# Defining the Collaborative Roles of Local Department of Social Services Case Managers, Voluntary Foster Care Agency Case Planners, and Health Home Care Managers

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A collaboration between IPRO, the New York State (NYS) Department of Health's Office of Health Insurance Programs (OHIP) and the New York State Office of Children and Family Services (OCFS). Its purpose is to assist Voluntary Foster Care Agencies in fulfilling their role as downstream Health Home Care Managers for children who are eligible for Health Home Care Management and are in foster care.

# Introductions and Today's Presenters

- Laura Velez, Deputy Commissioner, OCFS
- Lana Earle, Deputy Director, NYS DOH
- Mimi Weber, Bureau Director, OCFS
- Lisa Fiato, NYS DOH
- DOH and OCFS consulted with a group representing VFCAs, Local Social Service Districts, Island Peer Review Organization (IPRO), the New York Care Coordination Program (NYCCP), and the Sidney Albert Training and Research Institute (SATRI) to prepare this presentation.

  We thank them for their assistance.

# Context and Objectives

- Children in foster care may also be eligible for Health Home Care Management. Foster care does NOT make a child automatically eligible for Health Home Care Management.
- The Health Home Care Management Model for Children recognizes that children in foster care are in the care and custody of the Local Department of Social Services (LDSS) and as such requires that the Voluntary Foster Care Agency (VFCA) be the downstream care manager to provides Health Home Care Management to eligible children in foster care. Health Homes must contract with VFCAs to provide care management to Health Home eligible children in foster care.
- The integration of the role of the Health Home Care Manager (HHCM) within the child welfare system, and collaboration with the LDSS Case Manager and the VFCA Case Planner, will enhance the stability, overall health outcomes, and well being of the child.

# Context and Objectives Continued

- Today's Health Home training will:
  - Provide an overview of the New York State child welfare system and Health Home Care Management
  - Define the roles of each of the following parties in meeting the goals and requirements for children who are in foster care and also enrolled in Health Homes
    - Local Department of Social Services (LDSS) Case Manager
    - New York City Administration for Children Services (ACS) role
    - Voluntary Foster Care Agency (VFCA) Case Planner
    - Health Home Care Manager (HHCM)
- Future training will be scheduled for the Health Home Care Managers on understanding the Child Welfare System

# NYS Child Welfare Framework

To protect children from abuse and maltreatment, NYS created a child protective system (CPS) with the following:

- Mandatory and voluntary reporting of suspected child abuse and maltreatment to the NYS Office of Children and Family Services (OCFS) State Central Register (SCR).
- LDSS engage in child protective services investigations.
- When necessary, LDSS removal of a child and placement into custody by Family Court order.
- OCFS provides oversight and monitoring to each LDSS (Administration for Children's Services (ACS) in NYC).

When a child enters foster care, s/he is immediately assigned a **Case Manager** by the LDSS. The LDSS Case Manager plays a critical role in working with that child and family towards permanency, safety, and well-being.

Children in foster care are categorically eligible for Medicaid (to be eligible for Health Home services, the child must be enrolled in Medicaid and meet the Health Home eligibility and appropriateness criteria).

# New York State Child Welfare Operational Model

- New York State is a state supervised, locally operated child welfare system: State supervised by OCFS and locally operated by LDSS. LDSS in NYS includes:
  - 57 counties
  - NYC's ACS (the 5 Boroughs of NYC) and
  - St. Regis Mohawk Tribe

- LDSS maintains care and custody of children removed from their home.

# A note about New York City

- The New York City Administration for Children's Services (ACS) has delegated the majority of LDSS Case Management functions to the Voluntary Foster Care Agencies (VFCA). The VFCA assumes the role of the LDSS Case Manager in New York City.

# Foster Care

The general rule in foster care is to place the child in the least restrictive, most family-like placement appropriate to meet the needs of the child. The HHCM will enhance and support the ability to achieve this goal.

