Welcome!

We'll begin the meeting shortly.

CalAIM Foster Care Model of Care Workgroup

8-21-20

9:00 am-1:45 pm Meeting

1:45 pm - 2:00 pm Public Comment

Workgroup Members

- If using phone to call in, ensure video and phone are linked. Otherwise disconnect, and reconnect audio with option for Zoom to call you.
- Introduce yourself via chat with name, title, role, & a hope you have for today.
- Please add *Member* after your name.
- Connect your video & phone if unconnected.

Public

- Thank you for joining.
- You'll be placed on mute & your video turned off until the comment portion.
- Please email CalAIMFoster@dhcs.ca.gov with comments during the meeting and reference the agenda item. Email will be checked after the meeting.

Welcome

Will Lightbourne, DHCS Director

Kim Johnson, DSS Director

Jacey Cooper, Chief Deputy Director of Health Care Programs/ State Medicaid Director

- Data Follow-Up
- Presentations on Managed Care programs in Arizona and Washington
- Reflection and Discussion
- Behavioral Health Vision for Child Welfare
- Wrap Up & Next Steps
- Public Comment

We will take a 10-minute break at 10:15am and a 40-minute lunch break at 11:50am

Supporting better care for foster children and youth: Arizona

Shelli Silver
Deputy Director - Health Plan Operations

Presentation to the CA Foster Care Model of Care Workgroup

August 21, 2020

Who we serve

2 million total members (as of August 1, 2020)

- 1.6 million enrolled in integrated acute physical and behavioral health plans in a program called AHCCCS Complete Care (ACC)

- 13.4k kids enrolled in acute physical health plan for foster care youth called the Comprehensive Medical and Dental Program (CMDP)

    All CMDP kids also assigned to a behavioral health plan called a Regional Behavioral Health Authority (RBHA)

- 66.2k enrolled in integrated long term care physical and behavioral health plans in a program called the Arizona Long Term Care System (ALTCS)

- 243.4k enrolled in Fee-For-Service (American Indian members with choice and Federal Emergency Services Program)

Description

AHCCCS is a managed care model and has been since its inception in 1982 (Acute Program - now ACC) and 1989 (ALTCS)

Now fully integrated managed care model (except CMDP), including physical, behavioral and dental care

- Previously all Acute/ACC members received physical and dental care from one MCO and behavioral health care from a RBHA

3 geographical service areas (GSA) - North, Central, South, with choice of plan in every GSA

- 2-7 plans depending on GSA awarded via competitive bid
- Prior RFPs had been awarded for 5 years; last bids for 7 years, and now extended to 9 years

Description, continued

- RBHAs are also awarded via competitive bid and there is only 1 per GSA
  - Many changes have occurred with the RBHAs over the last 10 years due to integration efforts
  - Today the RBHAs are the integrated MCO for members determined to be Seriously Mentally Ill (SMI), and the behavioral health MCO for CMDP kids
- CMDP is a statewide health plan and, via statutory mandate, is managed by the state's Department of Child Safety (DCS)
  - Still considered a Managed Care Organization (MCO), has a contract with AHCCCS which is approved by CMS, and paid under capitated model like all other MCOs

Description, continued

- Integration has been a 10 year journey for AHCCCS using a phased approach
- CMDP will be the last program to be integrated - originally planned for 10/1/20 - now will be implemented 4/1/21
- CMDP will manage physical and behavioral health services statewide for all members
  - Arizona will be first state in nation to integrate service delivery in a dedicated health plan housed within child welfare agency
  - Awarded a sub-contract via competitive bid to full risk MCO Partner to share in management of the program

Integration Progress To Date

1989
ALTCS /EPD
29,200

2013
CRS 17,000

2014
SMI Maricopa
18,000

2015
SMI
Greater AZ
17,000

2016
AIHP/TRBHA
80,000

GMH/SA
Duals 80,000

2018
GMH/SA Adults
& Non CMDP
Children

Approximately
1.5 million

2019
ALTCS/DDD
35,000

Integration at all 3 Levels

New provider type - Integrated Clinics
Licensure changes
Provider payment incentives
Targeted Investment - $300M

ALTCS – EPD
Individuals with SMI
Non-SMI Dual Eligible Members
Children's Rehabilitative Services (one plan)
Oct 2018 – ACC/AIHP - 1.5M Children/Adults
Oct 2019 – ALTCS DD - 35,000 Members
Foster Children - 2021

Administrative Simplification – ADHS/BHS joins AHCCCS Administration
Grant/Housing Funding into Medicaid System

SMI Integration Evaluation Findings

All measures of ambulatory care, preventive care, and chronic disease management demonstrated improvement

Adult access to preventive/ambulatory health services: **+2%**

Comprehensive Diabetes Care - HbA1c: + **4%**

Medication management for people with Asthma (50% compliance): + **32%**

Medication management for people with Asthma (75% compliance): + **35%**

SMI Integration Evaluation Findings

All indicators of patient experience improved, with 5 of the 11 measures exhibiting double digit increases

Rating of Health Plan: + **16%**
Rating of All Health Care: + **12%**
Rating of Personal Doctor: + **10%**
Shared Decision Making: + **61%**
Coordination of Care: + **14%**

SMI Integration Evaluation Findings

Of the 8 hospital-related measures:

- 5 measures showed improvement
  - Emergency Department Utilization rate **decreased by 10%**
  - Readmission rate **declined by 13%**
  - Admissions for short term complications for diabetes **decreased by 6%**
  - Admissions for COPD/Asthma **decreased by 25%**
  - 30-day post hospitalization for mental illness follow up rate **increased by 10%**

Challenges and Successes

Communication, communication, communication - there is no such thing as too much communication

Success depends on shared commitment that members remain at the center of all decision making

Despite significant planning, challenges will invariably surface – may need to resolve some issues after the fact

And that may include resolving payment issues afterwards

Challenges and Successes, continued

Number of member protections in place during transition which extend for the duration of treatment or six months, whichever occurs first, and include:

- Members receiving behavioral health services from a specialist (treatment must be identified in the member's service plan)
- Members receiving an active course of treatment or ongoing care from a specialist for a serious and chronic physical, developmental or behavioral health condition (treatment must be identified in the member's service plan)
- Honor previously approved authorizations for a minimum of 30 days

