

California Children's Services Redesign

**Care Coordination / Medical Home /
Provider Access
Technical Workgroup Webinar**

October 9, 2015

Agenda

- **Welcome, Introduction, and Purpose of Today’s Meeting**
 - Anastasia Dodson, Associate Director for Policy, DHCS
- **Workgroup Charter and Goals**
 - Anastasia Dodson, Associate Director for Policy, DHCS
- **Managed Care: Care Coordination Standards**
 - Anna Lee Amarnath, MD, Acting Medical Quality and Oversight Section Chief, DHCS
- **Proposed County Performance Measures**
 - Anastasia Dodson, Associate Director for Policy, DHCS
- **Los Angeles County CCS – Operationalizing Best Practices: Update on Case Management Redesign**
 - Dr. Mary Doyle, Associate Medical Director, Los Angeles County CCS
- **Medical Therapy Program Overview, Data Analysis, and Coordination**
 - Pat Howard, OT Supervisor, MTP , Napa County CCS
 - Harriet Fain-Tvedt, PT, Chief, MTP, Orange County CCS
 - Tess O’Hern, Therapy Manager, Orange County CCS
- **CCS Transition of Care - Collaborative Coordination of Care**
 - Kathy Neal, Chief Health Services Officer, Central California Alliance for Health
- **Wrap-up and Next Steps**
 - Anastasia Dodson, Associate Director for Policy, DHCS

Welcome, Introductions, and Purpose Of Today's Meeting

Anastasia Dodson

DHCS Associate Director for Policy

CC/MH/PA Workgroup Charter and Goals

Anastasia Dodson
DHCS Associate Director for Policy

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.

CCS Care Coordination Standards in Managed Care

Anna Lee Amarnath, MD

Acting Chief Medical Quality and Oversight Section
Managed Care Quality and Monitoring Division

Managed Care: Care Coordination Standards

- Many Medi-Cal beneficiaries with California Children's Services (CCS) eligible conditions are also enrolled in a Medi-Cal managed care health plan (MCP).
- Most MCP contracts do not cover CCS services.
- For those MCPs in which CCS services are carved-in, the MCPs are responsible for covering CCS services in addition to all medically necessary services not related to the CCS condition.

Managed Care: Care Coordination Standards

- MCPs develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program.
- Policies and procedures are reviewed and approved by DHCS.

Managed Care: Care Coordination Standards

MCP's providers identify CCS-eligible members by:

- Performing baseline health assessments.
- Performing diagnostic evaluations.
- Providing sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition.

Managed Care: Care Coordination Standards

MCPs facilitate:

- Initial referrals of members with CCS-eligible conditions to the local CCS program by telephone, same-day mail or fax, if available.
- Supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.



Managed Care: Care Coordination Standards

- MCPs provide all Medically Necessary Covered Services for the Member's CCS-eligible condition until CCS eligibility is confirmed.
- MCPs provide all Medically Necessary Covered Services that are unrelated to the CCS-eligible condition.
- MCPs facilitate coordination of services and joint case management between their Primary Care Providers and the CCS program.
- MCPs execute a Memorandum of Understanding (MOU) with the local CCS programs for the coordination of CCS services to members. MOUs are reviewed and approved by DHCS.

COHS contract language; Exhibit A, Attachment 11 & Attachment 18

Proposed CCS County Measures

Anastasia Dodson

DHCS Associate Director for Policy

CCS County Measures

- The Department intends to monitor counties on:
 - Medical Home
 - Timely Administrative Case Management
 - Care Coordination
 - Health Care Transition Planning

Example: CCS County Measure 1

<p>Definition</p>	<p>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.</p>
<p>Numerator</p>	<p>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.</p>
<p>Denominator</p>	<p>The total number of unduplicated active children enrolled in the local CCS county program.</p>

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	<ul style="list-style-type: none"> 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”. 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”. 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”.
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 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 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



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 Care Coordination Technical Work Group

October 9, 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 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 has never used a standardized method for ICD code assignment for the covered medical condition
- Based on the the controlled assignment of ICD 9 codes to 1741 new referrals to the pilot team, a draft list of codes for CCS medically eligible conditions was “cross walked” to ICD 10 codes. This formed the starting point for the development of standardized lists of codes that will be used for LA Co. CCS
- Currently, a team is piloting a set of coding principles and revising 4 sets of standardized codes (NICU, MTU, standard, complex cases) with the goal of general program use by 1.1.16

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 assessment, development of a nursing care plan and 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!