Foster care placements include:

- **Direct Care Foster Care -** Children who are placed in foster homes licensed by the LDSS. This includes approximately 3,500 children across NYS.
  - Children in Direct Care Foster Care were transitioned to Medicaid Managed Care between April 1, 2013 – September 2013.
  - Children in Direct Care Foster Care receive their Medicaid benefits through Medicaid Managed Care Plans. All other children in foster care will transition to managed care in 2017.

# Foster Care Continued

Most LDSS have contracts with VFCAs to assist with the placement and care of the majority of children in foster care.

- **Foster Boarding Home** - These homes receive a certificate to provide foster care after a VFCA/LDSS home study finds that the family and household meets the certification requirements. The certificate limits the number of children to be placed in the home and states any other restrictions on placement. This process includes specialized foster homes such as Therapeutic Foster Boarding Homes.

# Foster Care Continued

- **Congregate Care -** Congregate care placements are group foster care placements operated by Voluntary Foster Care Agencies.

  - Group Homes (less than 12 beds)
  - Group Residences (12-24 beds)
  - Institutions (aka Residential Treatment Centers) (25+ beds)
  - Supervised Independent Living Programs (SILPs)
  - Agency Operated Boarding Homes (AOBH)

# Safety, Permanency, Well-Being

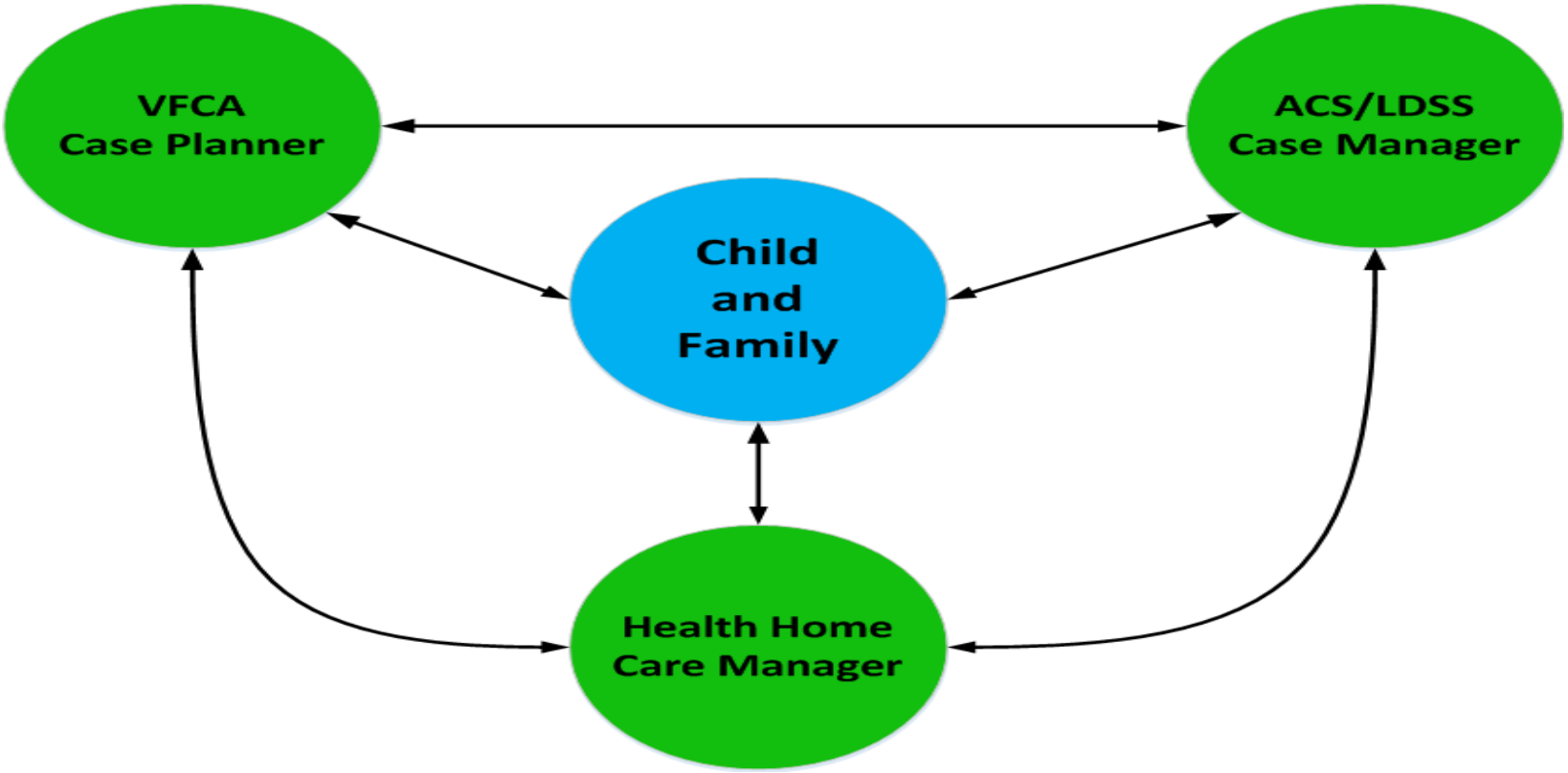
- When a child is removed from their home and placed in foster care, the LDSS and VFCA both have key roles in assuring the safety, permanency, and well-being of that child.