Challenges and Successes, continued

Significant Need for Post-Implementation and Transition Monitoring

- Daily/weekly calls and reporting with MCOs
- Issue identification and resolution
- Pharmacy/transportation transition
- Member care coordination
- Member and provider call center stats
- Provider contracting issues
- Claims processing updates

Next steps

Full integration of CMDP effective 4/1/2021

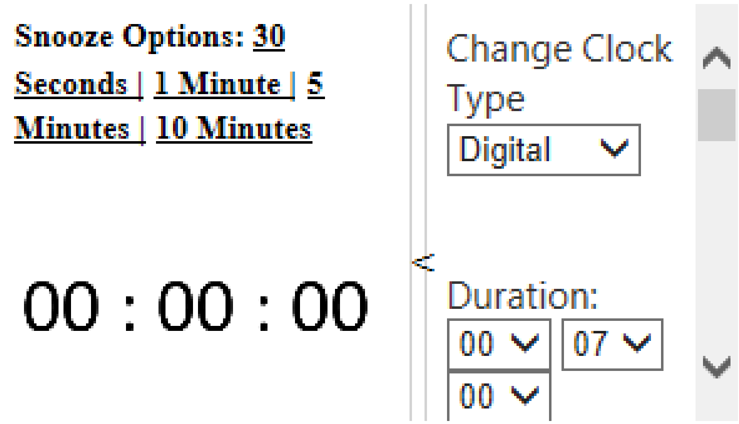
Will be renamed DCS Comprehensive Health Plan (DCS CHP)

Pre-transition meetings will begin 6 months prior to go-live

Post-implementation meetings will begin immediately after go-live

Break

Just arriving (or rejoining)?
We're on a 10-minute break.
We will resume the meeting shortly.

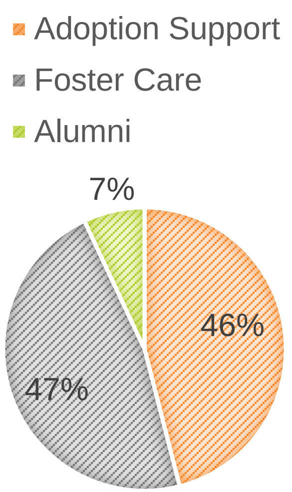


Supporting better care for children and youth in foster care: Washington State's Integrated FC Program

Presentation to the CA Foster Care Model of Care Workgroup

8/21/2020

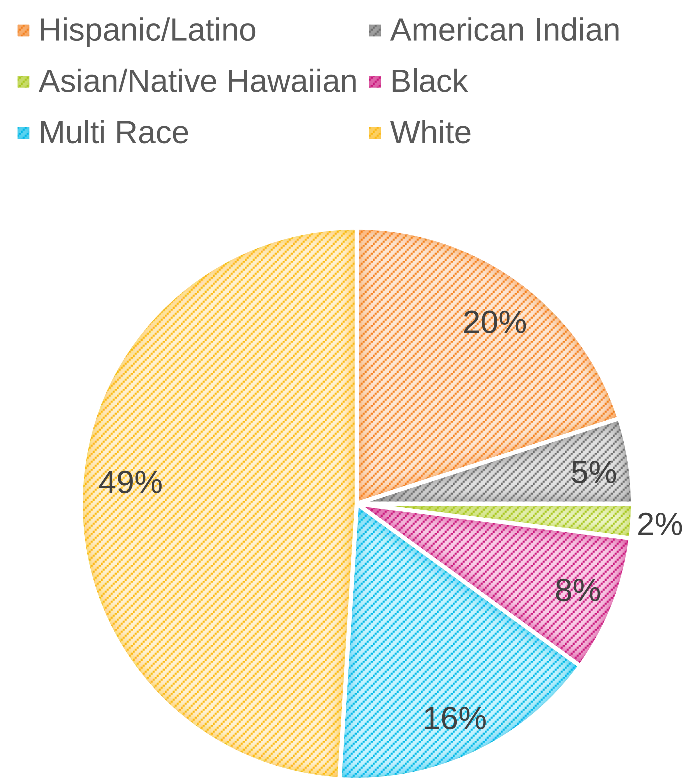
Who we serve



24,000+ members

- Children/youth in out-of-home placement
- Adoption Support
- Extended foster care (18-21)
- Alumni of foster care (18-26)
- Children/youth reunited with their parents, one year post dependency*

