

SECTION 3 – SCOPE OF WORK AND PERFORMANCE MEASURES

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Children's Medical Services (CMS) Branch used Fiscal Year 2002-03 to transition from an annual individualized reporting format to a continuous quality improvement format to evaluate and improve the performance of both local CMS programs and the CMS Branch. The guiding principles used to complete this transition were the CMS Branch Mission and Vision Statements.

Mission: Assuring the health of California's children.

Vision Statement: Children's Medical Services is the leader in assuring the health of California's children through access to services for all children, in an environment committed to excellence, in partnership with families and communities, as supported by information and communication.

During Fiscal Year 2002-03, a statewide workgroup assembled to review and revise the CMS Scope of Work and to incorporate performance measures in the context of our mission and vision statement. The five CMS broad goals, used over the past several years as a way of providing focus for local programs, were condensed into four. The workgroup considered the former CMS goal 1 "Children will receive quality medical, dental, and support services across all provider settings" duplicated concepts in the other goal statements.

Four goal statements continue to provide the foundation for program components and activities that move local California Children's Services (CCS), Child Health and Disability Prevention (CHDP), Health Care Program for Children in Foster Care (HCPFC) programs toward meeting the CMS Mission and Vision Statement.

CMS Goals

Goal 1: Families, children, and providers will be assisted in how to use new and ongoing CMS program services, and access and navigate changing health care systems to assure effective, continuous care delivery.

Goal 2: Health and support services for children with special physical, emotional and social health needs will be addressed efficiently and effectively by qualified CMS providers, private and public offices and clinics, special care centers, regional centers, medical therapy programs and through home health agencies.

Goal 3: Clinical preventive services will be provided to children eligible for CMS programs.

Goal 4: CMS outreach activities will be conducted to assure that all eligible children and their families are informed of program services in a manner that is culturally and linguistically competent.

CMS Program Components – Scope of Work

The day-to-day operations of the CCS, CHDP, and HCPCFC programs have been outlined in Program Components with associated activities. These Program Components are the basic required activities that must be performed to meet Federal and State requirements. The Program Components and activities are the CMS Branch Scope of Work.

I. Program Planning and Administration

- A. Develop CMS plans and updates reflective of CCS, CHDP, and HCPCFC programs according to guidelines distributed by the CMS Branch. Submit these plans according to the date specified in the Plan Guidelines. Review and update quarterly for their application locally.
 - 1. CCS, CHDP, and HCPCFC staff meet a minimum of two times a year to develop a CMS plan, identify priorities, and evaluate resources for a multi-year scope of work.
 - a. Identify and prioritize health department and community programs with whom CMS staff will meet, e.g., Tuberculosis, Immunizations, WIC, Dental, Maternal and Child Health, Public Health Nursing, Lead, Injury Prevention, HIV Program, Perinatal Services Program, Family Planning, Rural Health, Migrant and Indian Health, Mental Health, Head Start, Child Care Facilities, Regional Centers, Special Care Centers, Paneled Hospitals, and Providers.
 - b. Identify and evaluate mutual activities and areas of implementation. Participate as CMS Administrators in arranging for the development of special services as necessary, e.g., orthodontic screening, Medical Therapy Conferences at the MTU, primary care, foster care resources, dental care.
 - c. Identify and implement program activities to maintain services as necessary.
 - 2. Meet at least once each year with the staff of other health department and community programs working on behalf of children to discuss goals and activities for/with these populations.
 - 3. Collaborate with the CMS Branch on standards, guidelines, and policies through participation in statewide and regional meetings. Include reporting mechanism to local program so that State information flows back to the local level.
 - 4. Evaluate program outcome data to plan more effective use of program resources.
- B. Develop and monitor the CCS, CHDP, and HCPCFC yearly budgets and invoices according to the format and time frames established by the CMS Branch.
 - 1. Expend funds according to approved budgets.
 - 2. Develop budget revisions as necessary.