- Today's presentation will identify the roles of the LDSS Case Manager, the VFCA Case Planner, and the HH Care Manager, and discuss how they will collaborate to achieve these goals.

# NYS Children's Health Home Expansion

- Health Homes designated to serve children will begin enrolling eligible children in January 2016.
- Children enrolled in foster care may also be eligible for Health Home Care Management. Foster care status does NOT make a child automatically eligible for Health Home Care Management.
- VFCAs are required to be the downstream care management provider for Health Home eligible children/youth in foster care.
- The LDSS Case Managers, VFCA Case Planners, and HH Care Managers will function as a team to develop mutual goals to obtain optimal outcomes.

# A New Team Approach for Serving Children and Families in Voluntary Foster Care Agencies



# Who is eligible for Health Home Care Management?

- Medicaid (children in foster care are categorically eligible for Medicaid)
  - Fee for Service
  - Managed Care
- Health Home Eligibility Criteria
  - Does the individual meet Health Home eligibility criteria?
- Appropriate for Health Home
  - Not every child in foster care that meets Health Home eligibility requirements will be appropriate for Health Home. Does the child need the comprehensive care management provided by the Health Home?

# Current Health Home Eligibility Criteria and Proposal to Modify Health Home Eligibility Criteria (Modifications in *Bold*)

Person must be enrolled in Medicaid and have:

- Two or more chronic conditions or
- One single qualifying condition of
  - ✓ HIV/AIDS or
  - ✓ Serious Mental Illness (SMI) / Serious Emotional Disturbance (SED)*

***NOTE: Complex Trauma: discussions are underway with CMS to include trauma as an eligibility criteria.***

* As defined, upon CMS approval detailed definitions will be provided, See April 29, 2015 Webinar posted to DOH Website for Additional details

Chronic Conditions Include:

- ✓ Alcohol and Substance Abuse
- ✓ Mental Health Condition
- ✓ Cardiovascular Disease (e.g., Hypertension)
- ✓ Metabolic Disease (e.g., Diabetes)
- ✓ Respiratory Disease (e.g., Asthma)
- ✓ Obesity BMI >25 ***(BMI at or above 25 for adults, and at or above 85$^{th}$ percentile for children)***
- ✓ Other chronic conditions (see DOH website for list of chronic conditions) http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf

# Appropriateness Criteria for Health Home Eligibility

**Appropriateness Criteria:** Individuals meeting the Health Home eligibility criteria must be appropriate for intensive level of Health Home Care Management and a reasonable decision should be made if Health Home Care Management services would best serve the child and family. Assessing whether an individual is appropriate for Health Homes includes determining if the child meets at least one of the below:

