



California Children's Services Program Redesign

Advisory Group Meeting

October 21, 2015



Agenda

- 9:30-10:00 ■ Registration, Gather, and Networking
 - 10:00-10:15 ■ Welcome, Introductions, and Purpose of Today's Meeting
 - 10:15-11:00 ■ Follow-Up From Previous Meeting, Key Updates, AB 187, and Future Meetings' Topics/Goals
 - 11:00-12:15 ■ Care Coordination / Medical Homes / Provider Access
Technical Workgroup Update
 - Los Angeles County: Update on Case Management Redesign
 - Partnership HealthPlan of CA: Care Coordination
 - 12:15-1:00 ■ Lunch (Provided to CCS AG Group Members)
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Agenda (continued)

- 1:00-2:00 ■ Data & Quality Measures Technical Workgroup Update, Available Statewide Data, and County CCS Measures
- 2:00-3:40 ■ Instructions for Group Break-Outs
 - Group Break-Out Session on Specific Topics
 - Report out from Break-Out Session
- 3:40-4:00 ■ Public Comments
 - Next Steps and Next Meetings



Welcome, Introductions, and Purpose of Today's Meeting

Bobbie Wunsch

Pacific Health Consulting Group



Follow-Up from Previous Meeting, Key Updates, Future Meetings' Topics/Goals, and AB 187

Jennifer Kent

Director, DHCS

Anastasia Dodson

Associate Director for Policy, DHCS

Sarah Brooks

Deputy Director of Health Care Delivery Systems, DHCS



Care Coordination / Medical Home / Provider Access Technical Workgroup Update

Anastasia Dodson
Associate Director for Policy, DHCS



CC/MH/PA Workgroup Goals

- **Goal 1:** Provide the CCS AG and DHCS with technical consultation in regards to implementation of the Whole-Child model.
 - **Goal 2:** Advise the CCS AG and DHCS on ways to improve care coordination between all partners in all counties. Explore new, innovative models of care including Medical Homes, and devise strategies to incorporate relevant components that will increase care coordination and care quality.
 - **Goal 3:** Discuss provider standards and access requirements to promote continuity of care.
 - **Goal 4:** Improve transitions for youth aging out of CCS.
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October 9 Agenda

- Workgroup Charter and Goals
- Managed Care: Care Coordination Standards
- Proposed County Performance Measures
- Los Angeles County CCS: Operationalizing Best Practices: Update on Case Management Redesign
- Napa and Orange Counties: Medical Therapy Program Overview, Data Analysis, and Coordination
- Central California Alliance for Health: CCS Transition of Care - Collaborative Coordination of Care

Webinar recording available on AG website:

<http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx>



Los Angeles County CCS

Operationalizing Best Practices: Update on Case Management Redesign

Mary Doyle, M.D., FAAP

Associate Medical Director, LA County CCS

CCS Redesign Advisory Group

October 21, 2015





Overview

1. Recap: what we did
2. Implementation of lessons learned
3. What we are continuing to do



The Project: 2.1.14 through 1.31.15

- **Target Group:** 4493 cases
- **Sorted by complexity of case management need**
- **Assigned to team of 9 nurses:** 4 with complex cases
1 with Medical Therapy Program case load
4 for less complex cases
- **Case loads/nurse:** ~250 for complex & MTU cases;
~550 for less complex
- **Varied case management interventions:** based on complexity of need
- **Recorded case activities:** using a software system designed specifically for this project that allowed the capture of data that was both patient specific and reflective of case management interventions and CCS processes

Implementation: Case Sorting Definitions Finalized

- **Standard Case Management:** the CCS condition is
 1. Acute and expected to resolve in <1yr without complications
 2. Chronic and expected to require ongoing treatment and/or monitoring but is usually managed effectively through life and poses only a limited effect on the ability to function
 3. At risk for a CCS medically condition: i.e. – in a screening or diagnostic program (NBHS, NBMS, HRIF, HIV risk)
AND: there are NO other co-morbid physical, mental or developmental conditions or social issues that affect health
- **Complex Case Management:** all others

Implementation: Standardization of ICD-10 Assignment

- CCS program: lacked a standardized method for ICD code assignment for the covered medical condition until the release of standardized codes for MTP patients on 9.24.15
- Draft list of codes for the CCS MEC's developed/cross walked to ICD-10: based on the the controlled assignment of ICD 9 codes to 1741 new referrals to the pilot team; formed the basis for the development of standardized lists of codes to be used by LA Co.
- Piloting and revising: a set of coding principles and 3 sets of standardized codes (NICU, standard, complex cases) with the goal of general program use by 1.1.16, in addition to what is being used for the MTP patients



Implementation: Case Load Sorting

- Hybrid case load chosen: complex and standard cases
- Rather than limit the number of cases assigned to one nurse, the percentage of complex v. standard will be fixed:
 - 60%: standard
 - 40%: complex
- Requires an enhancement in CMS Net to insure that this assignment can be tracked by nurse
- New cases will be sorted on referral; existing cases will be sorted at any point that the nurse needs to interact with it



Implementation: Case Management Activities

- Standardized case management activities: close to completion
- Based on: analysis of 1 year's worth of nursing interventions on the pilot team patients
- Vary by need for standard v. complex case management
- Standard: introductory letter; authorizations; responses to inquiries; case closure at 1 year if the CCS condition resolves
- Complex: detailed needs assessment & development of a nursing care plan formed during the introductory call to the family; re-review during the year



Implementation: Case Management Software

- Process of revising the platform and software used to perform and record case management activities
- Enhancements:
 - Order of use/entry mimics nurse case workflow
 - Extensive drop down menus (~no free text) for interventions
 - Standardized ICD-10 choices
 - Resource directories
 - Patient/family specific indicators of quality: medical home, affected siblings, disease specific indicators, school, MTU
- Immensely searchable!!!



What's To Come:

- **Complex Cases in the Pilot Project:** being tracked into their 2nd year by diagnoses and health status group
- **Medical Home Questionnaire Project:** near completion of a project designed to assess the quality of a patient's medical home using a short set of questions asked over the phone.

Thank You!



PHC Care Coordination

by

Peggy Hoover, RN

Senior Director, Health Services

CCS Advisory Group

October 21, 2015

Organizational Structure

- ❖ County Organized Health System (COHS)
- ❖ Single Plan Model with automatic enrollment based on Aid Code
- ❖ Invited into the County by County Governance
- ❖ Currently serving 14 counties- Solano, Napa, Yolo, Sonoma, Marin, Mendocino, Lake, Shasta, Lassen, Modoc, Siskiyou, Trinity, Humboldt and Del Norte
- ❖ Office locations in Fairfield, Santa Rosa, Redding and Eureka
- ❖ Current membership 543,000

Governance

- ❖ Governed by Board of Commissioners
- ❖ Commissioners represent each County we serve
- ❖ Appointed by the County Board of Supervisors
- ❖ Recently added two Consumers to the Commission

Current CCS Models for PHC

❖ **Carved In** (Napa, Marin, Solano, and Yolo Counties)

- County CCS Staff is responsible for financial, medical eligibility and authorization of services for any CCS condition
- Claims for all conditions (CCS or non-CCS) are submitted to PHC for payment
- Coordination of Care is shared collaboratively between County CCS and PHC
- PHC authorizes and coordinates care and services for treatment not related to a CCS eligible condition

Current CCS Models for PHC

❖ **Carved Out** (Del Norte, Humboldt, Lake, Lassen, Modoc, Mendocino, Shasta, Siskiyou, Sonoma and Trinity Counties)

- **Independent Counties**

- County CCS Program
 - Determines financial, medical and residential eligibility
 - Completes Service Authorization

- **Dependent Counties**

- County CCS Program
 - Determines financial and residential eligibility
- State CCS
 - Determines medical eligibility
 - Completes Service Authorization Requests

Care Coordination for Children

❖ Special Programs Liaison Case Managers

- **Ellen McBride, MSW** Fairfield Office
(serves Solano, Yolo and Napa)
- **Joyce Aldred, MS, CCM** Santa Rosa Office
(serves Sonoma, Marin, Mendocino and Lake)
- **Diane Miller, RN, MSN, PHN** Redding Office
(serves Shasta, Lassen, Siskiyou and Modoc)
- **Angela Winogradov, BSN, RN, PHN** Eureka Office
(serves Humboldt, Del Norte and Trinity)

Care Coordination for Children

❖ Role is to:

- Coordinate care and services to ensure child's needs are met
- Provide education and support to parents, providers and community organizations
- Resolve issues regarding coordination and payment of services
- Coordinate Shift Nursing and other services under EPSDT
- Participate in Quarterly meetings with CCS staff representatives from each county
- Participate in regular meetings with four Regional Centers

Members with Complex Needs

- ❖ Seniors and Persons with Disabilities
- ❖ Members with multiple chronic conditions
- ❖ High Risk Pregnancy

Programs:

- Health Risk Assessment, outreach and coordination
- Complex Case Management
- Intensive Outpatient Care Management
- Care Transitions
- Growing Together Perinatal Program (GTPP)

Other PHC Program Initiatives

- ❖ Offering and Honoring Choices
- ❖ Palliative Care Pilot
- ❖ Managing Pain Safely

Building a Future CCS Network

- ❖ PHC has current contracts with many of the major centers in Northern California
- ❖ PHC will conduct a needs assessment to identify any gaps in existing network
- ❖ PHC will contract with any willing Medi-Cal provider who is able to meet PHC's credentialing criteria
- ❖ May enter into single case agreements as medically necessary to meet the needs of our member

Coordinating and Integrating Care in the New Model

- ❖ Structure and requirements still in development
- ❖ Most children would already be enrolled in the Plan
- ❖ Initial Action Plan:
 - Work closely with our County CCS Partners
 - Plan and execute multiple outreach efforts to disseminate information and assistance to caregivers, community organizations and Providers
 - Keep the member at the center of the implementation plan to ensure continuity of services and reduce anxiety to both the member and caregiver, as well as the provider



Lunch

(Provided for AG Members)



Data and Quality Measures TWG Update

Lee Sanders, MD

Stanford Center for Policy, Outcomes and Prevention

Brian Kentera

CMS Network IT Section Chief, DHCS

Sarah Brooks

Deputy Director of Health Care Delivery Systems, DHCS



Workgroup Goals

- **Goal 1:** Support data needs of the CCS Advisory Group and the technical workgroups.
 - **Goal 2:** Establish CCS performance and quality measures, for demographics, process, and outcomes.
 - **Goal 3:** Assess future data gaps and needs, particularly for Whole-Child Model implementation.
 - **Goal 4:** Inform the evaluation process for the Whole-Child Model.
-



CCS Measure Categories

- Demographics: Program size, Diagnosis, Age, Gender, Race/Ethnicity, Language
- Process Measures: Enrollment, Services, Utilization, Provider Types
- Outcome/Quality Measures: Health Status, Functional Status

Findings from CCS Administrative Data

Lee M. Sanders, MD, MPH

Lisa J. Chamberlain, MD, MPH

Stanford Center for Policy, Outcomes and Prevention (CPOP)

October 21, 2015

CCS Program Advisory Group

Essential Questions

How do we protect the health and well-being of a large population of children with serious chronic illness?

