community Support	Description
Short-term Post Hospitalization Housing	• Supports members with high medical or behavioral health needs who do not have a residence. • Gives members the opportunity to continue their medical, psychiatric, substance use disorder recovery immediately after their time in recuperative care • Allows the patient's stay to be extended.
Environmental Accessibility Adaptations (Home Modifications)	• Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home. • Can include ramps, grab-bars and other home modifications.
Respite Service for Caregivers	• Provided to caregivers of Members who require intermittent temporary supervision. • Provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. • Distinct from medical respite/recuperative care and is rest for the caregiver.
Personal Care and Homemaker Services	• Provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation or feeding. • Can also include assistance with Instrumental ADLs such as meal preparation, grocery shopping and money management.

Community Supports Services: Overview (cont.)

The Health Plan provides all 14 Community Supports Services

Community Support	Description
Asthma Remediation	Includes physical modifications to a home environment, without which acute asthma episodes could result in the need for emergency services and hospitalization.
Housing Transition Navigation Services	Assists members with obtaining housing.
Housing Deposits	Assists with identifying, coordinating, securing or funding one-time services and modifications necessary to enable a person to establish a basic household. Refer to services that do not constitute room and board.
Housing Tenancy and Sustaining Services	Provides tenancy and sustaining services with a goal of maintaining safe and stable tenancy once housing is secured.
Community Transition Services/Nursing Facility Transition to a Home	Supports members who have been living in a skilled nursing facility to live in the community and avoid further institutionalization by supporting members with becoming newly housed and covering nonrecurring setup expenses.
Nursing Facility Transition/Diversion to Assisted Living Facilities	Supports individuals to live in the community and/or avoid institutionalization. The service is for individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facility for the Elderly (RCFE) or an Adult Residential Facility (ARF).
Day Habilitation	Assists the member in acquiring, retaining, and improving self-help, socialization and adaptive skills necessary to successfully reside in the person's natural environment. Services are provided in the member's home or in an out-of-home, non-facility setting.

Assessment, Care Planning and Collaborating Across Teams

The Goal: A Comprehensive Care Plan

ECM Providers should leverage Child Welfare's comprehensive assessment and care plan to inform the ECM care management plan development

Care management plans should incorporate the member's needs and strategies across the areas of:

- Physical Health Care
- Mental Health Care
- SUD Care
- Oral Health Care
- Social Supports
- SDOH Care

Reminders:

- **Services need to be coordinated and not duplicative of services provided through related child welfare programs.**
- **Children do not have to be enrolled in ECM to qualify for CS services**

Community Health Plan OF IMPERIAL VALLEY

ECM Assessment – Indicators for Connections

If the Member is involved in other programs and care team members (case manager, care coordinators, case workers, etc) should be noted in the Care Plan.

Connect with other ECM providers or refer members ECM

Section 1. Indicate the C/Y member's Population of Focus and other Los Angeles County Programs the C/Y member is involved in.

The purpose of this section is to identify other programs the C/Y member is involved in; and support you to coordinate the C/Y member's care and health-related social needs.

Population of Focus for C/Y Member: ☐Experiencing Homelessness ☐At-Risk for Avoidable Hospital/ED Utilization ☐SMI/SUD ☐Transitioning from Youth Correctional Facility ☐CCS/CCS WCM ☐Child Welfare ☐I/DD ☐Pregnant/Postpartum
(As identified on the referral/authorization form)

Programs the C/Y Member is Involved in: ☐SMHS ☐DMC ☐DMC-ODS ☐Juvenile Justice ☐CCS ☐CCS WCM ☐Child Welfare ☐Regional Center Services
☐Local program serving pregnant/postpartum individuals (e.g., Comprehensive Perinatal Services Program [CPSP], California Home Visiting Program [HVP], etc.) (List):
☐Other(s), List:
☐N/A

Date of Consent for Opt-in to ECM services: _____ ☐Verbal ☐Written
☐C/Y Member ☐Parent/Guardian/Caregiver ☐DCFS ☐Court ☐Foster parent(s)

Is anyone else in the family enrolled in ECM? ☐Yes ☐No
If yes, list family member name(s), relationship(s) to C/Y member, and ECM Provider(s):

Proactive and frequent communication should occur with these programs/members of the C/Y's care team

ECM Assessment – Indicators for Connections

If applicable, leverage available assessments.