- ✓ At risk for an adverse event (e.g., mandated preventive services, out of home placement**,** death, disability, inpatient or nursing home admission)
- ✓ Has inadequate social/family/housing support, or serious disruptions in family relationships;
- ✓ Has inadequate connectivity with healthcare system;
- ✓ Does not adhere to treatments or has difficulty managing medications;
- ✓ Has recently been released from incarceration, placement, detention; psychiatric hospitalization;
- ✓ Has deficits in activities of daily living, learning or cognition issues;
- ✓ Is concurrently eligible or enrolled along with their caregiver, in a Health Home.

# Defining the Collaborative Roles

- **LDSS Case Manager**
  - Current role
  - New role related to Health Homes
- **VFCA Case Planner**
  - Current role
  - New role related to Health Homes
- **Health Home Care Manager**

# Current Roles of the LDSS Case Manager

The LDSS Case Manager is responsible for the following key elements:

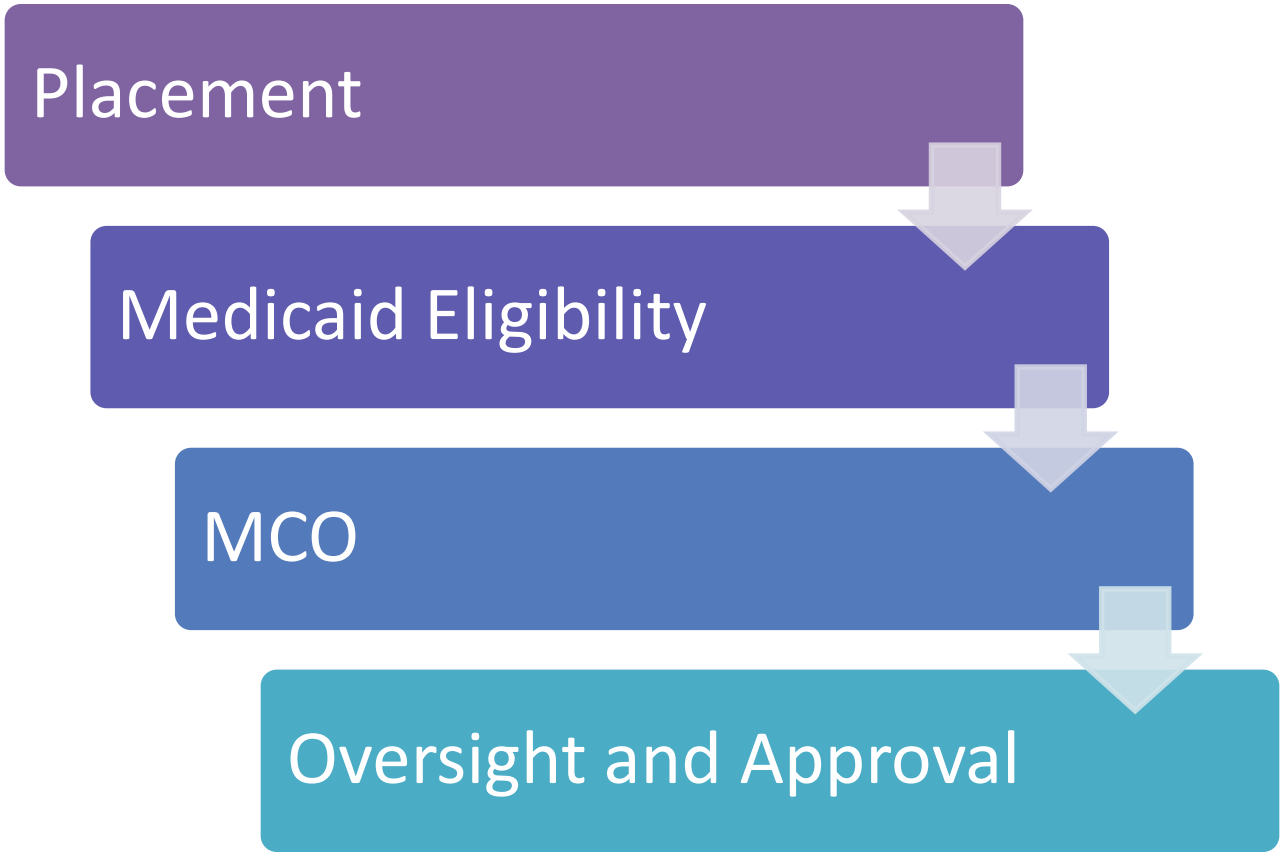
- The Adoption and Safe Families Act (ASFA) of 1997:
  - Promote permanency
  - Ensure safety and well-being for abused and neglected children
  - Accelerate permanent placements of children
- Concurrent Planning
- Placement of the child and authorizing the provision of services
- Medical consent for all related medical treatment and procedures
- Oversight of case, approving the Family Assessment and Service Plan (FASP) and working with the Family Court system
- Facilitate Medicaid eligibility
- Enrollment and Managed care plan selection, where applicable
- Adherence with applicable state and federal regulations related to health care services