1. How do these children **use** health care services?
2. What may be proxies for **quality** of care that can be derived from existing administrative data?
3. What is the distribution of program **spend** for that care?



Analytic Design

Retrospective, population-based analysis of all paid claims for the CCS Program (2007-2012)

Total capture of all care episodes

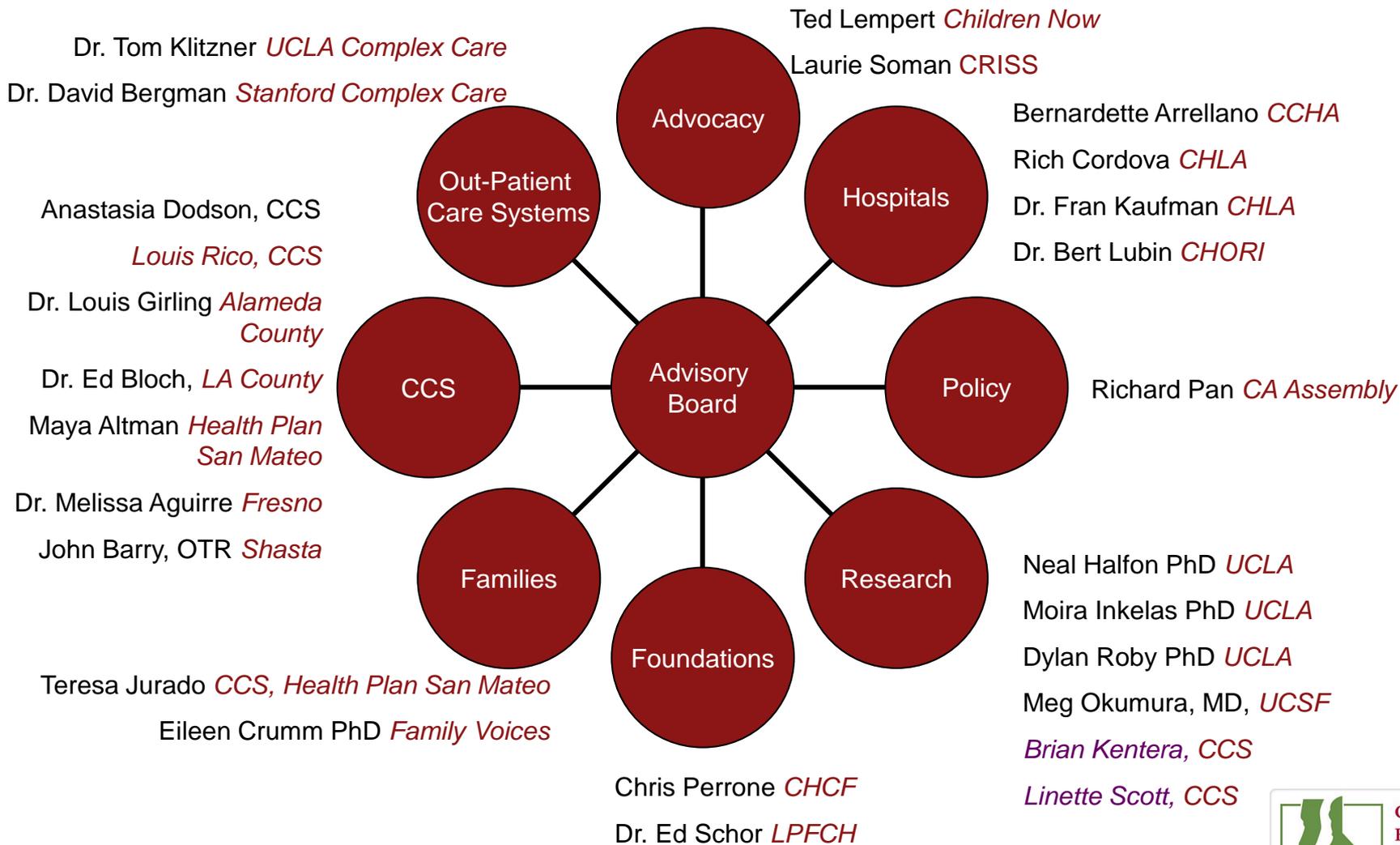
- Inpatient bed days
- Outpatient visits (primary, subspecialty, non-MD)
- ED visits
- Home health and Durable Medical Equipment (DME)
- Residential care
- Pharmacy

Total capture of all CCS-related costs

Partial capture of non-CCS-related costs (FFS)

N = 323,922 children

Stanford CPOP CCS Analytics Advisory Board



Data Source

All paid claims for all CCS enrollees, 7/1/2011 to 6/30/2012, abstracted from the state's Management Information System / Decision Support System.

“Total spending per child” includes all paid claims for children enrolled in fee-for-service Medi-Cal and all condition-specific claims for children enrolled in managed-care Medi-Cal.

Definitions

CCS enrollee: Any child enrolled in California Children's Services from 7/1/2011 to 6/30/2012. Data pulled January 2013. <http://www.dhcs.ca.gov/services/ccs>.

Types of Care: Broad categories based on claim type: Inpatient, Residential Facility, MD visit, Pharmacy, DME, Home Health, ED visit, Dental, Other Outpatient.

Counties, County Groups and Regions: County defined as place of child's residence at enrollment. County groups (3) defined by DHCS CCS Redesign Plan. Regions (5) defined by California Department of Social Services.

Definition of County Groups

Carved-In Counties

Marin, Napa, San Mateo, Solano, Santa Barbara, Yolo

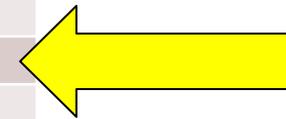
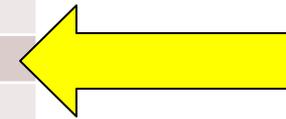
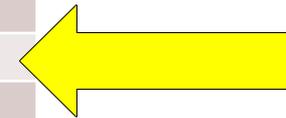
“Whole Child” Counties

Del Norte, Humboldt, Lake, Lassen, Mendocino, Merced, Modoc, Monterey, Orange, Santa Cruz, San Luis Obispo, Shasta, Siskiyou, Sonoma, Trinity

Other Counties

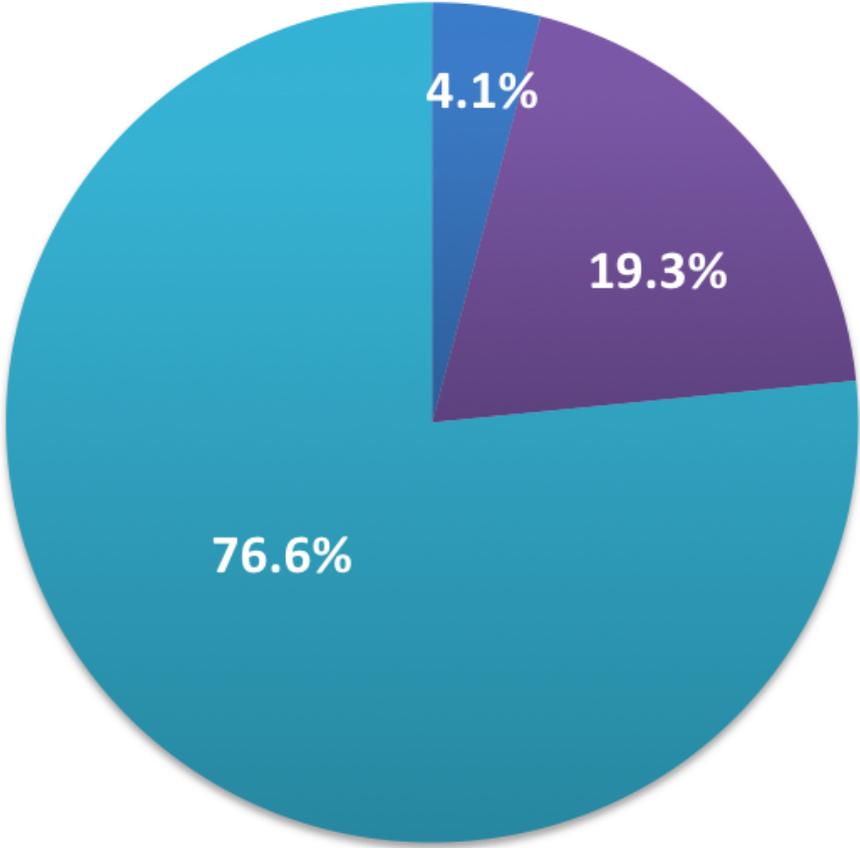
CCS-enrolled Children: Social and Clinical Characteristics

Social and Clinical Characteristics of CCS Enrollees, FY 2012	Mean	Percentage
Age – mean (SD)	8.6 (6.4) years	
Sex - Female		41.8
Race/Ethnicity		
White		15.2
Black		6.5
Hispanic		50.0
Insurance		
MediCal Managed care		50.8
MediCal Non-Managed Care		23.4
Healthy Family		8.1
Mixed / Other		17.7
Medical complexity		
Complex Chronic		28.8
Non-complex Chronic		21.3
Non-Chronic		49.9
Diagnostic category		
Neurology		13.8
Cardiology		12.3
ENT / Hearing Loss		12.0
Trauma / Injury		9.1
Endocrine		8.4



> 2 organ systems, or progressive

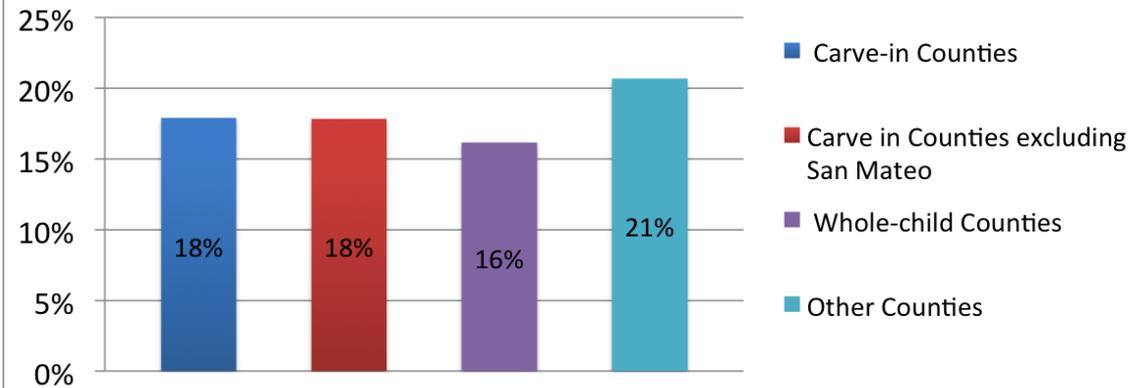
Proportion of Children



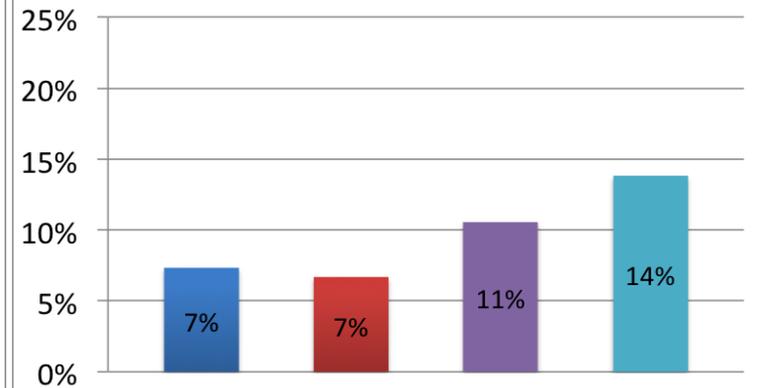
- 1. Carve-in Counties
- 2. Whole-child Counties
- 3. Other Counties