3. Prepare and submit quarterly invoices to the State *no later than 60 days after the end of each quarter*. Track timeliness of, and invoiced payments for CCS services.
 4. Prepare and submit expenditure reports reallocating or requesting additional funds as appropriate and as requested by the CMS Branch.
 5. Use all equipment purchased with designated State program funds for the specified program purposes only.
 6. Complete and retain daily time studies a minimum of one month each quarter according to State provided guidelines.
 7. Maintain an audit trail for all expenditures for three years after the current fiscal year unless an audit has been announced or is in process.
- C. Assure a competent public health workforce for CMS Programs (CCS, CHDP, and HCPCFC).
1. Recruit, orient, supervise, provide ongoing training, and evaluate personnel responsible for implementing the Plan/Program.
 2. Assure sufficient adequately trained staff for performing the required activities in accordance with CMS standards.
 3. Develop and review with personnel their duty statements and their performance of allowable enhanced/nonenhanced functions pertinent to their classification.
 4. Provide comprehensive orientation and updates that should include information on all three programs.
 5. Provide **annual** update to **all local CMS staff** on the Plan (i.e., the budget, scope of work, performance measures) and its progress.
- D. Develop and obtain signed Intra/Interagency Agreements (IAA) and Memoranda of Understanding (MOU) with agencies/organizations serving California's children.
- E. Develop, implement, and monitor working relationships with Medi-Cal Managed Care Plans and between Health Families and the CCS program. Reflect these working relationships in an MOU between local CHDP and CCS programs and Managed Care Plan(s). Reflect the scope and responsibilities of both parties in the MOU, including but not limited to outreach, provider training, referral tracking and follow-up, health education, data management, and quality assurance and problem resolution.
- F. Develop an IAA between the Department of Social Services (DSS), Juvenile Probation Department, and the HCPCFC program according to the model IAA provided by the CMS Branch.
- G. Develop an MOU, for implementing responsibilities in the HCPCFC program, among the local CHDP program, local Child Welfare Agency of the County

Department of Social Services, and the Juvenile Probation Department according to the outline provided by the CMS Branch.

- H. Develop and maintain an IAA between:
 - 1. CMS and the local Head Start program,
 - 2. The MTP and the Local Educational Agency (LEA), and
 - 3. CMS and the Early Start program.
- I. Discuss with other departments, agencies, and organizations ways and means to inform and empower families about obtaining and utilizing quality health care services.
 - 1. Make available current, comprehensive listings and resources of agencies and organizations providing services to children related to CHDP and Prevention Services, Foster Care, and/or CCS. Listing would include official and voluntary agencies, serving health, social, and related issues to assist families in understanding services available and how to obtain them.
 - 2. Develop and maintain a collaborative working relationship among health department programs serving children, e.g., Lead; Maternal and Child Health; Black Infant Health; Public Health Nursing; Comprehensive Perinatal Services; Immunizations; Women, Infants, Children (WIC), Children and Families Commission. Prepare a written agreement with WIC and other programs, as needed.
 - 3. Maintain a liaison with public and private schools and Head Start/State Preschools to ensure:
 - a. Dissemination of CMS information.
 - b. Participation in CMS services among eligible children.
 - c. Coordination of applicable health care and related services to support school readiness.
 - d. Provision of in-services for school personnel on CHDP standards and services according to the provisions in the California Health and Safety Code, 124025-124110 and the applicable sections in the California Code of Regulations, Title 17.
 - e. Implementation of school reporting requirements.

CHDP Program Letter No.: 05-01 documents changes brought about by AB2855, Chapter 895, Statutes of 2004 included amendments to the Health and Safety (H & S) Code Section 124100. The amended H & S Code no longer require every public school district and private school in California to report data on the number of children receiving health screening examinations at school entry. Therefore, public school districts and private schools are NOT required to submit the CHDP Annual School Report (PM 272) to the CHDP Program within the local

health department and there will be no reimbursement provided. Private schools and public school districts may continue to gather and share this information at their discretion.

Local CHDP programs continue to have the responsibility to work collaboratively with schools to inform and empower families about obtaining and utilizing quality health care services. The activities involved in maintaining a liaison with public and private schools will help to support school readiness and ensure healthy children ready to learn.