Indicate if you used any of the following, recently completed assessments or tools to complete/inform this assessment.

The Lead Care Manager should incorporate findings from all available assessments. Assessments do not replace this comprehensive assessment but should inform development of the care plan.

☐ ACEs or PEARLS	☐ Yes. Date Completed:_____	☐ No	☐ N/A

If no ACEs or PEARLS screening completed: refer to PCP/SW for screening.

☐ CANS Assessment[1]	☐ Yes. Date Completed:_____	☐ No	☐ N/A
☐ PSC-35[2]	☐ Yes. Date Completed:_____	☐ No	☐ N/A
☐ Needs Evaluation Tool[3]	☐ Yes. Date Completed:_____	☐ No	☐ N/A
☐ Youth Screening Tool[4]	☐ Yes. Date Completed:_____	☐ No	☐ N/A
☐ (DPH Foster Care) Child Health Evaluation	☐ Yes. Date Completed:_____	☐ No	☐ N/A
☐ Protective Factors Survey[5]	☐ Yes. Date Completed:_____	☐ No	☐ N/A
☐ (DCFS) Multidisciplinary Assessment Team[6]	☐ Yes. Date Completed:_____	☐ No	☐ N/A
☐ (CCS) Patient Care Assessment	☐ Yes. Date Completed:_____	☐ No	☐ N/A
☐ (DDS) Regional Center Assessment	☐ Yes. Date Completed:_____	☐ No	☐ N/A
☐ (Pregnant/Postpartum) CPSP Assessment	☐ Yes. Date Completed:_____	☐ No	☐ N/A
☐ (Justice Involved) Re-entry Transition Plan	☐ Yes. Date Completed:_____	☐ No	☐ N/A
☐ Other(s) (list with date completed):			

[1] The Child and Adolescent Needs and Strengths Assessment is used by DCFS/Child Welfare and by SMHS/DMH
[2] The Pediatric Symptom Checklist is used by SMHS/DMH
[3] The Needs Evaluation Tool is used by DMH
[4] The Youth Screening Tool is used for Medi-Cal Mental Health Services, DHCS
[5] The PFS is used by the Prevention and Aftercare Network, DCFS
[6] The Multidisciplinary Assessment Team includes their level of care tool and the Resource Family Reporting Tool, used by DMH for a child newly entering the foster care system

Care Management for the Member also Enrolled in Child Welfare

ECM Services

- Outreach and Engagement
- Comprehensive Assessment and Care Management Planning
- Enhanced Coordination of Care
- Health Promotion
- Comprehensive Transitional Care
- Member and Family Supports
- Coordination of and Referral to Community Social Support Services

HCPCFC Case Management Service Components

- 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
- Participate in the Creation and Updating of the Health and Education Passport for Every Child as Required by Law

CA Wraparound Case Management Service Components

- A Process for strengths-based planning using a team setting that:
  - Enhances strengths by creating a strength-based intervention plan with a child and family team
  - Promotes youth and parent involvement with family voice, choice, and preference
  - Uses community-based services
  - Creates independence and stability
  - Provides services that fit a child and family's identified needs, culture, and preferences
  - Creates one plan to coordinate responses in all life domains
  - Focuses on achieving positive goals

Tip: By identifying gaps in care, you can identify where ECM and/or CS can add additional services and address gaps in care..

ECM Provider Cross Collaboration Checklist

How will you collaborate with other organizations for effective care management?