Use of Health Care Services

Percent Hospitalized

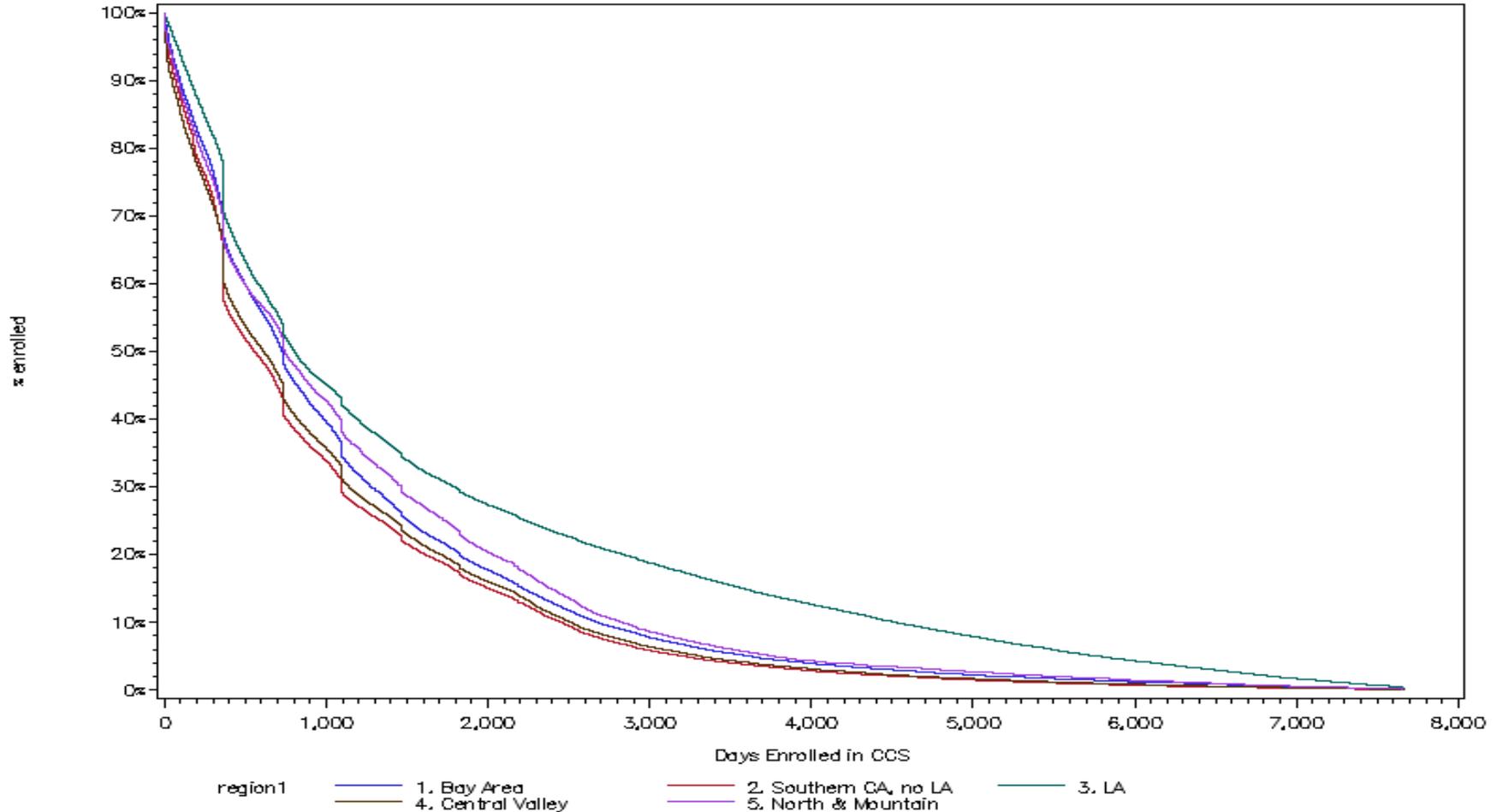


Percent with Home Health Services

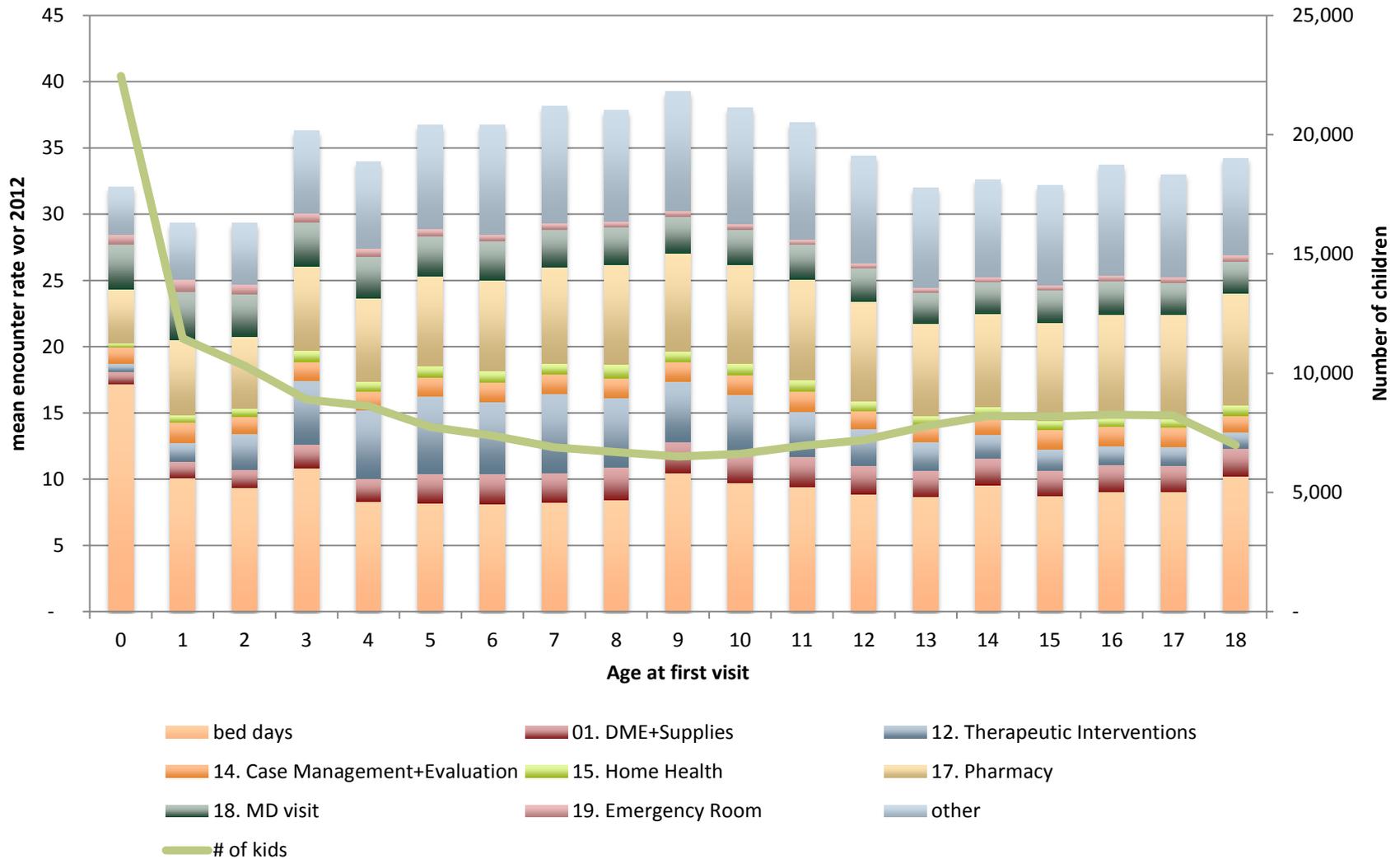


CCS-enrolled Children: Enrollment Periods

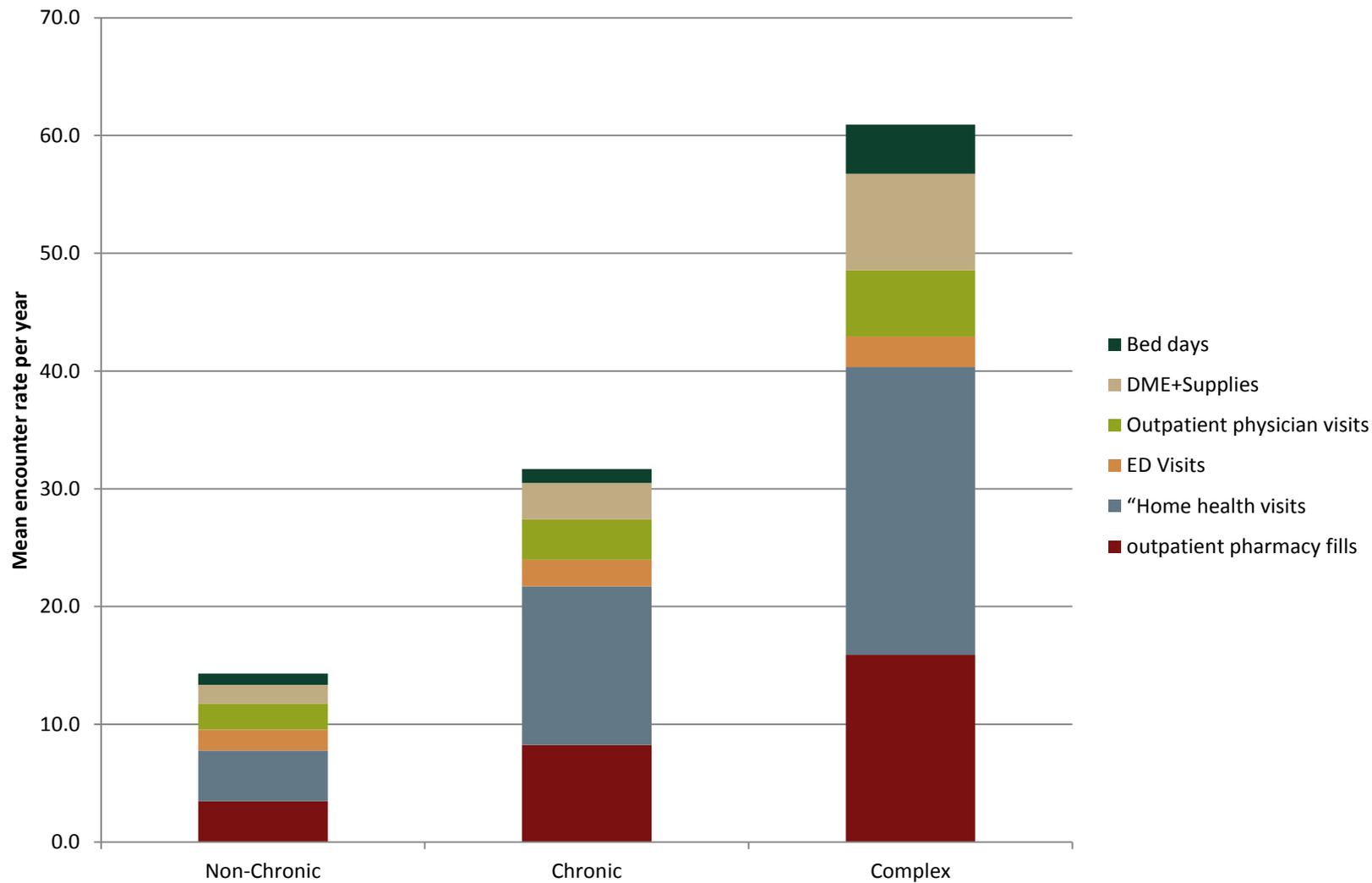
Enrollment Lengths. Children enrolled 7/1/2009–6/30/2012
by region