Average age 10



Description

coordinated care
Apple Health Core Connections

Statewide Sole Source Trauma Informed Integrated Model

- – Dental and a few other services carved out

✓ 4/01/2016 medical, pharmacy, vision, low to moderate behavioral health

✓ 01/1/2019 intensive behavioral health included

Legislatively mandated and funded through $$Medicaid and Block Grant/Wrap Around

Timeline to Sole Source Managed Care

coordinated care
Apple Health Core Connections

1997
managed care multiple plans and back to fee for service

2008
interview TX Superior Star Health

2012-2013
Stakeholder feedback development of RFP

2014-2015
AHFC RFPS

Roadshows prior to launch

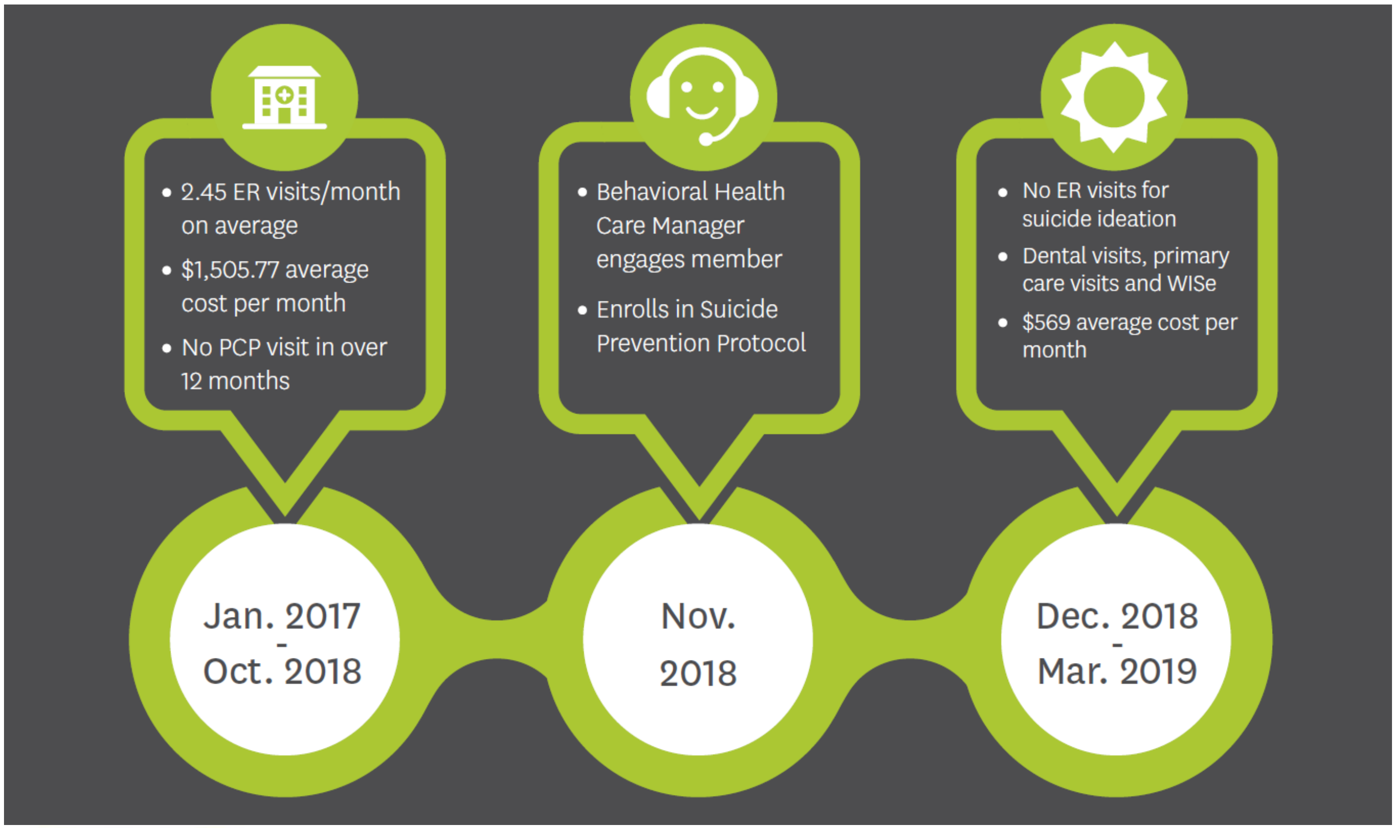
2016
Launch AHFC

2017 Role in MICP population into AHFC

2019
AHFC Integrated Managed Care and change to Single PDL

Why we do what we do

RECOVERY IS POSSIBLE.



Challenges and Success: Key lessons learned planning & pre-launch

- Communication
- Strong state agency partnership
- Good data
- Limit carve outs

Challenges and Success: Key lessons learned early implementation

- Partner with state agency for training and development of program, statewide roadshows
- Team Design: balance of child welfare experience and health care delivery system experience.
- Focus on behavioral health care
- Data risk stratification with child welfare data
- Zero Suicide: Protocols, Columbia Suicide Screening
- Screen for social determinants of health
- Develop screening process with the state

Challenges and Success: Challenges

- Length of time to get things done with multiple agencies and stakeholders
- Data agreements and data sharing
- Contract language intent didn’t match with reality
- Getting people to call us, shifting view that MCO is helpful
- Role clarity with stakeholders

Who Supported, Who Opposed

- Bipartisan legislature support
- Child welfare agency support
- Medicaid agency support
- Stakeholder communication and opportunities for feedback

Minimal opposition but there was some

- Initial fear of managed care
- Union concerns over scope of work
- Regional Service Areas/County based system

Challenges and Success: What would you have done differently

- Data sharing implementation pre-go live
- Phased in approach worked for this type of implementation
- Design fully integrated program – Dental, transportation, behavioral health
- Equity framework, culturally responsive programs
- Staffing and leadership

Customized Program

coordinated care
Apple Health Core Connections

coordinated care

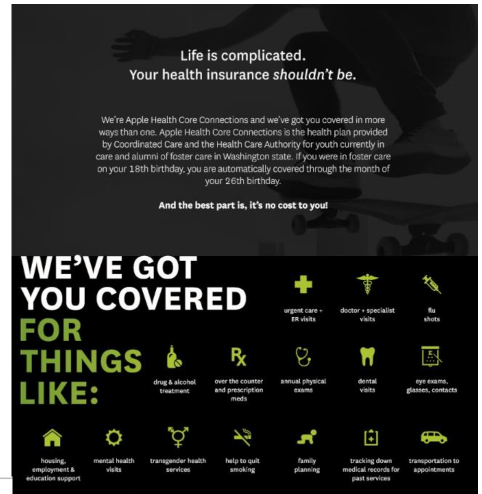
Five Principles of SOGIE-Positive Teams

PRINCIPLES FOR WORKING WITH PEOPLE ACROSS THE SPECTRA OF SEXUAL ORIENTATION, GENDER IDENTITY AND GENDER EXPRESSION (SOGIE)

Principles for Interactions

- Felt Safety
- Awareness vs. Assumption
- No Singular Experience
- Self-Forgiveness and Apology
- Make space for members to identify

Member Name:	Member ID:	
Please answer these questions about the past month.	Enter "x" to answer:	
	YES	NO
1. During the past month, have you wished you were dead or wished you could go to sleep and not wake up?		
2. During the past month, have you actually had any thoughts of killing yourself?		
3. During the past month, have you been thinking about how you might kill yourself?		
4. During the past month, have you had some intention of acting on those suicidal thoughts?		
5. During the past month, have you worked out some or all of the details of how to kill yourself?		
6. If YES to #5, do you intend to carry out this plan?		
7. Have you ever done anything, started to do anything, or prepared to do anything to end your life? Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
8. If YES to #7, how long ago did you do any of these?		
Over a year ago?		
Between three months and a year ago?		
Within the last three months?		
COLUMBIA SCORE	**0**	



"I owe you an overdue thank you for the trainings you provided to our Parent Ed Lab staff. I find them extremely valuable and I'm grateful for your time and expertise."
Seattle Schools

"To be able to offer the trainings is such a gift to our community, it's a huge help!"
YMCA Staff

"I love your training online!"
Foster Parent

Photo: Connie Lambert-Eckel Children's Administration Acting Assistant Secretary presenting award

DSHS Secretary Cheryl Strange recognized Coordinated Care's work, saying,

"All this is done through a lens of trauma-informed care, which is crucial to the needs of our children and youth as well as the families, caregivers and staff who serve them... Congratulations, your work is nothing short of remarkable."