	Description	Check Box if "Yes"
Clearly Defining Roles	All involved in the member's care are identified and documented, each with roles and responsibilities outlined, agreed upon, and understood by others	☐
	Child and family are the center of the "team", informing all decisions as an equal partner	☐
Establishing Communication Channels	Determine if the member has an existing interdisciplinary or multidisciplinary care team and how interactions with this team will occur	☐
	Create a communication plan (includes frequency and type(s) of interaction – e.g., monthly zoom with quarterly in-person, updates sent to PCP and specialist between meetings)	☐
Avoiding Duplication	Understand applicable HCPC codes and service descriptions for care and case management	☐
	Create workflows showing distinct times/needs to use ECM as an additive to what is already in place for the member (could include a swim lane for this)	☐

Scenario 1: Harper Smith

Harper is a 3-year old girl who was recently placed in foster care after a CPS investigation determined that she was chronically neglected following an event where police were called to investigate a loud party at her home, where all the adults were intoxicated.

Her foster parents have taken Harper to the ER three times in the last two weeks because she was been having issues breathing; she has now been diagnosed with asthma.

She has been prescribed medicines to help manage her asthma, but her foster parents are confused about best to create an environment to prevent future attacks.

Scenario Questions

1. Is Harper at risk for future ED visits or hospitalizations?

2. Is she a good candidate for Enhanced Care Management and/or Community Supports? If so, why?

Scenario 2: Elliot Jones

Elliot is a 19-year old who recently moved to California to attend college. He was in foster care in Arizona before moving to California.

He is currently living on the couch with a former foster sibling. He was diagnosed with diabetes and has struggled with depression since high school.

He has the medicine he needs for his diabetes and SSRIs for depression, but he is concerned about his diet and finding his own place to live.

Scenario Questions

1. What else could be factors in Elliot's life that are important to his health and social well-being?

2. How can ECM and/or Community Supports support Elliot?

Provider Spotlight

Monica Dedhia, LCSW
Director of Community Health
Children's Institute, Inc
https://www.childrensinstitute.org/

Provider Spotlight

Chanel Wen Boutakidis, MA, MFT
Chief Executive Officer
Five Acres
www.5acres.org

Chat

What are some other resources, tips, or guidance you use to help inform your approach to care planning and collaboration?

How do you connect with your Child Welfare programs now?

How can the Health Plan help support local/regional collaboration with Child Welfare other child serving systems?

What’s on the Horizon

2024 Managed care plan (MCP) contract provisions

NEW CONTRACT REQUIREMENTS

Designate one individual to serve as the foster care liaison

- Foster Care Liaison should be the point of contact at an MCP for local child welfare agencies and for ECM providers working directly with children, youth, and families