For those private schools and public school districts that will continue to report:

- 1) Review the local school compliance statistics. Develop specific activities to increase the compliance rate of any school falling below the statewide average.
 - 2) Analyze the proportion of waivers and certificates for complete health examinations. Identify causative factors for the schools with a high incidence of waivers and develop strategies to increase the number of complete health examinations among school entrants when the factors are not based on personal/religious beliefs.
- f. Provision of lists of CHDP providers biannually to Head Start/State Preschool programs.
 - g. Provide an overview of eligibility requirements to school personnel regarding the CCS Program.
- J. Develop and maintain a collaborative relationship with the Medi-Cal Program: (i.e., Field Offices, In-Home Operations, and Medi-Cal Managed Care Plans).
 - K. Develop and maintain collaborative relationships with the regional Hearing Coordination Center to facilitate the process of newborn referral and testing for hearing loss; and the diagnostic testing and follow-up care for infants identified with suspected hearing loss through the Newborn Hearing Screening Program (NHSP).
 - L. Establish a process in counties/cities for CMS programs to participate in the MCH Title V planning process.
- II. Resource Development - Provider Relations, Recruitment, Maintenance, and Quality Assurance**
- A. Recruit, orient, and maintain a collaborative relationship with CMS providers serving all eligible children.
 1. Facilitate CMS provider application process.
 2. Train/orient all CMS providers to program responsibilities.

3. Provide on-going information, assistance, resources, and support necessary to ensure quality program implementation including, but not limited, to Provider Notices sent by CMS Branch and returning Reports of Distribution (DHS 4504) to the CMS Branch.
- B. Develop and implement a quality assurance plan to ensure CMS children receive quality care.
1. Conduct periodic formal and informal review of CMS providers' compliance with program standards.
 2. Support providers in development and implementation of corrective action plans when indicated.

III. Case Coordination/Case Management, Tracking, and Quality Improvement in Public Health Services

- A. Implement care coordination/case management to assure children known to CMS programs use available services.
1. Receive or initiate referrals among:
 - a. CCS,
 - b. CHDP,
 - c. HCPCFC/Child Welfare Services (CWS),
 - d. Outside agencies/individuals,
 - e. Managed care plans, and
 - f. Health care providers.
 2. Inform the family about health care/services in their community and how to access these services.
 3. Determine eligibility and link all eligible members of a household to health services by inquiring of each child's health status, health care coverage, and need for health care services.
 4. Facilitate all necessary services within program standards and guidelines.
 5. Document and report the results of care coordination/case management in accordance with program standards and guidelines.
- B. Implement and maintain a data/file tracking system(s) to assure data retrieval and recovery in accordance with program standards and guidelines for a period no less than three years or until the completion of any federal audit in progress, including but not limited to:
1. Referrals,

2. Health status,
 3. Care coordination/case management activities,
 4. Services utilization,
 5. Informing activities,
 6. Documentation, and
 7. Reports.
- C. Develop, implement, and maintain a quality improvement system to assure CMS programs assist children receive quality medical, dental, and support services across all provider settings.
1. Develop measures to gauge quality of care coordination/case management including:
 - a. Timely services delivery,
 - b. Completeness and accuracy of documentation,
 - c. Effective interdisciplinary/interagency collaboration,
 - d. Culturally and linguistically competent care,
 - e. Family centered care,
 - f. Service delivery outcomes, and
 - g. Access to a medical home.

IV. Outreach and Education

- A. Employ a multifaceted approach working with community agencies; informal networks; residents; health, education, human service, and legal systems; providers; and policy makers to increase value and understanding of, access to, and participation in, primary and specialty health services in accordance with CMS standards, for all children, including children with special health care needs (CSHCN), across the continuum of care.
1. Address those population groups known to have low utilization or high incidence patterns of conditions that are of local concern.
 2. Determine ways and means to inform and encourage families about obtaining health care coverage and utilizing quality health care services.
 3. Establish contacts and inform the community where CMS services are not known, understood, and/or not utilized.
 4. Review, coordinate distribution, and promote the utilization of health education and CMS program materials.