# LDSS Case Manager Continued

The Family Assessment and Service Plan includes the following:

- Family Update
- Safety Assessment
- Strengths, Needs and Risks of the Child and Parent/ Caretaker
- Appropriateness of Placement
- Adjustment and Functioning
- Permanency Progress / Concurrent Planning
- Life Skills Assessment
- Family/Child Visiting Plan
- Foster Care Discharges
- Programmatic Eligibility
- Service Plan

# ACS/LDSS Case Manager



# *NEW* Functional Roles of the LDSS Case Manager Related to Health Homes

These roles* include:

- Referring Health Home eligible children/youth through the MAPP referral portal to the Health Home program.
  - For more information on the MAPP referral process please see the April 29, 2015 and May 11, 2015 webinars on the DOH website.
  - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/4_29_2015_children_webinar.pdf
  - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hhsc_5_11_2015_webinar.pdf

- Collaborating with the HHCM and the VFCA Case Planner in the development, implementation and modification of Health Home Plan of Care to assure it is consistent with the FASP.

* In NYC the LDSS Case Manager roles will be assumed by the VFCA Case Planner.

# Roles of the VFCA Case Planner

The VFCA Case Planner has the primary responsibility for providing or coordinating and evaluating the provision of Child Welfare Services including:

- Completing the FASP.
- Referring the child in foster care and his/her family to providers of services and delineating the roles of the various service providers related to the child's permanency planning.
- Collaborating with all case workers assigned to the family's case so that a single FASP is developed for a child.

# *New* Functional Roles of the VFCA Case Planner

These roles include:

- Collaborates with the HHCM and LDSS Case Manager (with the exception of NYC foster care children).
- Coordinates and facilitates the FASP team meetings with the HHCM.
- Collaborates with the HHCM on the development of the Health Home Plan of Care.

# Health Home Care Manager

**Six Core Services of Health Home Care Management:**

1. Comprehensive Care Management
2. Care Coordination and Health Promotion
3. Comprehensive Transitional Care
4. Patient and Family Support
5. Referral to Community and Social Support Services
6. Use of Health Information Technology (HIT) to Link Services

Detailed description of the activities to be performed to deliver the six core services can be found in the Health Home Application to Serve Children Part II at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_serving_children_app_part_II.pdf

# Comprehensive Care Management

- The HHCM, in collaboration with the child's family and the multi-disciplinary team (which includes the child welfare team), the LDSS Case Manager and/or VFCA Case Planner, develops and executes the HH Plan of Care.
- The HH Plan of Care identifies all providers (the multi-disciplinary team) directly involved in the child's care (e.g., the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), community, social and peer supports).
- All parties should agree with the goals, interventions and time frames contained in the Plan of Care.
- The HHCM is the single point of contact for creating, documenting, executing and updating the individualized child centered HH Plan of Care that integrates medical, behavioral health, rehabilitative, long term care, community and social services, family and peer supports.