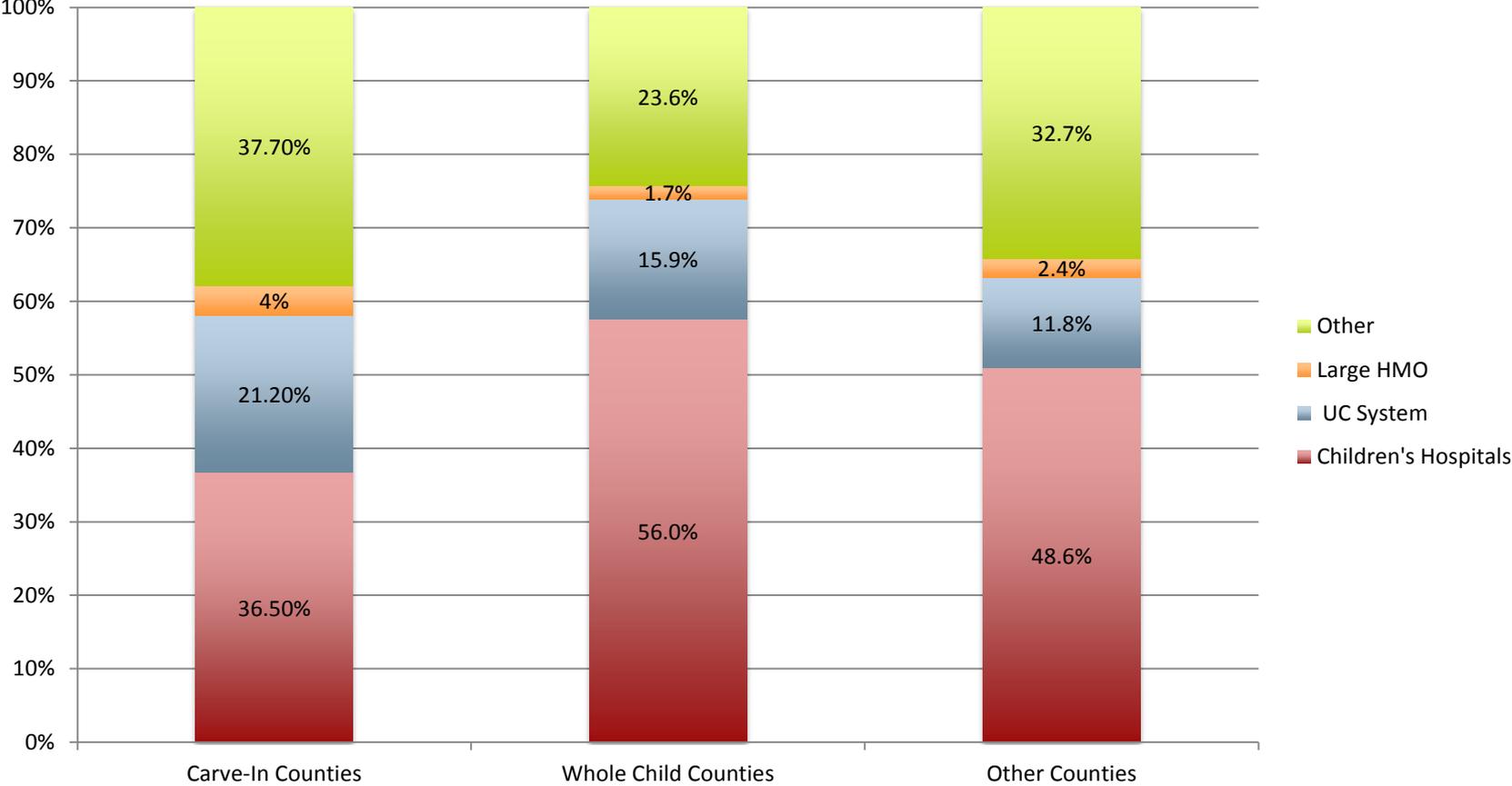
Patterns of Care by Age



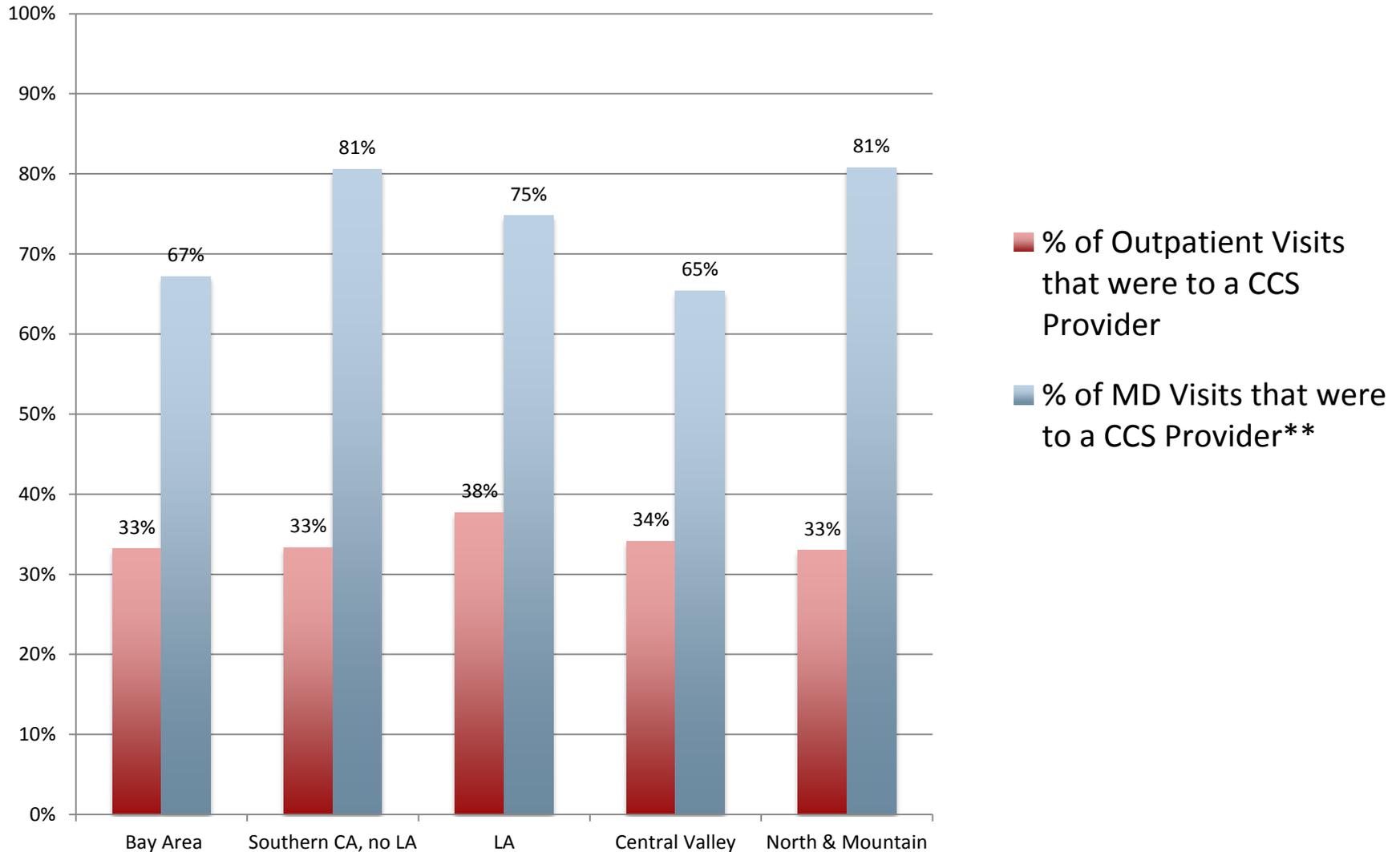
Patterns of Care by Medical Complexity



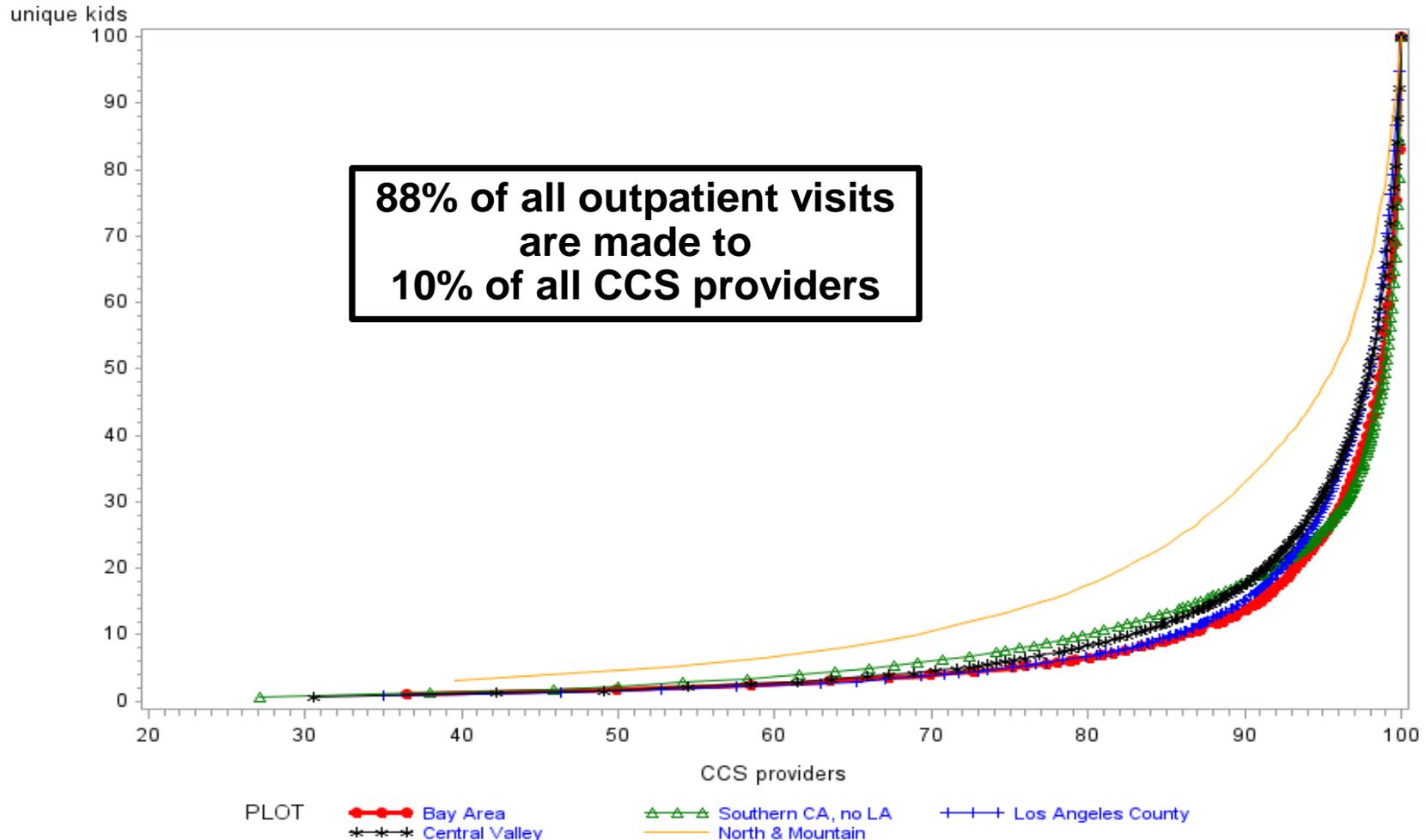
Hospital Care Patterns by Site of Care



Outpatient Care Patterns by Site of Care (CCS vs. non-CCS)



Outpatient Care Patterns by Site (among CCS providers)

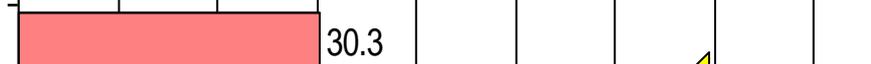


“Quality of Care” Proxy?

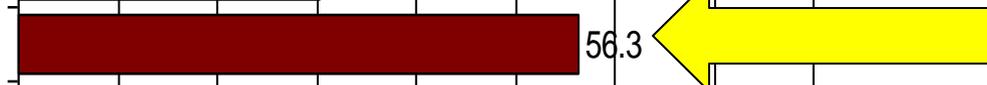
No Care After Hospital Discharge

(Overall Readmission Rate: 9.6%)

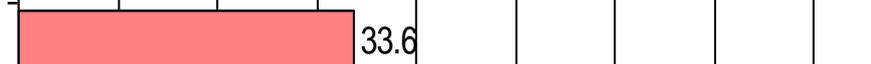