5. Develop, arrange, and/or conduct educational programs regarding health care needs of children.

Using and Reporting Performance Measures in CMS Programs

The use of performance measures to evaluate the effectiveness and success of public health program interventions and activities is part of public health practice. With time, effective program activities enable the attainment of CMS goals and outcomes.

Reporting on the CMS performance measures is a Scope of Work requirement that started in Fiscal Year (FY) 2002-03. CMS local programs have been using tracking systems and other data collection methods for five years to measure their work with communities, provider networks, and target populations.

Accountability is determined in three ways:

1. by having budget and expenditure figures;
2. by measuring the progress towards successful implementation and achievement of individual performance measures; and ultimately,
3. by having a positive impact on the desired outcomes of the program. These outcome measures are the CMS goals. If program activities are effective and successful, the CMS goals/outcomes will be accomplished.

While improvement in outcome measures is the long-term aim, more immediate success may be demonstrated through performance measures that are shorter term, incremental, intermediate, and/or precursors for the outcome measures. To that end, in Fiscal Year (FY) 2007-08 the performance measures have been revised to reflect program specific measures which are to be reported separately.

The following performance measures were selected by state staff with local program input to represent the focus of CMS programs. Data are to be reported annually for each performance measure.

Directions for Completing the Report of Performance Measures

Reporting on the CMS performance measures is a Scope of Work requirement.

The following outlines the requirements for reporting annually **by November 30th**. One original and three copies of the CMS Report of Performance Measures are to be sent to the local program's CMS Regional Administrative Consultant.

- I. CCS, CHDP, and HCPCFC programs under **joint** administrations are to submit a **single joint** performance report when submitting to the CMS Branch.
- II. Performance measures should be reported in the appropriate format identified for each performance measure. Include a narrative description of the process used to define a percentage for the performance measure or to achieve the score presented.
- III. Performance and monitoring of the performance measures will be evaluated on an annual basis.
- IV. The Annual Report of the Performance Measures of the following elements.
 - A. Report the Results of the Performance Measures using the report forms provided.
 - B. Include a narrative **not to exceed one page**. The narrative should outline the ways that each program approached the task of data collection, and any unique issues related to the measure, e.g. sampling methodology, information used to validate the data to ensure measures were being tracked correctly.
 - C. Describe plans to enhance or change interventions or monitoring activities based on review of this data.

CHDP Performance Measure - Care Coordination

The degree to which the local CHDP program provides effective care coordination to CHDP eligible children.

Definition: This measure demonstrates effective care coordination in the CHDP program.

Numerator: Number of CHDP health assessments (PM-160) coded 4 or 5 where the follow-up appointment was within 120 days of receipt of the PM 160.

Denominator: Number of CHDP health assessments (PM-160), coded 4 or 5, indicating a need for further diagnosis and treatment.

Data Source/Issue: Local program tracking system.

Reporting Form:

Element	Number of Children with Code 4 or 5	Number who received follow-up care	Percent who received follow-up care
Fee-for-service Medi-Cal children whose CHDP screening exams reveal a condition requiring follow-up care (Code 4 or 5 on the PM-160), actually received follow-up within 120 days of receipt of the PM 160.			
Non-Medi-Cal children (Aid code 8Y) whose CHDP screening exams reveal a condition requiring follow-up care (Code 4 or 5 on the PM-160), actually received follow-up within 120 days of the receipt of the PM 160.			

CHDP Performance Measure - New Provider Orientation

The percentage of new CHDP providers with evidence of quality improvement monitoring by the local CHDP program through a **New Provider Orientation**.

Definition: The number of *new* CHDP providers for whom the local program staff has done an orientation within the past fiscal year.

Numerator: The number of *new* CHDP Providers who completed an orientation within the past fiscal year.

Denominator: The number of *new* CHDP providers in the county or city enrolled within the past fiscal year.

Data Source/Issue: Local program/area tracking report system.