Data and outcomes

- HEDIS Measures
- Emergency Room Diversion
- Access to Care
- Number of youth receiving health care coordination
- Connection to intensive BH out patient services

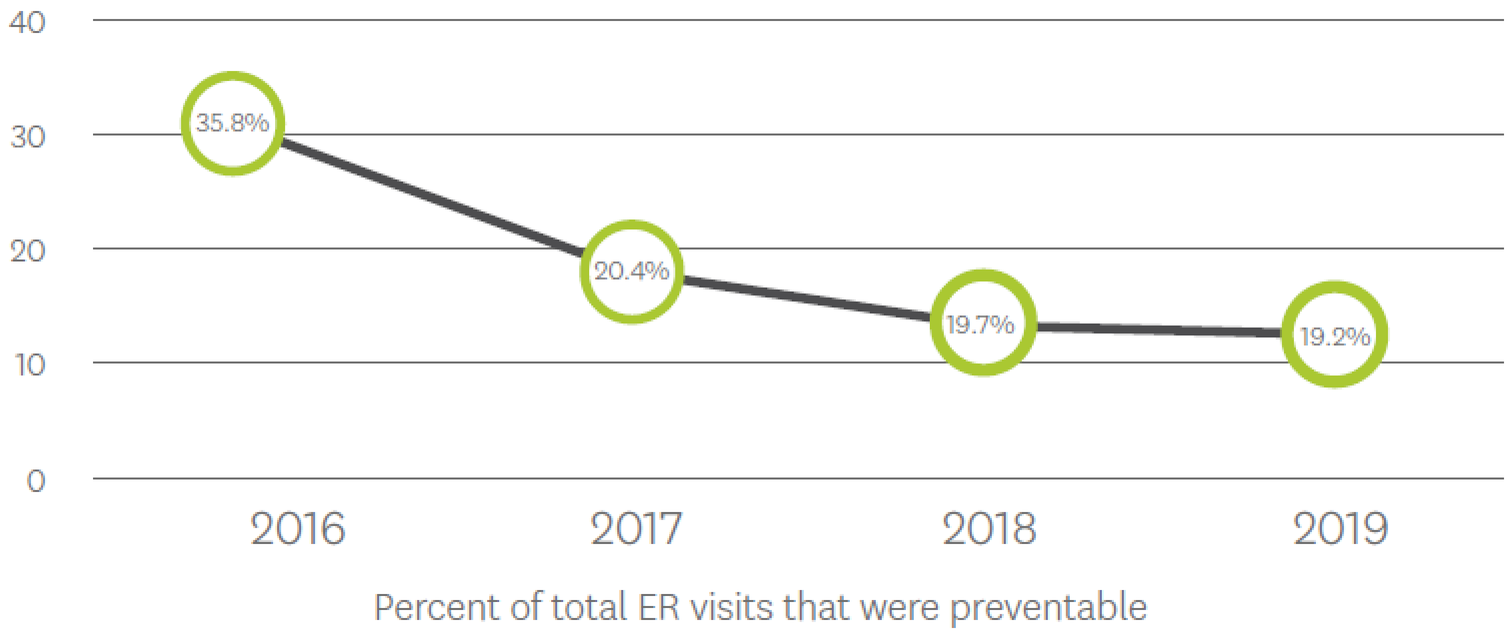
Data and outcomes

coordinated care
Apple Health Core Connections

HEDIS Measure	AHCC 2018	AHCC 2019	75th Percentile
Well Child Visits in the First 15 Months of Life	69.94%	68.56%	68.66%
Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life	73.25%	**74.78%**	78.51%
Adolescent Well Care Visits Ages 12-21	44.4%	**47.62%**	59.72%
Childhood Immunization—Combo 2	79.66%	78.71%	79.08%
Childhood Immunization—Combo 10	52.29%	**54.78%**	39.66%
Children Access to PCP 12 to 24 months	99.13%	**99.32%**	97.04%
Children Access to PCP CAP 25 months to 6 years	89.87%	**91.09%**	90.32%
Children Access to PCP CAP 7 to 11	87.21%	**88.24%**	93.41%
Children Access to PCP CAP 12 to 19	85.74%	**94.66%**	86.42%
Follow-up Care for Children Prescribed ADHD Medication Initiation	39.46%	**45.64%**	51.83%
Follow-up Care for Children Prescribed ADHD Medication Continuation	42.73%	**46.89%**	63.77%
Asthma Medication Management, Ages 5-11	27.47%	**45.83%**	34.2%
Asthma Medication Management, Ages 12-18	34.57%	**35.56%**	33.01%
First Time Psychological Care Before Prescription of Antipsychotics	13.06%	**58.37%**	68.18%
Lead Screening for Children	32.37%	32.34%	80.9%
Immunization for Adolescents	74.45%	**75.66%**	83.89%