# Comprehensive Care Management Continued

- The HHCM completes the Child and Adolescent Needs and Strengths-NY (CANS-NY).
  - The CANS-NY is a decision support tool designed to serve as a guide to assist in developing a HH Plan of Care for children with behavioral needs, medical needs, developmental disabilities, and juvenile justice involvement.
  - The HHCM will also use other assessment and information obtained from the multi-disciplinary team to complete the Plan of Care.

# Comprehensive Care Management Continued

- The HHCM will update the Plan of Care, including periodic reassessment of the child's individual needs and his/her progress in meeting goals.
- The HH Plan of Care should include, facilitate, and be consistent with the FASP.
- Ensures compliance with Health Home policies, standards and requirements:
  - Eligibility
  - Timeframes
  - Documentation
  - Provision of six core services

# Care Coordination and Health Promotion

- Engages and retains Health Home enrollees in care; coordinates and arranges for services; supports adherence to treatment recommendations; monitors and evaluates children/youth's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services through the creation of a Plan of Care.
- The HHCM works with the multi-disciplinary team to discuss changes in the child's condition that may necessitate treatment and service changes.

# Care Coordination and Health Promotion Continued

- Ensures the availability of priority appointments for Health Home enrollees for medical and behavioral health care services within their Health Home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.
- Ensures timely access to care.
- Consults with LDSS Commissioner should conflicting treatment recommendations occur.

# Care Coordination and Health Promotion Continued

- Supports continuity of care and health promotion through the development of a treatment relationship with the child/youth and the multidisciplinary team.
- Schedules and/or attends regular case review meetings, including all members of the multidisciplinary team on a schedule determined in collaboration with the LDSS, VFCA and HHCM.
- Ensures 24 hours/seven days a week access to a HHCM within the agency to provide information and emergency consultation services. This will be reported to the Case Planner.
- Will have a system to track and share patient information and care needs across providers and to monitor patient outcomes and initiate changes in care, as necessary.

# Comprehensive Transitional Care

- Ensures all members of the multi-disciplinary team are aware of admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.
- Ensures coordinated, safe transitions for children who require transfers in their site of care consistent with established policies and procedures.
- Ensures ongoing care and seamless transitional planning (i.e. Medicaid coverage, linkage with health care providers) upon discharge from foster care.

# Comprehensive Transitional Care Continued

- Provides timely access to follow-up care post discharge from hospital, emergency room or residential/rehabilitation setting. This includes:
  - Receipt of a summary care record from the discharging entity;
  - Medication reconciliation;
  - Timely scheduled appointments with recommended outpatient providers;
  - Verification with outpatient providers that the child/youth attended the appointment, as well as a plan to outreach and re-engage in care if the appointment was missed.

# Patient and Family Support

- Communicates and shares information with LDSS, VFCA and families/caregivers.
- Shares HH Plan of Care and options for accessing clinical and other information with caregivers.
- Utilizes peer supports, support groups and self-care programs to increase child/youth knowledge about his/her disease/behavioral health care needs, engagement and self-management capabilities to improve adherence to prescribed treatment.