Reporting Form:

Provider Name	Provider Number	Date of Orientation	# of Provider staff in attendance

Number of New Providers	
Number of New Providers Receiving Orientation	
Percent of New Providers Oriented	

CHDP Performance Measure - Provider Recertification

The percentage of CHDP providers who have **completed** the re-certification within the past fiscal year. The purpose of this performance measure is to ensure that at least 1/3 of providers are recertified every year. The goal is that all providers in each county/city will be recertified every 3 years. This performance measure is a benchmark to ensure that all providers are recertified.

Definition: An office visit which includes a medical record review and a facility review or Critical Element Review with a Managed Care Plan.

Numerator: The number of CHDP providers who have completed the Re-certification within the past fiscal year using the facility review tool and medical record review tool.

Denominator: The number of active CHDP provider sites in the county/city.

Data Source: Local program tracking report system.

Reporting Form:

Number of Completed Re-certifications	
Number of Active CHDP Providers	
Percent of Completed Re-certifications (33 1/3% is the desired goal)	

CHDP Performance Measure - Desktop Review

The percentage of PM-160's reviewed for compliance with the CHDP Periodicity Schedule as evidenced by documentation when utilizing the desktop review.

Definition: A targeted desktop review for the three highest volume county/city active providers by determining the per cent of PM-160's that documentation is present for:

- A. BMI Percentile for all ages over 2 years
- B. The number of children referred to a dentist (1yr of age and older)
- C. The number of children referred for a lead test (minimum of 1 referral for age 2 and under)

Numerator: The number of PM-160's elements recorded correctly per provider

Denominator: The number of PM-160's reviewed per provider

Data Source: Local program tracking system

Reporting Form:

	BMI		Dental		Lead	
	Number of PM-160s reviewed (ages 2yrs and over)	Percent compliance	Number of PM- 160s reviewed (age 1 year)	Percent Compliance	Number of PM 160s reviewed (1 referral for age 2 and under)	Percent Compliance
Provider						
A						
B						
C						

CHDP Performance Measure - Childhood Overweight

Identification of the prevalence rate of overweight children in a “critical group” according to Pediatric Nutrition Surveillance System (PedNSS) Annual Report and description of local program use of PedNSS reports in healthcare and community venues.

Definition: “Critical group” is the age and/or race/ethnic group with the highest prevalence rate of overweight as indicated by Body Mass Index (BMI)-for-Age \geq 95th % in County/City PedNSS reports. PedNSS is the national surveillance system which tracks population nutrition status trends of children 1-19 years of age and by various race/ethnic groups. It supports Goal 4 of the California Obesity Prevention Plan (2005), “Create and implement a statewide tracking and evaluation system”.

Local CHDP program use of County/City PedNSS reports with other agencies and organizations for the purposes of informing and promoting appropriate community and healthcare responses to the prevalence of childhood overweight.

Data Source: Most current Centers for Disease Control and Prevention, PedNSS Annual Report, County/City Specific Data, Table 16B, Growth Indicators by Race/Ethnicity and Age. Values are obtained by referring to the right-hand column % \geq 95th of Table 16B. Please attach your county/city Table 16B to your submission.

Reporting Form*: Overweight Prevalence Rate by Critical Age Group

For _____ County/City

Critical Group	Overweight (BMI-for-Age \geq 95 th %) Prevalence Rate

*When the number of children for any age category is less than 100, CDC does not provide a prevalence rate. It is “optional” for counties to report prevalence rates when they have less than 100 children. A hand count (manual) will be accepted, if available.