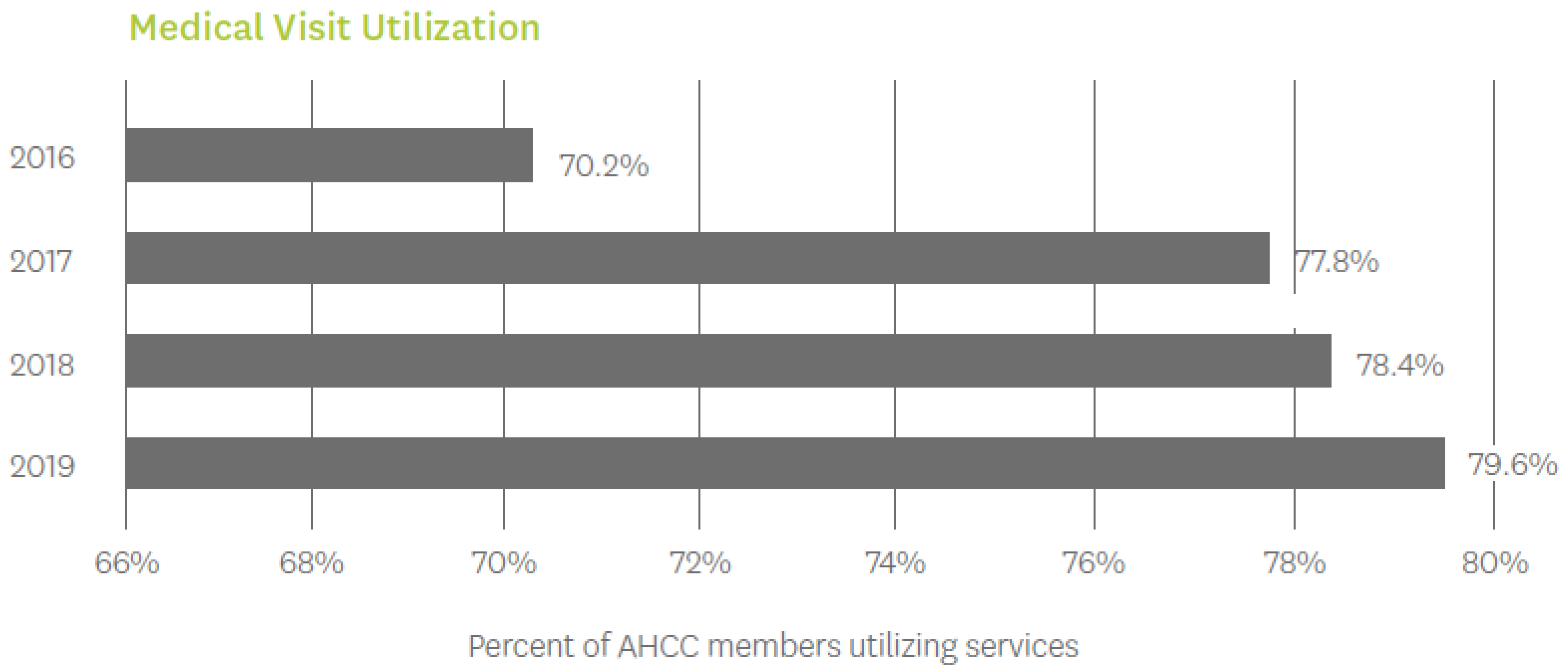
Data and outcomes

46% decrease preventable ER visits



Data and outcomes

coordinated care
Apple Health Core Connections



Data and outcomes

coordinated care
Apple Health Core Connections

Service Contracting Entity: **Apple Health Foster Care**
Medicaid Coverage Population: **All Medicaid**
Performance Measure: **Mental Health Treatment Penetration - Broad Definition**
Third-party coverage included? **No**
Age group **6-26**

May 26, 2020

Integrated Managed Care	Twelve Months Ending		
	2017Q3	2018Q3	2019Q3
Statewide	72.5%	75.0%	75.5%

Integrated Managed Care	2017Q3		2018Q3		2019Q3	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
Statewide	5,728	7,897	6,332	8,441	6,735	8,915

Data and outcomes

coordinated care
Apple Health Core Connections

Service Contracting Entity: **Apple Health Foster Care**
Medicaid Coverage Population: **All Medicaid**
Performance Measure: **Use of First-Line Psychosocial Care for Children/Adolescents on A**
Third-party coverage included? **No**
Age group **1-17**

May 26, 2020

Integrated Managed Care	Twelve Months Ending		
	2017Q3	2018Q3	2019Q3
Statewide	66.7%	68.5%	70.4%

Integrated Managed Care	2017Q3		2018Q3		2019Q3	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
Statewide	80	120	115	168	138	196