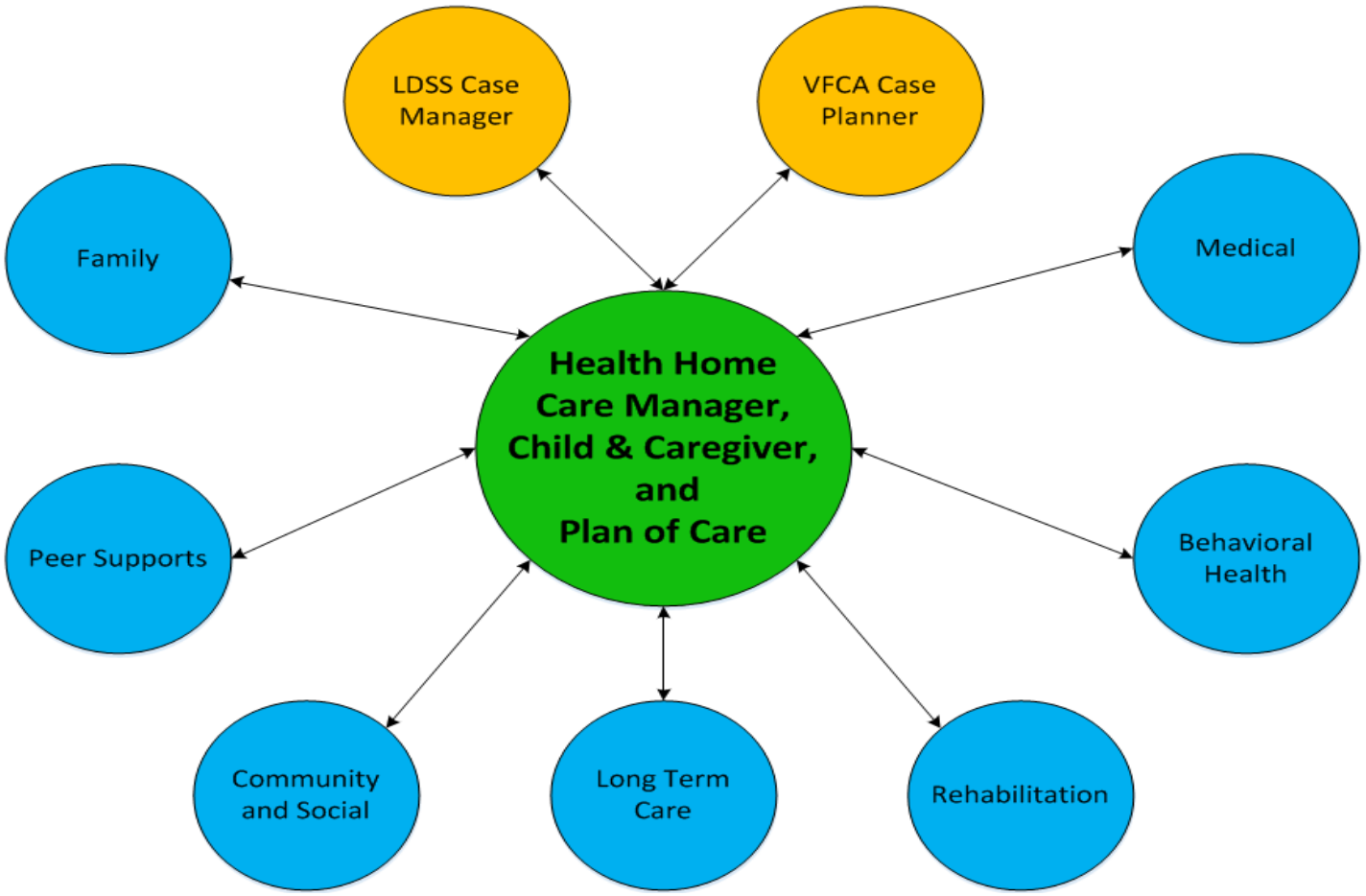
# Referral to Community and Social Support Services

- In collaboration with the LDSS and VFCA, identifies available community-based resources and actively manages appropriate referrals, access, engagement, social supports, follow-up and coordination of services that respond to the child's needs and preferences and contribute to achieving the child's goals.

# Use of Health Information Technology (HIT) to Link Services

- The HHCM inputs information into the Health Home's administrative system/care coordination software to allow the child's health information and HH Plan of Care to be accessible to the multi-disciplinary team, and also allowing for population management and identification of gaps in care. The HHCM documents follow up on tests, treatments, services, and referrals to be incorporated in the child's HH Plan of Care in the Health Home's administrative system/care coordination software.
- Inputs information in MAPP as required.
- The HHCM will have access to CONNECTIONS to view required information that may assist in developing the HH Plan of Care and shall input information in CONNECTIONS Progress Notes as needed.