Childhood Overweight

County/City Use of PedNSS Prevalence Rates

1. PedNSS Shared with CHDP Providers to:	YES	NO
Inform about overweight prevalence rates		
Conduct office staff BMI training or other training <i>Please specify:</i>		
Provide office resource materials related to healthy weight		
Conduct Desktop Reviews specific for _____		
2. PedNSS Shared to support Local Assistance grants and implementation of multi-sector policy strategies to create healthy eating and active living community environments (Goal 3, California Obesity Prevention Plan 2005): (check yes for each category that is applicable and circle all that apply)		
<u>Academic:</u> University, Academic Institutions, Educators and Researchers <i>Other (Please specify):</i>		
<u>Community Coalitions/Committees:</u> Health Advisory Committee, Health Collaboratives/Coalitions <i>Other (Please specify):</i>		
<u>Community Planning:</u> City Planners, County Land Use Staff, Built Environment Groups		
<u>Community Programs:</u> Faith-based Groups, YMCA/YWCA, After School programs, Parks and Recreation programs, Child Care, University Cooperative Extension <i>Other (Please specify):</i>		
<u>Healthcare:</u> Managed Care Health Plans and Insurers, Hospitals, CCS Program/Special Care Centers, Medical Provider Groups, Medical Societies, Health Associations <i>Other (Please specify):</i>		
<u>Policy Makers:</u> County Board of Supervisors, City Council, Community Planners, Legislators <i>Other (Please specify):</i>		
<u>Projects or Funding Entities:</u> First Five Commission, Public and Private Foundations/Endowments/Grants <i>Other (Please specify):</i>		

<p><u>Public Health:</u> Programs-WIC, Foster Care, MCAH, Nutrition Network Funded Projects</p> <p>Key Personnel- Health Officer, Epidemiologists, Program Directors</p> <p>Other (<i>Please specify</i>):</p>		
<p><u>Schools:</u> School Health Nurses, School Health Coordinators, County Office of Education, Elementary, Junior High and High School, Head Start, other preschool programs, student groups and parent groups.</p> <p>Other (<i>Please specify</i>):</p>		

HPCFC Performance Measure - Care Coordination

The degree to which the local HPCFC program provides effective care coordination to eligible children.

Definition: This measure demonstrates effective care coordination in the HPCFC program. Please indicate the score based on the level of implementation.

Numerator: Number of CHDP health assessments (PM-160) coded 4 or 5 where the follow-up appointment was kept within 120 days of receipt of the PM 160.

Denominator: Number of CHDP health assessments (PM-160) indicating a need for follow-up (coded 4 or 5).

Data Source/Issue: Local program tracking system.

Reporting Form:

Number of Children in out-of-home placement whose CHDP health assessments reveal a condition requiring follow-up care (Code 4 or 5 on the PM-160).	
Number of those children who received follow-up care within 120 days of receipt of the PM 160.	
Percent of those children who received follow-up care within 120 days of receipt of the PM 160.	

HCPCFC Performance Measure - Health and Dental Exams for Children in Out-of-Home Placement

The degree to which the local HCPCFC program ensures access to health and dental care services for eligible children according to the CHDP periodicity schedule.

Definition: This measure is based on characteristics that demonstrate the degree to which the PHN in the HCPCFC facilitates access to health and dental services as evidenced by documentation of a health and dental exam in the health education passport.

Numerator 1: Number of children in out-of-home placement with a preventive health exam, according to the CHDP periodicity schedule documented in the Health and Education Passport, and

Numerator 2: Number of children in out-of-home placement with a preventive dental exam, according to the CHDP dental periodicity schedule documented in the Health and Education Passport.

Denominator: Number of children in out of home placement during the previous fiscal year supervised by Child Welfare Services or Probation Department.

Data Source/Issue: Child Welfare Services Case Management System (CWS/CMS), and county specific data for Probation Department.

Reporting Form:

Element	Number of Children	Number of Children with Exams	Percent of Children with Exams
Children in out-of-home placement supervised by Child Welfare Services or Probation Department have a preventive <u>health exam</u> according to the CHDP periodicity schedule documented in the Health and Education Passport.			
Children in out-of-home placement supervised by Child Welfare Services or Probation Department have a preventive <u>dental exam</u> according to the CHDP dental periodicity schedule documented in the Health and Education Passport.			

CHDP Performance Measure - School Entry Exams - OPTIONAL -

The percent of children entering first grade in public and private school by school district reporting a "Report of Health Examination for School Entry" (PM 171 A) or "Waiver of Health Examination for School Entry" (PM 171 B).