Data and outcomes

coordinated care
Apple Health Core Connections

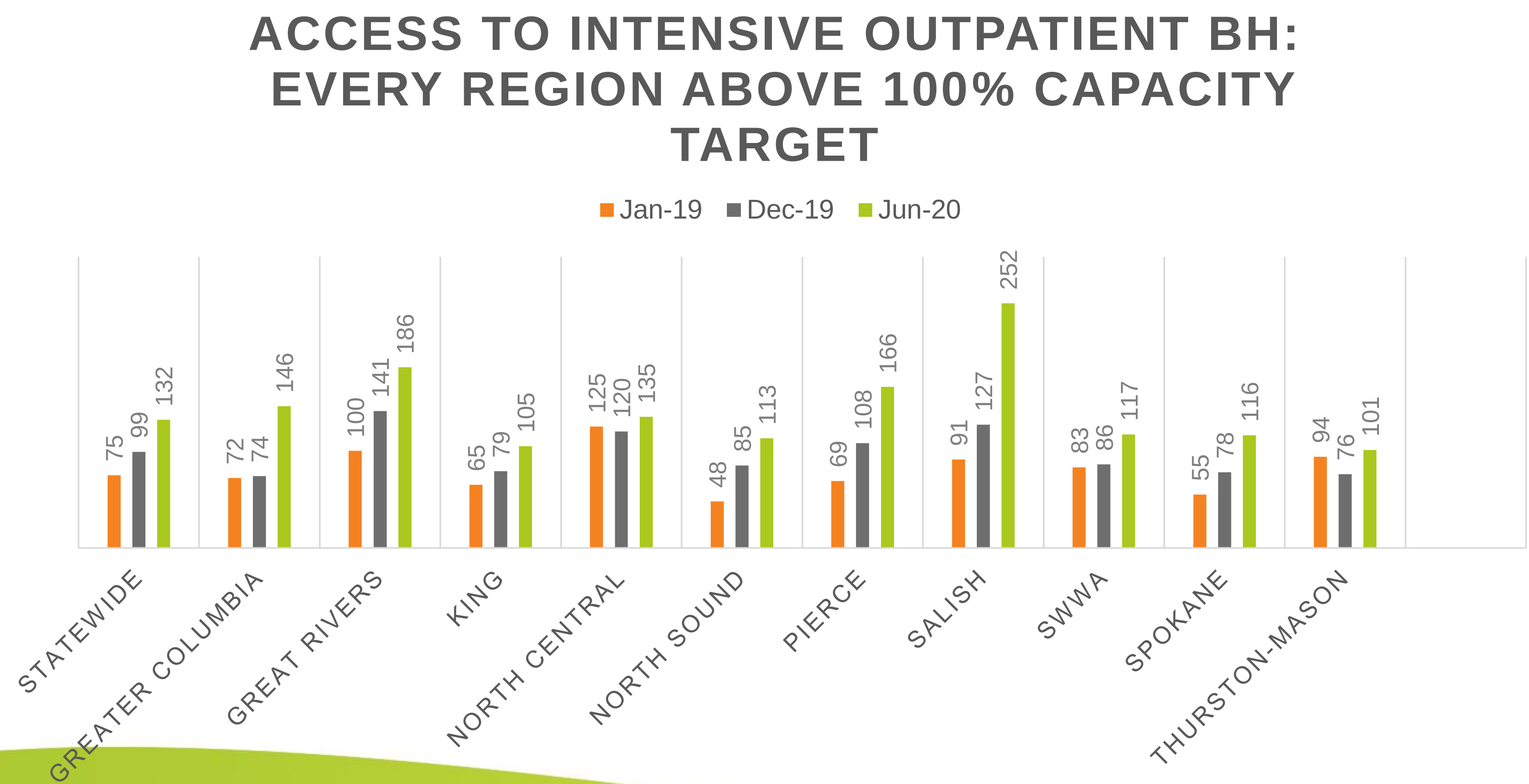
1,379 care management

7,924 care coordination

In 2019

over 30% received Health Care Coordination

Data and outcomes



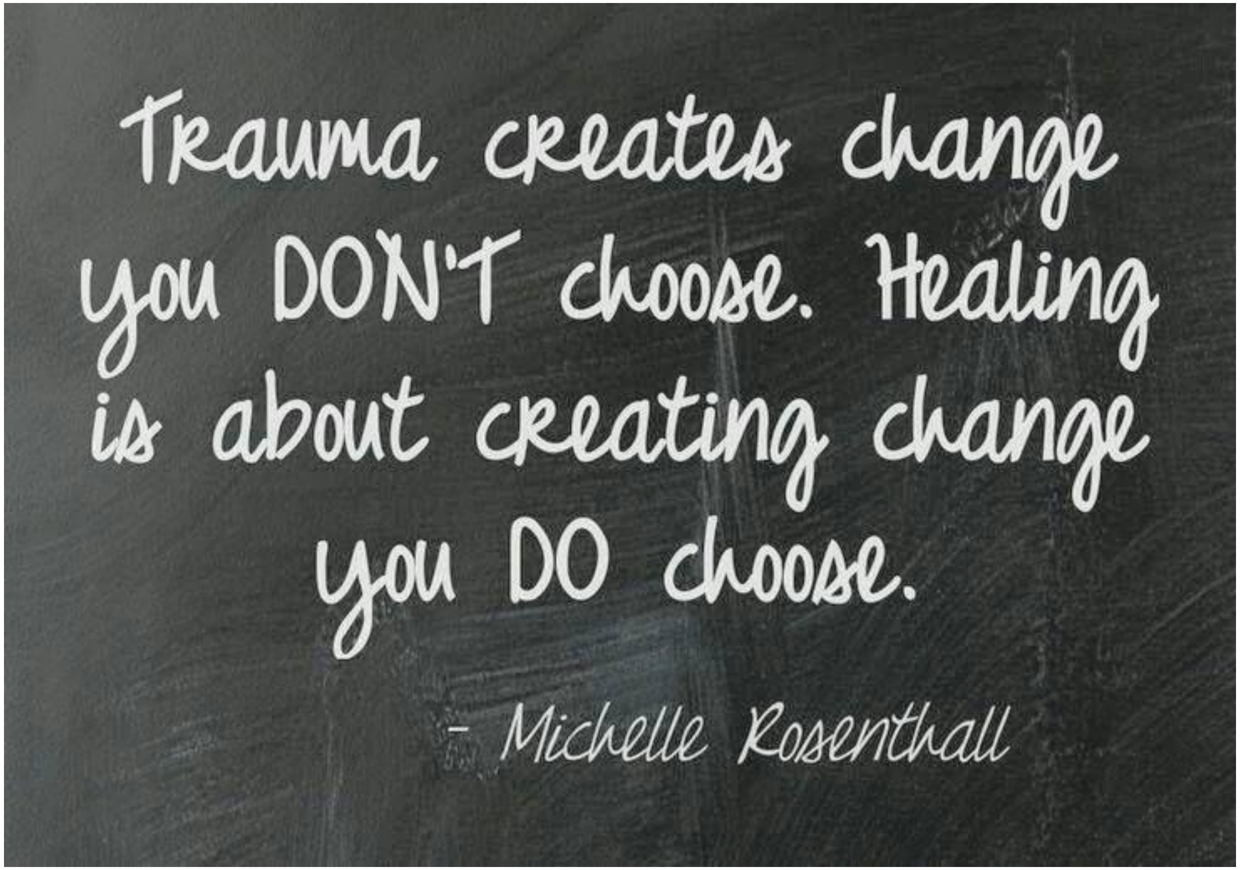
Next steps: 1 to 3 years

- Building population health specific programs
- Integrating into more child welfare processes
- Equity

Next steps: Recommendations for California

- Avoid carve outs
- Standardization if you don’t go with statewide model
- Integration medical and behavioral health
- Full integration in a region at a time
- Include Tribal from the beginning

Questions?