# Development of Health Home Plan of Care



# Functional Roles of HHCM related to NYS Child Welfare

- Completes the Child and Adolescent Needs and Strengths-NY (CANS-NY).
- The Plan of Care is developed in collaboration with the multi-disciplinary team, and should reflect the child's Foster Care permanency goals.
- In developing the Health Home Plan of Care, the HHCM is expected to participate in the development of the FASP.

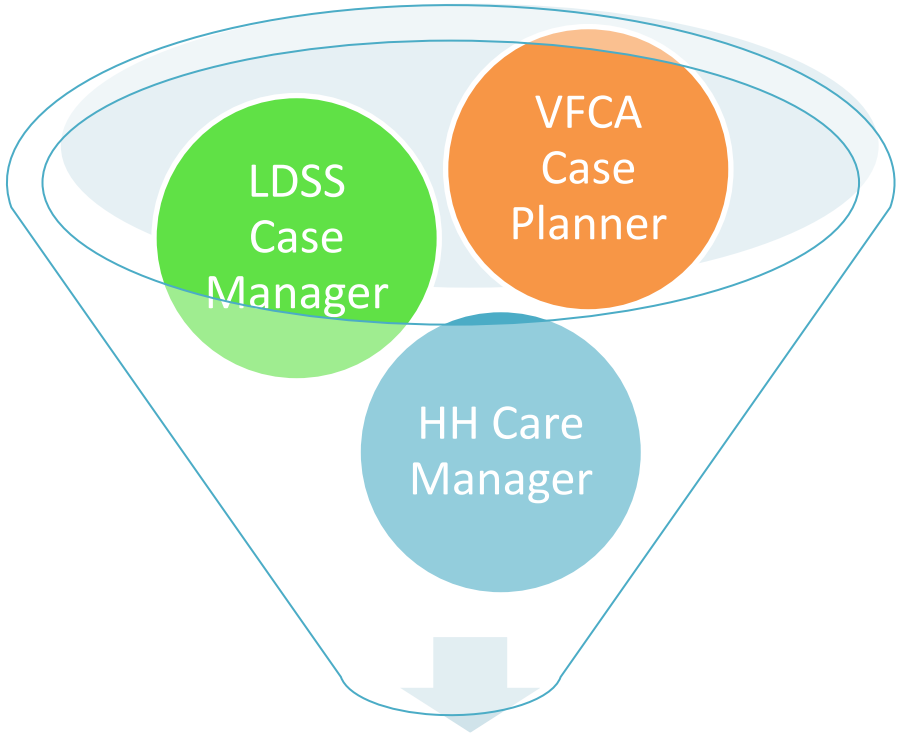
# Functional Roles of HHCM related to NYS Child Welfare Continued

- Provides all information about the child's health and welfare to the LDSS.
- Collaborates to ensure that safety, permanency and well-being are addressed within the provision of the six core services of Health Home Care Management, and that services are not duplicated.

# What Happens at Discharge from Foster Care?

- The primary goals of the foster care system are to achieve safety, permanency, and well-being for the child and family.
- At final discharge, the roles of the LDSS Case Manager and the VFCA Case Planner end.
- A child who remains eligible for Health Home can continue to receive services from the HHCM if they choose to do so.
- The provision of Health Home Care Management, including whether there is a need to transition the HH Care Management and the HH Plan of Care to another HHCM, should be reflected in the discharge plans created by the VFCA Case Planner and LDSS Case Manager. All parties should work together to ensure this transition is as smooth as possible.

# Bringing it together…




## HH Plan of Care + FASP

## Safety, Permanency, Well Being

# Questions and Answers

**NOW:** Please submit questions via the chat box on the webinar screen

**AFTER THE WEBINAR:** Submit any questions/comments on Health Homes Serving Children to hhsc@health.ny.gov . All submitted comments should include "Your Organization Name" and "Partner Network/Downstream Care Management Agency " in the subject line.