No Outpatient Visit of any kind within 28 days Post-Hospitalization



No MD visits within 28 days Post-Hospitalization



No Outpatient Visit of any kind within 21 days Post-Hospitalization



No MD visits within 21 days Post-Hospitalization



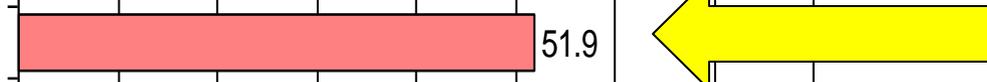
No Outpatient Visit of any kind within 14 days Post-Hospitalization



No MD visits within 14 days Post-hospitalization



No Outpatient Visit of any kind within 7 days Post-Hospitalization



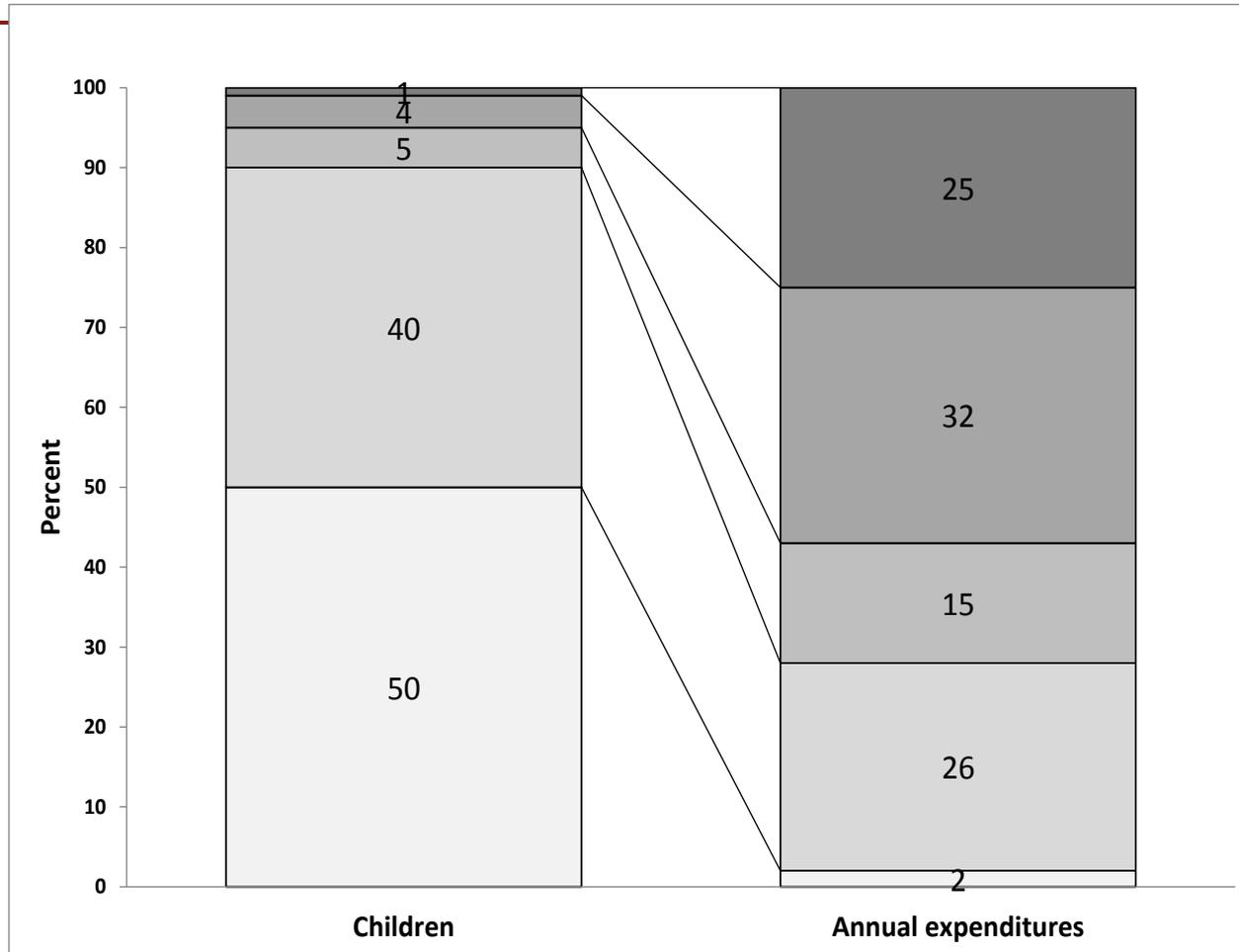
No MD visits within 7 days Post-hospitalization