- Definition:** The percent of children entering first grade with a health exam certificate or waiver.
- Numerator:** Among those private and public school districts continuing to report: The total number of children entering first grade with a:
- a. Certificate and
 - b. Waiver.
- Denominator:** Among those private and public school districts continuing to report: The total number of children enrolled in first grade in public and private school.
- Data Source/Issue:** Public school districts and private schools serving first grade students.
- Reporting Form:** Local program/area tracking report form.

CHDP Optional Performance Measures

Clinical preventive services for CHDP eligible children and youth are expected in accordance with the CMS/CHDP Health Assessment Guidelines. The delivery of those services is documented on the Confidential Screening/Billing Report (PM 160). Examples of evidence-based performance of these services includes focused monitoring for presence of completed fields on the PM 160 for:

- Number and percent of children 2-years old fully immunized,
- Number and percent of age appropriate children given a WIC referral,
- Number and percent of age appropriate children screened for asthma, and
- Number and percent of children and youth with health needs being detected and addressed through clinical preventive services in the CHDP program.
- Number and percent of CHDP health assessments (PM-160) coded 4 or 5 for dental where the follow-up appointment was kept
- Number of providers returning PM 160's within 30 days.

CCS Performance Measures

The purpose of the CCS Performance Measures is to determine the degree to which county CCS programs provide or monitor effective case management and care coordination to eligible children. County programs will evaluate and rate **each** of the five components as individual indicators of program effectiveness.

The five components for review are:

1. Medical Home

Purpose: To identify children in the CCS program who do not have an identified Primary Care Provide (PCP) or Medical Home. The continued monitoring of this performance measure is to ensure all children in the CCS Program have a PCP or medical home identified.

2. Determination of CCS Eligibility

Purpose: To examine whether CCS Program Eligibility Guidelines are being met in the local program.

3. Special Care Center (SCC)

Purpose: To determine if the children that are authorized to a special care center are seen annually and to ensure that visit is documented by an interdisciplinary team report. In addition, the CMS Branch wishes to evaluate the number of children with a medical condition that warrant SCC service to measure the CMS Program's compliance with the requirement for appropriate referral follow-up with a special care center authorization.

4. Transition Planning

Purpose: To evaluate the status of transition planning that is currently taking place for CCS and MTP Children by CCS partners who provide CCS services. The current activity will focus on the documentation received in the local CCS program from a variety of sources such as center report, IEP report, etc. This Performance Measure is to begin evaluation of CCS partner transition services planning, not CCS County program's performance.

5. Family Participation

Purpose: To evaluate the level of family participation and the integration of Family Centered Care in the CCS programs.

CCS Performance Measure – Medical Home

Children enrolled in the CCS Program will have documented Medical homes/primary care providers. The goal is to have 100% compliance.

Definition: Children in the CCS program will have a designated primary care physician and/or physician who provides a medical home.

Numerator: The total number of open cases, excluding pending and orthodontic cases with a completed field in the CMS Net Registration Sheet indicating medical home.

Denominator: The total number of children in the local CCS county program.

Data Source: Medical Home field in CMSNet on the Registration Face Sheet for all counties on CMSNet. *

Reporting Form:

*Counties not yet on CMS Net, a data source and tracking system will need to be established to measure this criterion.

#of children with a primary care physician/ Medical Home	# of children in the local CCS program	% compliance

CCS Performance Measure – Determination of CCS Program Eligibility

Children referred to CCS have their program eligibility determined within the prescribed guidelines per Title 22, California Code of Regulations, Section 42000, and according to CMS Branch policy. Counties will measure the following:

Numerators:

- a. Medical eligibility within five working days of receipt of all medical documentation necessary to determine whether a CCS-eligible condition exists.
- b. Residential and financial eligibility within 30 days of receipt of documentation needed to make the determination.

Denominator: Number of CCS unduplicated new referrals to the CCS program assigned a pending status in the last fiscal year.