Trauma creates change you DON'T choose. Healing is about creating change you DO choose.
- Michelle Rosenthall

- What did you see in the presentations of WA and AZ that informed your opinion about the value (or lack thereof) of a single statewide plan or “model of care?”

- What are your thoughts about the value of an integrated behavioral, physical and oral health model of care?

- Were there examples from WA and AZ that demonstrate a strong connection between the model of care and the needs identified by the child welfare system of children in foster care?

Identified Problems

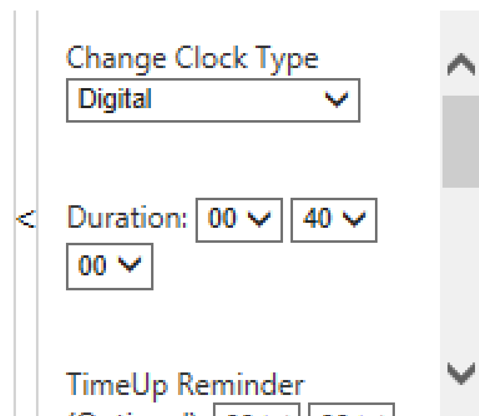
- Interruption of continuity and stability
- Poorly defined outcomes and little accountability
  - Lack of data
- Difficult to navigate systems
  - Need more coordination and integration of services for youth
- Lack of capacity to meet the unique needs of foster youth: trauma, separation, and loss
- Need more timely and appropriate levels of care
- Inadequate focus on ensuring equity and equitable outcomes

- …What else?

Break

Just arriving (or rejoining)?
We’re on a 40-minute break.
We will resume the meeting shortly.

00 : 40 : 00



County Behavioral Health Directors Association California

CWDA

Advancing Human Services for the Welfare of *All* Californians

COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA (CBHDA)

COUNTY WELFARE DIRECTORS ASSOCIATION OF CALIFORNIA (CWDA)

JOINT BEHAVIORAL HEALTH VISION FOR CHILD WELFARE

PRESENTATION TO THE FOSTER CARE MODEL OF CARE WORKGROUP

AUGUST 21, 2020

PRESENTATION OVERVIEW

1. Context setting - *Michelle Cabrera, CBHDA and Cathy Senderling McDonald, CWDA*
1. Proposal Overview - *Diana Boyer, CWDA*
2. Eligibility and Teaming - *Diana Boyer, CWDA*
3. Services - *Molly Kholos, CBHDA*
4. Additional Considerations – *Molly Kholos, CBHDA*
5. Summary/Discussion/Questions - *All*

CONTEXT SETTING

CBHDA/CWDA Proposal:

- A visionary document for serving children, youth and families who are impacted by abuse, neglect and exploitation.
- Informed by growing body of research on the impacts of childhood trauma and exposure to toxic stress.
- Maps out a full continuum of services from prevention to intensive intervention. Services follow the child/family from "start to end".
- Necessary if we are to achieve Continuum of Care Reform goals and improve child, youth and family outcomes.

PROPOSAL OVERVIEW

Addresses:

- The "who": Eligibility and who should receive services
- The "what": What services should individuals have access to.
- The "how": Manner that we identify services to deliver and reduce barriers to those services.

CWDA and CBHDA propose:

"Automatic eligibility for child welfare system-involved children and youth and their families to a minimum, mandatory set of behavioral health services."

ELIGIBILITY

Automatic eligibility for children/youth served by the child welfare system to receive Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) Services.

This would include:

1. Children/youth who come into foster care (under juvenile court order) and who are served by a child welfare or probation agency.
2. Children/youth 6 months post-permanency (reunification, guardianship or adoption).
3. "Candidates" for foster care under the "imminent risk" definition per FFPSA*

*Families First Prevention Services Act (FFPSA) – Federal legislation approved in 2018 that permits states to serve children and their families who are at risk of foster care using foster care funding for direct services designed to prevent foster care entry.

ELIGIBILITY

Candidacy definition (pending definition under FFPSA):

- A child who is identified as being at **imminent risk** of entering foster care, but **who can remain safely at home as long as prevention services are provided**.
- **"Imminent Risk"** may be determined by the caseworker based upon an in-person assessment and includes one or more of the following criteria:
  - The child's risk assessment score is high or very high or the child' safety assessment indicates the presence of at least one safety threat.
  - The child has one or more siblings or half-siblings placed into foster care.
  - The child's adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement.
  - The youth is a nonminor under the age of 21 who is eligible for extended foster care, and their living arrangement is at risk of a disruption that would result in the youth re-entering foster care.
  - Other criteria includes referral from a tribe if the child is an Indian child, if the child is under the supervision of a juvenile court pursuant to a Section 300 petition and under a family maintenance plan, and if the probation department has determined that a child subject to a Section 602 petition needs prevention services to prevent the child's entry into foster care.

ELIGIBILITY

"Family" also entitled to behavioral health services. Family includes:

- Resource parents (including relative caregivers)
- Birth families (including siblings and half-siblings)
- Other caring adult who is a significant support to the foster child/youth, and
- Any other non-related persons with an established relationship that is reasonably considered family by the person served.

Because Medi-Cal is a provider of last resort, any privately insured individual will not be automatically eligible for Medi-Cal services covered by their private insurance. Service and payment alignment will require further discussion.

ELIGIBILITY

“Automatic Eligibility”

- **Child/youth/NMD is eligible for services no matter what - a “diagnosis” of impairment is not a pre-condition to eligibility.**
- Recognizes that every child who is served by the child welfare services system has experienced a significant enough degree of trauma that they meet the new standard for medical necessity, as proposed under CalAIM.
- A diagnosis will still be determined to inform clinical treatment needs, but it is not the precursor to obtaining services.
- All children will receive some type/level of services based on a more complete, team-based assessment that will be described next.

SERVICES

- Broadest range of services based on individualized needs.
- A continuum of services that includes:
  - resiliency building and wellness-oriented services to prevent the onset of behavioral health issues later
  - primary intervention services that include clinical therapies
  - embraces "full-service partnership" efforts that embody a "do-whatever-it-takes" approach to child safety, permanency and well-being.