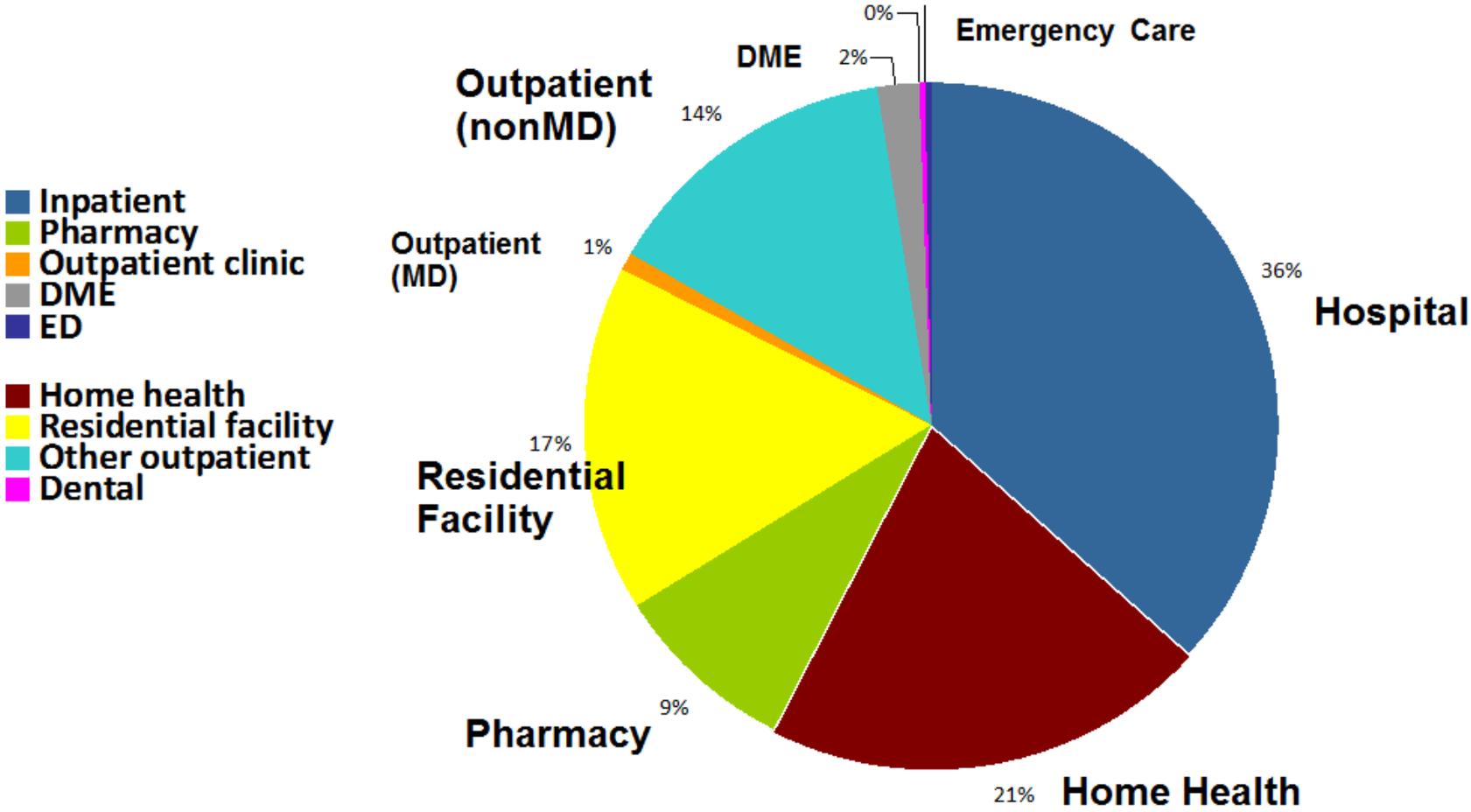
0 10 20 30 40 50 60 70 80

Percent of hospitalized CCS enrollees

Spend Distribution By Child



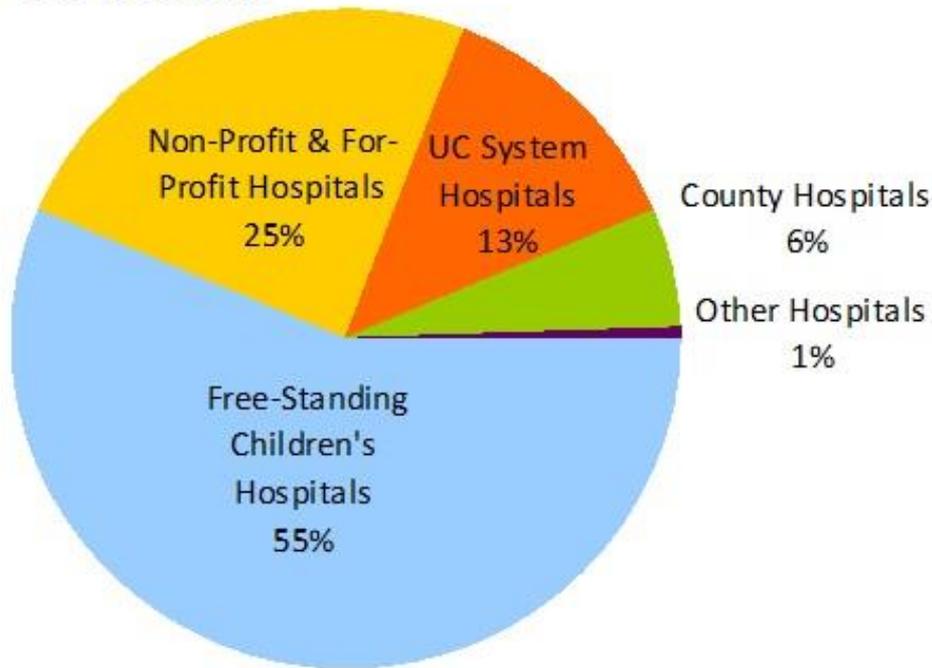
Spend Distribution By Type of Care



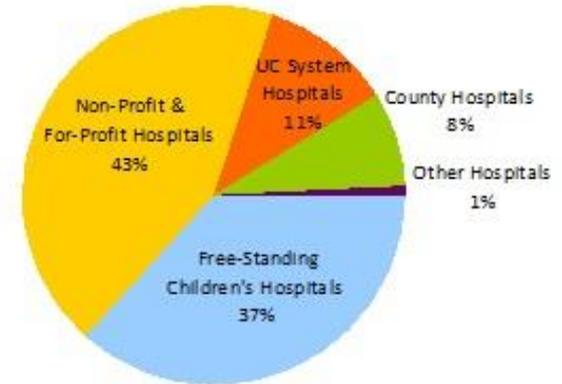
Spend Distribution

Hospital Spend, by Hospital Type

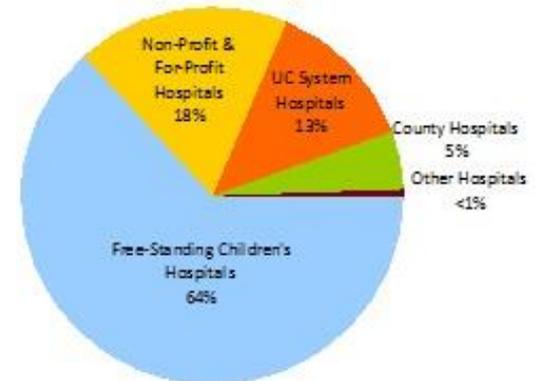
All Children



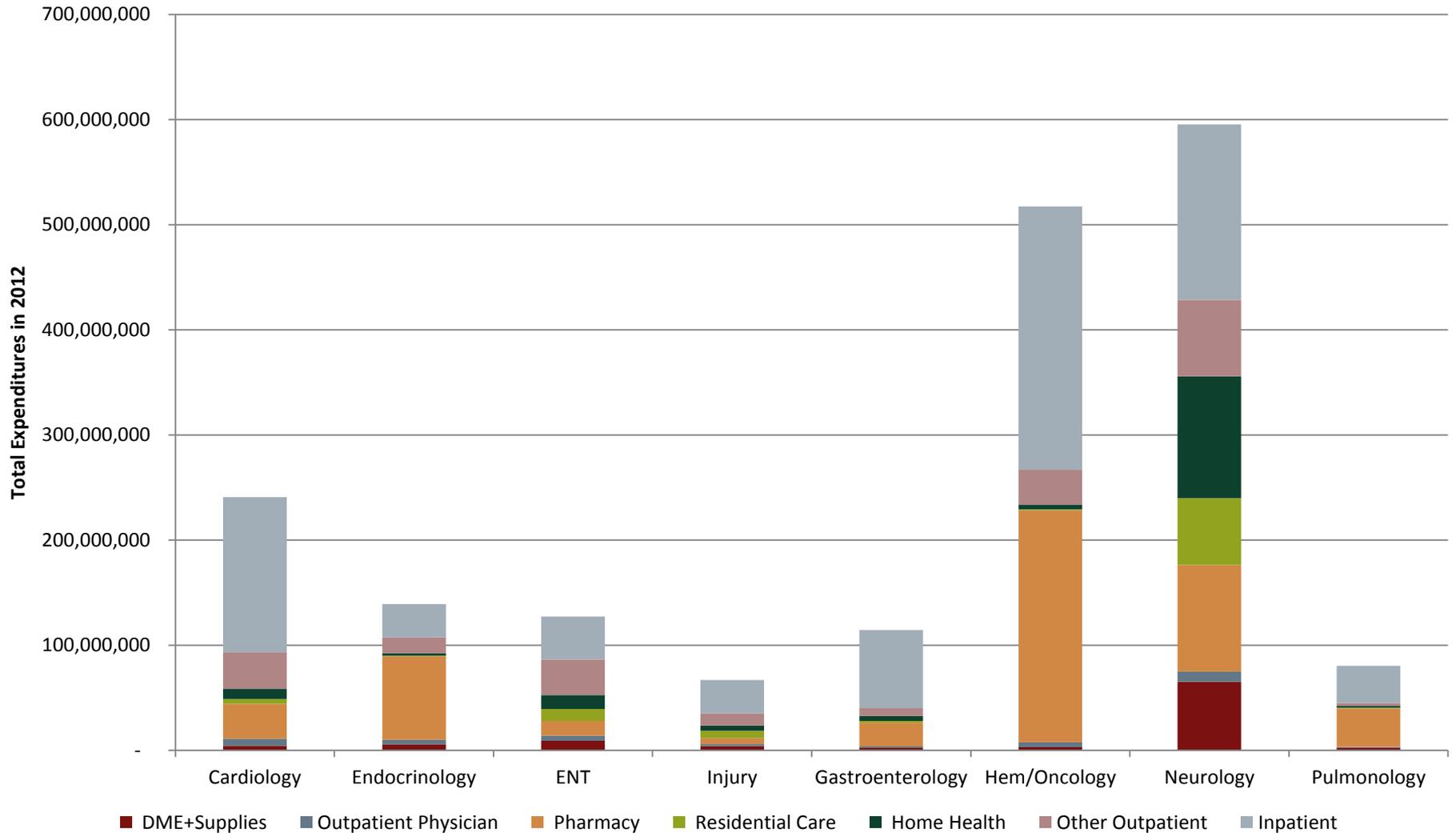
Infants (< 12 months)



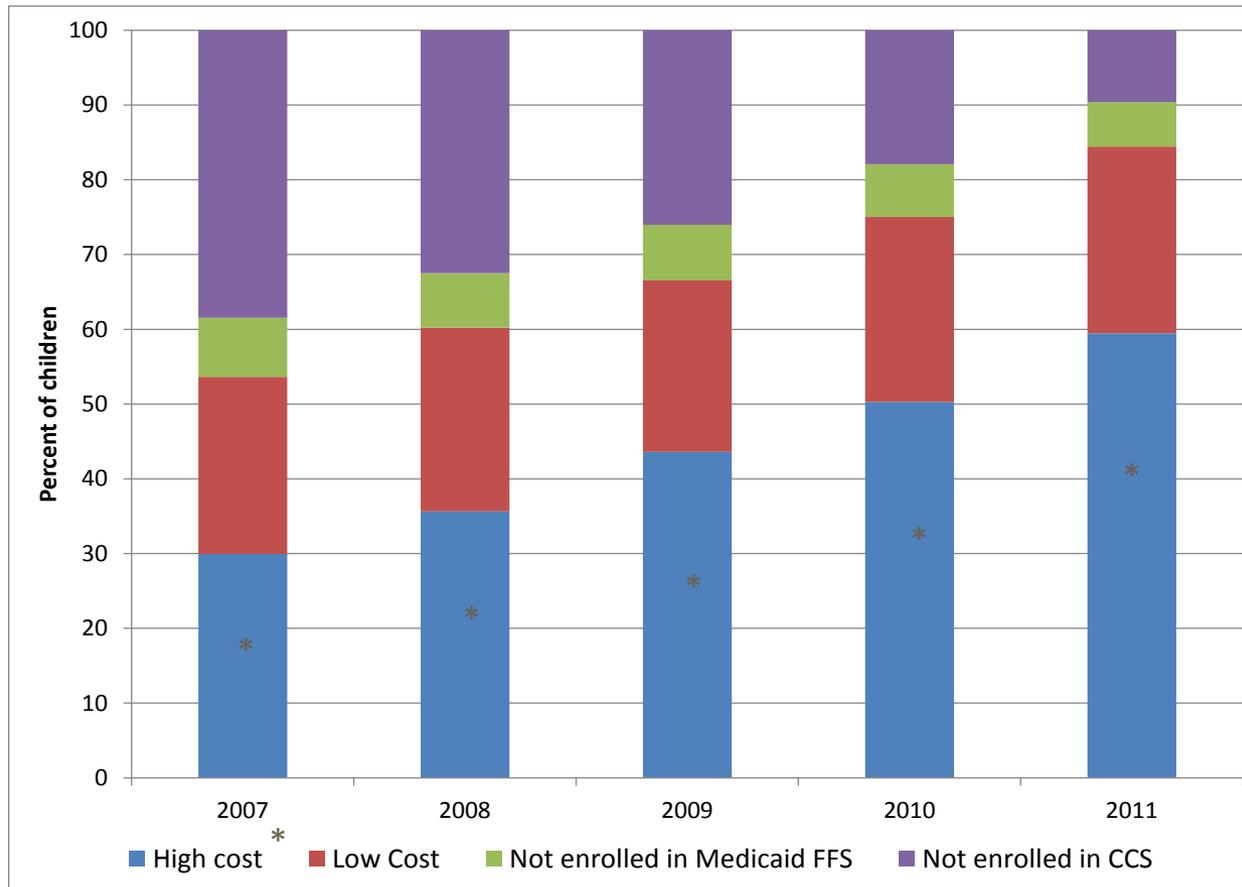
Medically Complex Children



Spend Distribution by Diagnostic Category



Persistence of “High Cost” Over Time



***Among children in FFS program all years (2009-2012) – the proportion of “2012 High Cost Children” who were “high cost” in each of the previous years.**

Summary

- Distinct patterns of care use – particularly by age and medical complexity.
- Wide variability in care patterns, particularly before and after hospitalization.
- Costs are highly skewed, driven by inpatient and residential care, and persistent over time.