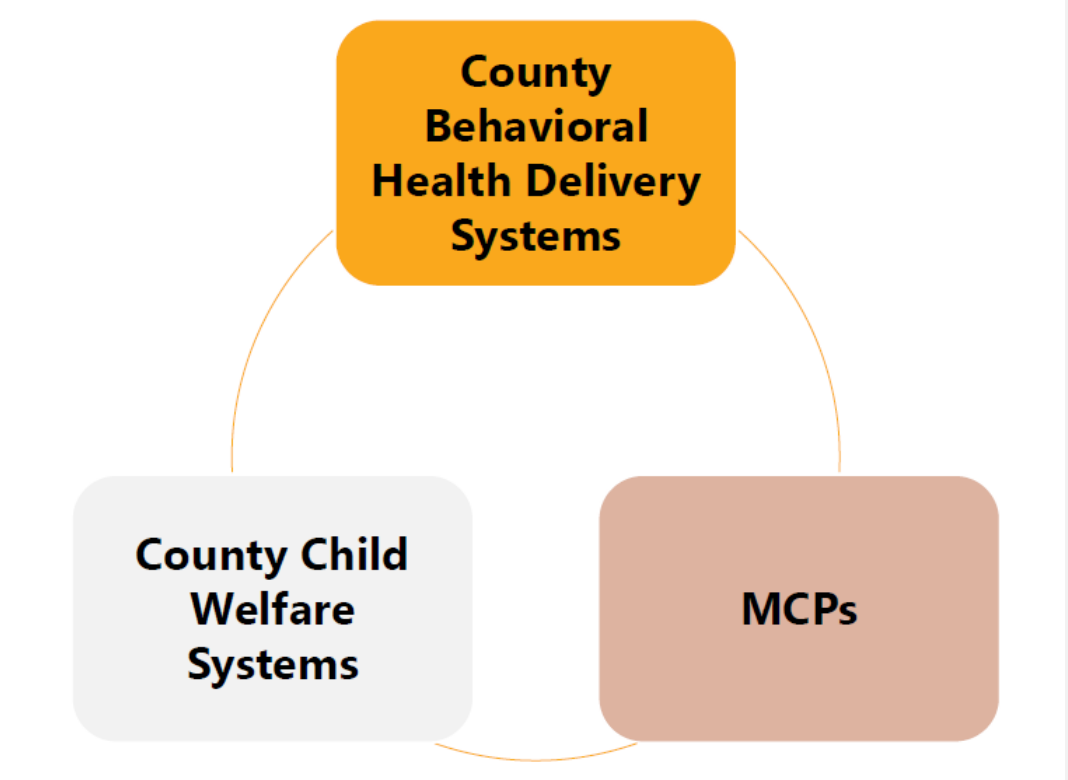
Have an MOU with local child welfare departments

- MOU should include clarifying roles and responsibilities for care coordination and data sharing requirements
- Not new requirements, but cross-reference existing responsibilities

Other Potential Initiatives on the Horizon

DHCS plans to establish a cross sector incentive program to facilitate innovation and drive outcome improvements for children involved in child welfare

DHCS requesting expenditure stipends for children involved in child welfare to promote involvement in extracurricular activities



Questions?

if time allows

THANK YOU!!!!
Before You Go…

Please Complete the Evaluation of Today's Session

Once the webinar has concluded, the survey will pop-up in a separate browser.

Health Plan Tools for Child Welfare and ECM Providers

Swim Lane – Delineation of Roles for Members Involved in Child Welfare

Steps	Health Plan	CW Providers (CA Wraparound Care Coordinators, HCPCFC Public Health Nurses, County Child Welfare Program Staff, etc)	ECM Provider*	Other Providers (e.g., PCP, specialists, school, CBOs, public health and social services programs)	Family (Biological family, foster family, relative caregiver, adopted family)
IDENTIFICATION	Use available data for timely identification	May refer to the MCP if they suspect eligibility criteria are met		May refer to the MCP if they suspect eligibility criteria are met	May self-refer
OUTREACH AND ENGAGEMENT			ECM Services offered to the member** and consult with other providers as appropriate		
COMPREHENSIVE ASSESSMENT AND CARE MANAGEMENT PLANNING		Develops and Maintains the following, as applicable: Wraparound Plans (CA Wraparound), Care Plans and Health Education Passports (HCPCFC)	Complete assessment and develop care plan, leveraging existing assessments where appropriate		
COORDINATING CARE	Facilitates assignment to the ECM Provider (preferably the existing CW Provider, if ok with the family) Foster Care Liaison facilitates connections to health plans and foster care agency partners		Whole-child care coordination, acting as "air-traffic control", facilitating access to services, helping with transition planning, and ensuring foster families have the knowledge and resources needed. This includes consultation was the Member's CFT, as applicable		
SERVICES	Ensures there is no duplication of care/case management services	Provides services, in accordance with their program and professional scope		Provides services, in accordance with their practice and professional scope	

*If the ECM provider is also the CW provider, or other provider such as the PCP or a local CBO, they would incorporate these roles into their existing workflows
**If the member's CW Provider is also their ECM Provider, ECM services could be provided where the member receives their California Wraparound or HCPCFC services.