SERVICES

Model builds upon work underway:

- Integrated Core Practice Model
- Katie A. Settlement Agreement/Continuum of Care Reform Efforts
- Strengthening Families/Youth Thrive Frameworks
- AB 2083 Interagency Coordination

Team-based services begin immediately upon “entry” to CWS services.

- For timely identification of service needs and access to services.
- Not waiting for behaviors to manifest first.
- Reduces likelihood of more intensive, higher cost interventions later.

SERVICES

Team-Based services through a broadened ICC (Intensive Care Coordination) effort:

- Team includes both CWS social worker and a behavioral health specialist/case manager
- BH specialist/case manager can serve as the ICC coordinator to work with the Child and Family Team to coordinate services.

SERVICES

Team Responsibilities:

1. BH/CWS "team" engages with the family within 30 days of coming to CWS attention via the CPS Hotline.
2. Provides immediate and on-going engagement of the youth and caregivers throughout the life of the case & "on demand" clinical or supportive services as warranted in home-based settings.
3. Continuous screening and joint assessments to inform the CANS as part of the CFT discussions and link to clinical and resiliency-building services.
4. Assist CWS social workers in case plan development.
5. Ensuring linkage to clinical and non-clinical services/supports.

RESILIENCY BUILDING / WELLNESS ORIENTED SERVICES AND SUPPORT

Trauma Informed-Resiliency Building Therapeutic Services

- Programs must be trauma informed, culturally responsive and evidence based
  - Examples: 3-5-7 Model, Parent/Child Interactive Therapy, Trauma-Focused Cognitive Behavioral Therapy, Functional Family Therapy, Multi-Systemic Therapy, etc.

EXPANSION OF MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES (SMHS)

- Individual Child and Family Therapy
  - Provide within the home/community (if client is comfortable with the setting)
  - Create flexibilities to deliver this services to the caregivers, parents and family members, with or without the child/client present.
- Therapeutic Behavioral Services (TBS)
  - Expand eligibility criteria
  - Include less intensive, coaching services within TBS
- Intensive Home-Based Services (IHBS)
  - Expand eligibility criteria, such as for "candidates" of foster care
- Z & V Billing Codes

PROGRAM MODELS / BEST PRACTICES

- Therapeutic Relationship- Building Services for Families
  - Provided to a parent or caregiver who needs interventions to strengthen their ability to engage and respond to their child
- Family Reunification Partnership (FRP) Program
  - Fully integrated Behavioral Health and Child Welfare approach targeted for children, youth and families in reunification
- Adopt Full -Service Partnerships and Wraparound Programs for Child-Welfare Linked Populations
- Increase Peer Support – Youth and Parent Partners

SUBSTANCE USE DISORDER (SUD)

SUD Evaluation

- Ensure that CFT/CANS includes SUD evaluation at the forefront for the child/youth, caregiver and parent
- Increase integration and coordination for those children, youth and caregivers with mental health, SUD and, co-occurring MH and SUD treatment needs
- Additional funds should be allocated to build out this system of care to provide all necessary SUD services to child welfare linked populations

INTENSIVE NEEDS YOUTH – ACUTE CARE DELIVERY

Explore alternate funding and program models for high needs children/youth

- Ensure suitable treatment and facility types are available for those with acute needs such as, Commercially Sexually Exploited Children (CSEC), those with SUD treatment needs and those with co-occurring developmental delays and mental health needs

ADDITIONAL CONSIDERATIONS

Workforce, Training and Funding:

Workforce:

- Prioritize capacity building in partnership with counties.
- Must be culturally-responsive and reflective of the diversity of the population.
- Include para-professionals including peer advocates.

Training: Support cross-training of CWS and BH staff.

Funding: Additional investments will be necessary to support staffing and services envisioned in this proposal. Further discussion needed to quantify.

Summary/Discussion/Questions

Summary of Key Elements:

1. Automatic eligibility to SMHS for child-welfare involved children, youth and caregivers
2. Teaming between CWS and BH from 'start to end'
3. Full continuum of services, including resiliency-building prevention services to more intensive services
4. Commitment to build workforce and capacity and funding for services
5. Builds toward full realization of CCR goals to reduce congregate care use and increase support for placements with relatives and in the most family like settings possible.

Discussion & Questions

- What would it take for individual county plans to achieve the state-wideness and continuity of care potentially achieved under a single statewide plan?

Next Steps

Transition to Public Comment Period

Thank you for joining the Public Comment Period

- Please raise hand to be put in comment queue
- We will call on you and you will have 2 minutes to comment. Please unmute yourself only when commenting to eliminate noise.
- You may also comment via chat or by emailing CalAIMFoster@dhcs.ca.gov

Snooze Options: 30 Seconds | 1 Minute | 5 Minutes | 10 Minutes

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Change Clock Type

Digital

Duration: 00 02 00

TimeUp Reminder (Optional): -- -- --

Choose Sound Effect Tick

Choose TimeUp Sound Alarm

☐ Enable Count Up ☐ Combine With Bar Clock

Start Pause Stop Reset

CalAIM Foster Care Model of Care
Workgroup Timeline

Together, we're re-imagining a responsive model of care that prioritizes and supports our children and youth touched by the foster care system to be healthy, whole and connected.

JUN 2020

Discuss workgroup goals and objectives, charter, and scope of work;
Review current policies and delivery systems;
Identify high-level challenges/short-comings

JUL 2020

Review national models of care;
Discuss approaches (short-term and long-term) in terms of a model of care for this population;
Discuss implications in lieu of services, Enhanced Care Management, and Behavioral Health Medical Necessity

AUG 2020

Review list of previously identified challenges to begin building consensus on short-term and long-term challenges

OCT 2020

Develop a working paper on identified challenges and corresponding proposed short-term / long-term solutions;
Request stakeholder comments on working paper

DEC 2020

Discuss challenges and corresponding proposed short-term / long-term solutions;
Request stakeholder comments on proposed short-term / long-term solutions;
Further refine working paper

FEB 2021

Review proposed recommendations;
Review and discuss stakeholder feedback;
Engage in consensus building on final recommended model of care approach

APR/JUNE 2021

Present final recommended model of care / approach

Rev 7/22/20