Data Requests from CCS RSAB

1. Denied claims (not feasible)
2. Enrollment periods, by diagnostic category and county
3. Description of CCS NICU population, by region
4. Types of outpatient Care
5. Enrollees and spending by type of care.
6. Sites of hospital and outpatient care
7. List of CCS providers (by DHCS)
8. Number of CCS enrollee hospital stays, by hospital
9. Hemophilia claims by county (not PHI feasible)
10. Spending trends over last 3 years (by DHCS)
11. Use and Spending across 3 County groups

Data Request #2

No.	Date Rec'd	Category	Description of Data Request	Status
2	4/2/2015	Caseload	Assess distribution of enrollment length (in months) for CCS patients, both by county/region across the State and by CCS-eligible diagnostic category. No population restrictions; data for all years with complete enrollment information. Stated policy goal is to understand how quickly children move in and out of CCS care, allow for research into demonstrated variations in enrollment length, and see stability of enrollment across the CCS population.	Completed. Link to results.  Results were presented during Data Webinar #3. Slides 17-19.
3	4/2/2015	Services	Specifically for NICU care, data on number of discharges and length of stay across counties/regions, by diagnosis, procedure, and severity tiers. No population restrictions; request most recent data for relevance, along with a range of years to understand trends/changes in NICU population over time. Stated policy relevance is to inform the RSAB – who have raised the issue of NICU care – about the varying levels of NICU patients within CCS.	Pending.

CPOP Policy Briefs

<https://cpopstanford.wordpress.com/our-work/state/>

Center for Policy, Outcomes & Prevention



Center Analytic Team

The Center Analytic Team for the Center for Policy Outcomes and Prevention (CPOP) includes expert pediatric clinicians from across the subspecialties, dedicated data analysts, experts in health service research, biostatistics, epidemiology, economic and the social sciences. Working with state-level stakeholders and community-based partnership team seeks to provide real-world analytic guidance policy efforts to improve the health and health of all children, with a particular focus on children's health care needs (CSHCN).

Analytic Guidance for the California Children's Services (CCS) Program

Funded in part by the California HealthCare Foundation (CHCF), CPOP is applying rigorous analytic population-data to provide policy-relevant

information for the reform of the California Children's Services (CCS), the nation's largest Title V program for more than 150,000 children per year through county- and state-based case management services. The project is led by **Paul H. Wise, MD, MPH** and **Lee M. Sanders, MD, MPH**, faculty at CPOP. **Lisa Chamberlain, MD, MPH**, Assistant Professor of Pediatrics at Stanford University, leads the policy bridging activities, and **Yandana Sundaram, MPH**, leads the data analyses.

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CENTER FOR HEALTH POLICY/
CENTER FOR PRIMARY CARE AND
OUTCOMES RESEARCH

Health Policy Facts

March 2014, Issue 8

Quality of Care: Outpatient Care Before Hospitalization

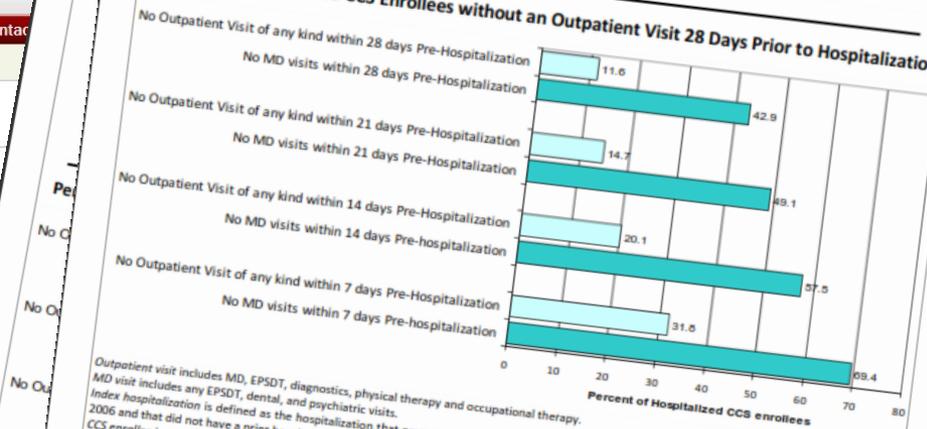
THE FINDINGS

- 12% of CCS enrollees had no outpatient care during the 28 days prior to hospital admission.
- 42% of CCS enrollees had no MD clinic visits during the 28 days prior to hospital admission.
- Those in the following categories had higher-than-average rates of "no visits in 28 days:"
 - Ages 13-21 years
 - Non-complex chronic conditions (e.g., Diabetes, Inflammatory Bowel Disease, Sickle Cell Disease, Hemophilia)¹

POLICY IMPLICATIONS

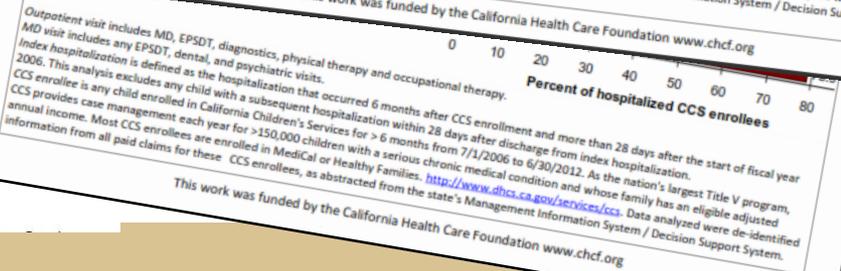
- "Outpatient care before hospitalization" may be a useful quality indicator for some CSHCN. This may be particularly true for children with specific, non-complex chronic conditions.
- Systems of care may be able to reduce some preventable hospitalizations, by identifying and improving outpatient-care delivery to children most at risk for "no outpatient care before hospitalization."

Percent of Hospitalized CCS Enrollees without an Outpatient Visit 28 Days Prior to Hospitalization



Outpatient visit includes MD, EPSDT, diagnostics, physical therapy and occupational therapy. MD visit includes any EPSDT, dental, and psychiatric visits. Index hospitalization is defined as the hospitalization that occurred 6 months after CCS enrollment and more than 28 days after the start of fiscal year 2006 and that did not have a prior hospitalization within 28 days prior. CCS enrollee is any child enrolled in California Children's Services for > 6 months from 7/1/2006 to 6/30/2012. As the nation's largest Title V program, CCS provides case management each year for >150,000 children with a serious chronic medical condition and whose family has an eligible adjusted annual income. Most CCS enrollees are enrolled in MediCal or Healthy Families. <http://www.dhcs.ca.gov/services/ccs>. Data analyzed were de-identified information from all paid claims for these CCS enrollees, as abstracted from the state's Management Information System / Decision Support System. *Mangione-Smith, in press

This work was funded by the California Health Care Foundation www.chcf.org



Outpatient visit includes MD, EPSDT, diagnostics, physical therapy and occupational therapy. MD visit includes any EPSDT, dental, and psychiatric visits. Index hospitalization is defined as the hospitalization that occurred 6 months after CCS enrollment and more than 28 days after the start of fiscal year 2006. This analysis excludes any child with a subsequent hospitalization within 28 days after discharge from index hospitalization. CCS enrollee is any child enrolled in California Children's Services for > 6 months from 7/1/2006 to 6/30/2012. As the nation's largest Title V program, CCS provides case management each year for >150,000 children with a serious chronic medical condition and whose family has an eligible adjusted annual income. Most CCS enrollees are enrolled in MediCal or Healthy Families. <http://www.dhcs.ca.gov/services/ccs>. Data analyzed were de-identified information from all paid claims for these CCS enrollees, as abstracted from the state's Management Information System / Decision Support System.

Thank You

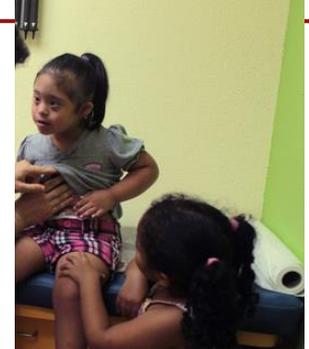
CCS and DHCS

California Stakeholders

Robert Dimand, MD
Katie Schlageter, Alameda
Louis Girling, MD, Alameda
Maya Altman, HPSM
Fiona Donald, MD; Anand Chabra, MD
Teresa Jurado
David Alexander, MD
Ed Schor, MD
Juno Duenas
Eileen Crumm
Laurie Soman
Christy Sandborg, MD, Stanford
David Bergman, MD, Stanford
Jori Bogetz, MD; Doriel Pearson-Nishioka
Bert Lubin, MD, CHRCO
Tom Klitzner, MD, UCLA
Moir Inkela, PhD, UCLA
Dylan Roby, PhD, UCLA
Megie Okumura, MD, UCSF

Stanford University Center for Policy, Outcomes and Prevention

Paul Wise, MD, MPH
Jason Wang, MD, PhD
Vandana Sundaram, MPH
Ewen Wang, MD
Ben Goldstein, PhD
Monica Eneriz-Wiemer, MD
Keith van Haren, MD
Stafford Grady, MD
Susan Fernandez, RN, PhD
MyMy Buu, MD
Nathan Luna, MD
Rachel Bensen, MD
Stephanie Crossen, MD
Olga Saynina, MS
Gene Lewitt, PhD
Maureen Sheehan, RN
Regan Foust
Sonja Swenson





CCS County Measures

- The Department intends to review and publish data from counties on:
 - Medical Home
 - Timely Eligibility Determination
 - Referrals to Specialty Care Centers and Annual Assessments
 - Health Care Transition Planning



Example: CCS County Measure 1

■ Medical Home

- Coordinated comprehensive care: preventative, acute and chronic
- Interdisciplinary team: patient, families, PCP, Specialists, subspecialists, hospitals and healthcare facilities, public, and the community.
- Four key features: patient-centered, comprehensive, coordinated, accessible
- Goal: Document a Primary Care Physician medical home for 95% of all active CCS clients in each county



Example: CCS County Measure 1

Definition	Clients enrolled in CCS, including NICU infants, will have a designated physician, subspecialty physician or nurse practitioner, in a usual place of care (e.g. clinic, office, where care is provided normally), who addresses preventative, acute, and chronic care from birth through transition to adulthood.
Numerator	The total number of unduplicated active children with a Medical Home address in the addressee tab of CMS Net Registration with the Provider Type field identifying a Certified Nurse Practitioner or Physician. A blank Medical Home or another Provider Type in the field will be designated incorrect and not counted.
Denominator	The total number of unduplicated active children enrolled in the local CCS county program.