Data Source: Conduct a random sample of 10% of cases from CMS Net (not to exceed 100 or be less than 10).

Reporting Form:

	Number of Clients	Percentage %:
New unduplicated referrals		
Medical eligibility determined within 5 days		
Residential and financial eligibility determined within 30 days		

CCS Performance Measure – Special Care Center

This Performance Measure will be evaluated in two parts:

PART A

Definition: This measure is based on the CCS requirement for an annual team report for each child enrolled in CCS whose condition requires CCS Special Care Center services and has received an authorization to a Special Care Center. County CCS programs will evaluate by the presence of an annual team conference report in the file.

Numerator: Number of children that received a Special Care Center authorization and were seen at least annually at appropriate Special Care Center as evidenced by documentation and completion of the interdisciplinary team report.

Denominator: Number of children enrolled in CCS whose condition require CCS Special Care Center services and has received an authorization to a Special Care Center.

Data source: 10% of the cases from local Cystic Fibrosis/Pulmonary and Craniofacial Centers. Counties have an option of reviewing additional Special Centers if there is an identified county need. If a county is located in area without local SCC, use the two specific SCC where local children are referred.

Reporting Form for PART A:

# Children with team services authorization in a Craniofacial Center	# Children with annual team report	%
# Children with team services authorizations in CF/Pulmonary Center	# Children with annual team report	%
# Children with team services authorization in Optional Center	# Children with annual team report	%

CCS Performance Measure – Special Care Center

PART B:

Definition: This measure is based on the CCS requirement that certain CCS eligible medical conditions require referral to a CCS Special Care Center for ongoing coordination of services.

Numerator: Number of children enrolled in CCS, with medical conditions requiring Special Care Center Authorization, who receive an authorization for services.

Denominator: Number of children enrolled in CCS, with medical conditions, requiring Special Care Center Authorizations.

Date Source: Conduct a random sample of 10% of cases from CMS Net (not to exceed 100 or be less than 10). This number would accommodate both small and large counties.

Reporting Form for PART B

# Children with eligible medical conditions that require referral to a Special Care Center.	# Children with authorization to a Special Care Center	%
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CCS Performance Measure – Transition Planning

Definition: Children, 14 years and older will have documentation of transition planning for preparation to into adult services on an annual basis.

Numerator: Number of CCS charts containing documentation of at least one element in the Transition Check List for children aged 14 years and over.

Denominators:

- a. Number of CCS charts reviewed in 10% of a sample of children aged 14 and over.
- b. Number of MTP charts reviewed in 10% of a sample of children aged 14 and over.

Data Source: Chart Audit, Completion of Transition Check List.

* Due to caseload numbers in Los Angeles County, LA County should work with Regional Office to select an appropriate number of clients to be included in their sample size.

CCS - Transition Planning Checklist

Transition Documentation	YES	NO	Comments
1. Transition planning noted in child's medical record			
2. Transition planning noted in SCC reports			
3. Vocational Rehab noted in child's reports			
4. Adult provider discussed or identified.			
5. Transition planning noted in IEP.			

Reporting Form:

# of CCS charts reviewed	# with transition planning	%
# of MTP charts reviewed	#with transition planning	%

CCS Performance Measure – Family Participation

The degree to which the CCS program demonstrates family participation.

Definition: This measure will be evaluated based on **each** of the following three specific criteria that documents family participation in the CCS program. Counties need to indicate the score based on the level of implementation.

Checklist documenting family participation in the CCS program.	Yes	No	Please submit explanation with your response.
1. Family members are offered an opportunity to provide feedback regarding their satisfaction with the services received through the CCS program by participation in such things as surveys, group discussions, or individual consultation.			
2. Family members participate on advisory committees or task forces and are offered training, mentoring and reimbursement when appropriate.			
3. Family advocates, either as private individuals or as part of an agency advocating family centered care, which have experience with children with special health care needs, are contracted or consultants to the CCS program for their expertise.			

Reporting form:

Criteria	Performing (33.33% for each criteria)	Not Performing
1.		
2.		
3.		
Total	<hr/> %	