Example: CCS County Measure 1

CCS Performance Measure 1 Medical Home as of 9/22/2015

Number of children with a primary care physician or nurse practitioner Medical Home	Number of children in the local CCS program	Percent achieved (Goal: 95%)
126,840	179,483	70.67%



Example: CCS County Measure 2

- **Timely Administrative Case Management**
 - Provision of timely administrative case management services including determination of initial medical, financial and residential eligibility
 - Assess when a child is first referred to the CCS program
 - Medical eligibility is determined within 7 calendar days
 - Residential eligibility is determined within 30 calendar days
 - Financial eligibility is determined within 30 calendar days
-



Example: CCS County Measure 2

Definition	Children referred to CCS have their initial medical and program (financial and residential) eligibility determined within the prescribed guidelines per California Codes of Regulations (CCR), Title 22, and according to established CCS policy * and procedures**. Counties will measure the following:
Numerator	<p>a. Medical eligibility is determined within seven calendar days of receipt of all medical documentation necessary to determine whether a CCS-eligible condition exists in the last fiscal year. (CCR, Title 22, Section 42132; CCS N.L. 20-0997) Measure number of days between the referral date and the last case note within the reported Fiscal Year with a type of “Medical Documentation Received”.</p> <p>b. Residential eligibility is determined within 30 calendar days of receipt of documentation needed to make the determination in the last fiscal year. (CCR, Title 22, Section 41610) Measure number of days between the referral date and the last case note within the reported Fiscal Year with a type of “Residential Documentation Received”.</p> <p>c. Financial eligibility is determined within 30 calendar days of receipt of documentation needed to make the determination in the last fiscal year. (CCR, Title 22, Section 41610). Measure number of days between the referral date and the last case note within the reported Fiscal Year with a type of “Financial Documentation Received”.</p>
Denominator	Number of unduplicated new referrals to the CCS program in each county assigned a pending status in the last fiscal year.



Example: CCS County Measure 2

Medical Eligibility

	Number of referrals determined medically eligible within 7 calendar days	Number of new unduplicated referrals	Percent determined eligible
FY 2012/13	45,614	74,734	61.04%
FY 2013/14	44,012	69,327	63.48%
FY 2014/15	40,455	68,405	59.14%



Example: CCS County Measure 2

Residential Eligibility

	Number of cases determined eligible within 30 days of receipt of documentation needed to make the determination	Number of new unduplicated referrals	Percent determined eligible
FY 2012/13	55,596	74,734	74.39%
FY 2013/14	53,051	69,327	76.52%
FY 2014/15	54,954	68,405	80.34%



Example: CCS County Measure 2

Financial Eligibility

	Number of cases determined eligible within 30 days of receipt of documentation needed to make the determination		Number of new unduplicated referrals		Percent determined eligible	
	MC/OTLICP	CCS	MC/OTLICP	CCS	MC/OTLICP	CCS
FY 2012/13	38,031	17,417	43,826	30,908	86.78%	56.35%
FY 2013/14	40,776	12,132	46,517	22,810	87.66%	53.19%
FY 2014/15	44,939	9,942	50,237	18,168	89.45%	54.72%



Example: CCS County Measure 3

- Care Coordination
 - Oversee a system of Special Care Centers that provide comprehensive and coordinated multidisciplinary specialty health care
 - Annual comprehensive assessment/evaluation report on Special Care Centers
 - Three key features: patient-centered, comprehensive, coordinated



Example: CCS County Measure 3

Definition	Clients enrolled in CCS, in the identified ICD categories, will have a referral to a designated Special Care Center and an annual SCC Team Report.
Numerator	<p>Number of clients in CCS, with a medical condition in the following ICD categories, who actually received an authorization for SCC services in the last fiscal year:</p> <ol style="list-style-type: none"> 1. Cardiac Defect: 745. or any 5-digit 745. code Cardiac Anomalies: 746. or any 5-digit 746. code 2. Cystic Fibrosis: 277. or any 5 digit 277. code Respiratory Failure: 518. or any 5-digit 518. code 3. Diabetes Type I: 250. or any 5-digit 250. code 4. Factor Disorder: 286. or any 5-digit 286. code Leukemia: 204. or any 5-digit 204. Code Sickle Cell: 282.62 or .63 or .64 or .68 or .69 5. Post-Transplant: 33.50, 33.51, 33.52, 33.6, 37.5, 37.51, 41.01, 41.02, 41.03, 41.04, 41.05, 41.06, 41.07, 41.08, 41.09, 46.97, 50.51, 50.59, 52.80, 55.61, 55.69
Denominator	Number of unduplicated CCS clients in each category and subcategory who should receive an authorization for SCC services in the last fiscal year.



Example: CCS County Measure 3

Part A: Referral of a CCS Client to SCC

Fiscal Year	Number of clients with authorization to SCC	Number of clients in CCS, 18 -20 yrs., with a medical condition in the following ICD-9 categories: 1. Cardiac Defect Cardiac Anomalies 2. Cystic Fibrosis Respiratory Failure 3. Diabetes Type I 4. Factor Disorder Leukemia Sickle Cell 5. Post-Transplant 6. Infantile Cerebral Palsy, Unspecified	Percent achieved (Goal: 95%)
FY 2012/13	25,083	40,367	62.14%
FY 2013/14	24,834	38,800	64.01%
FY 2014/15	25,716	39,164	65.66%



Example: CCS County Measure 3

Part B: Annual Team Report

Fiscal Year	Number of clients with authorization to SCC and an annual SCC team report in the client's CCS case record	Number of clients with authorization to SCC	Percent achieved (Goal: 95%)
FY 2012/13	0	25,083	0.00%
FY 2013/14	4	24,834	0.02%
FY 2014/15	1,586	25,716	6.17%

Note: Data source is county case notes entered into CMS Net. Information requested August 14, 2014 in Information Bulletin #447. As such, counties may have completed the task without documenting them in CMS Net.



Example: CCS County Measure 4

- Health Care Transition Planning
 - CCS clients 18 years and older are evaluated for long-term health care transition planning
 - CCS clients who have a chronic health condition that is expected to extend beyond their 21st birthday
 - Three key features: patient-centered, comprehensive, coordinated



Example: CCS County Measure 4

Definition	<p>The percentage of youth enrolled in the CCS program 18 years and older identified by ICD Categories in Performance Measure 3 who are expected to have a chronic health condition that will extend past their 21st birthday will have CMS Net case notes documentation of health care transition planning.</p>
Numerator	<p>The number of youth enrolled in the CCS program who are 18 years and older identified in the denominator below who have documentation in either the <u>Transition Planning Required</u> Case Note or the <u>Transition Planning Not Required</u> Case Note identified during the Annual Medical Review for each client.</p>
Denominator	<p>Number of clients in CCS, age 18 through 20, with a medical condition in the following ICD-9 categories:</p> <ol style="list-style-type: none"> 1. Cardiac Defect: 745. or any 5-digit 745. code Cardiac Anomalies: 746. or any 5-digit 746. code 2. Cystic Fibrosis: 277. or any 5 digit 277. code Respiratory Failure: 518. or any 5-digit 518. code 3. Diabetes Type I: 250. or any 5-digit 250. code 4. Factor Disorder: 286. or any 5-digit 286. code Leukemia: 204. or any 5-digit 204. Code Sickle Cell: 282.62 or .63 or .64 or .68 or .69 5. Post-Transplant: 33.50, 33.51, 33.52, 33.6, 37.5, 37.51, 41.01, 41.02, 41.03, 41.04, 41.05, 41.06, 41.07, 41.08, 41.09, 46.97, 50.51, 50.59, 52.80, 55.61, 55.69



Example: CCS County Measure 4

Part A: Transition Planning

Fiscal Year	The number of youth enrolled in the CCS program who are 18 years and older identified in the denominator below who have documentation in either the Transition Planning Required Case Note or the Transition Planning Not Required Case Note identified during the Annual Medical Review for each client.	Number of clients in CCS, 18 -20 yrs., with a medical condition in the following ICD-9 categories: 1. Cardiac Defect Cardiac Anomalies 2. Cystic Fibrosis Respiratory Failure 3. Diabetes Type I 4. Factor Disorder Leukemia Sickle Cell 5. Post-Transplant 6. Infantile Cerebral Palsy, Unspecified	Percent achieved (Goal: 95%)
FY 2013/14	288	6,298	4.57%
FY 2014/15	474	6,570	7.21%

Note: Data source is county case notes entered into CMS Net. Information requested February 14, 2014 in Information Bulletin #443. As such, counties may have completed the task without documenting them in CMS Net.



Example: CCS County Measure 4

Part B: Transition Plan Checklist

Transition Documentation

1. Client has an identified need for long-term transition planning.
2. Transition planning noted in client's CMS Net case notes.
3. Transition planning noted in medical reports from PCP, SCC or other specialty providers.
4. Did the doctors document discussion of the child's changing needs as he or she approached adulthood, insurance coverage in adulthood.
5. Vocational Rehabilitation noted in client's reports.
6. Adult provider discussed or identified for clients 18 years of age or older.
7. Transition planning noted in SELPA for clients in the MTP.

Note: Checklist will not be tracked in CMS Net and not all items in Checklist will be applicable for each chart review.



Instructions for Group Break-Outs

Bobbie Wunsch

Pacific Health Consulting Group



Group Break-Out Session on Specific Topics

- **Transitions for Youth Aging Out of CCS**
 - What standards on transitions for youth should be added to county or managed care requirements?
 - **Care Coordination: Review of various approaches and how they can be applied in managed care for children with CCS conditions**
 - What aspects of CCS care coordination model can be applied to managed care plans?
 - **CCS Credentialing Standards**
 - How do CCS standards differ from managed care provider credentialing standards?
-



Report Out from Break-Out Session

Bobbie Wunsch

Pacific Health Consulting Group



Public Comments

Bobbie Wunsch

Pacific Health Consulting Group



Next Steps and Next Meetings

Jennifer Kent
Director, DHCS

Bobbie Wunsch

Pacific Health Consulting Group



Next Meetings

2016 CCS Advisory Group Meeting Dates:

- January 6, 2016
- April 6, 2016
- July 6, 2016
- October 5, 2016



Information and Questions

- For CCS Redesign information, please visit:
 - <http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx>
- Please contact the CCS Redesign Team with questions and/or suggestions:
 - CCSRedesign@dhcs.ca.gov
- If you would like to be added to the DHCS CCS Interested Parties email list, please send your request to:
 - CCSRedesign@dhcs.ca.gov