Pat Howard, OT
Harriet Fain, PT, MPA
Tess O'Hern, DPT

California Children's Services Medical Therapy Program

Medical Therapy Program (MTP)

- o Medical Therapy Units (MTUs)
 - Located on school campuses per State interagency agreement
 - MediCal certified outpatient rehab centers
- o Physical and Occupational Therapy
 - Based on medical necessity
 - General service delivery model: International Classification of Functioning, Disability and Health (ICF)
- o Medical Oversight
 - Special Care Centers managing children with complex needs *or*
 - Medical Therapy Conference (MTC) physicians may include
 - Pediatricians
 - Orthopedists
 - Psychiatrists
 - Neurologists
 - MTCs in large counties include nurses, social workers, nutritionists, orthotists and/or durable medical equipment (DME) providers

Purpose of the MTP

- Provide medically necessary physical and occupational therapy to children with qualifying diagnoses from birth to age 21

MTP Diagnoses

- Cerebral Palsy
- Neuromuscular diseases, e.g., muscular dystrophy
- Musculoskeletal diseases, e.g., arthrogryposis, juvenile rheumatoid arthritis
- Spina bifida
- Brachial plexus injury
- Acquired conditions
 - Spinal cord injury (SCI)
 - Traumatic brain injury (TBI)
 - Sequelae of brain tumors

Intake and Services

- MTP medical eligibility determined
 - Patients and families oriented to the program
 - OT and PT assessments completed
- Goals and objectives based on
 - Family input
 - Functional need
 - Evolving evidence for best-practice

Service Delivery Framework

International Classification of Functioning, Disability and Health

Sample ICF for a child with CP

Health Condition
10 year old male with a diagnosis of Cerebral Palsy. GMFCS III- MACS II- CFCS I.

Body Structure and Function (Impairments)	Activity	Participation
Decreased strength <ul style="list-style-type: none"> Especially hip abductors and extensors Decreased grip and pinch strength Decreased active and passive range of motion <ul style="list-style-type: none"> tight hip flexors, hamstrings, ankle plantar flexors, shoulder flexors Decreased balance Decreased postural control Decreased endurance	Abilities/Restrictions Sitting: indep Standing: contact guard support/ requires equipment to transfer to stand Ambulation: Household distances with reverse walker/unable to ascend/descend stairs Propels manual WC indep/needs min assist for ramps and inclines; fatigues after 30 minutes propelling WC ADL- difficulty with fasteners Min assist with bathing/grooming	Abilities/Restrictions Rides adaptive trike/Requires assistance to transfer on/off trike Participates in Cub Scouts/requires adult assistance on outings

Environmental			
Internal		External	
+	-	+	-
Motivated Able to follow instructions	Distractible	Supportive family Accessible home and school	Distance to therapy clinic

Jonathan's Story



Neurologists

Pediatric ICU Physicians

Physical Therapists

Occupational Therapists

Speech Therapists

JONATHAN **Physiatrists**

Respiratory Therapists

Nurses

Orthopedists

Social Workers

Gastroenterologists

**All of these services and
Jonathan's ongoing care are
coordinated and authorized
by
California Children's Services**

Therapy Evaluations



Medical Therapy Conference (MTC)



Orthopedist measuring scoliosis curve

Scoliosis Management in Orthotics Clinic



Fitting the body jacket for optimal posture and comfort

Durable Medical Equipment (DME)



**Wheelchair
adjustments needed
to accommodate
the new
body jacket**

PT and OT Sessions

Activities of Daily Living



Working on a switch toy ...



Got it!

7 Years Later, 12 years old

...



**Jonathan,
his parents
and
full time nurse**

**Nursing care:
40 hours/week**

**Respite Care:
24 hours/month**

Full Scope MediCal

SSI

Daily Home Program



Dependent Transfers



**Jonathan being transferred by his dad
Height: 61.5", Weight: 113 pounds**

Customized Equipment



**That's just one patient's story,
and one diagnosis.**

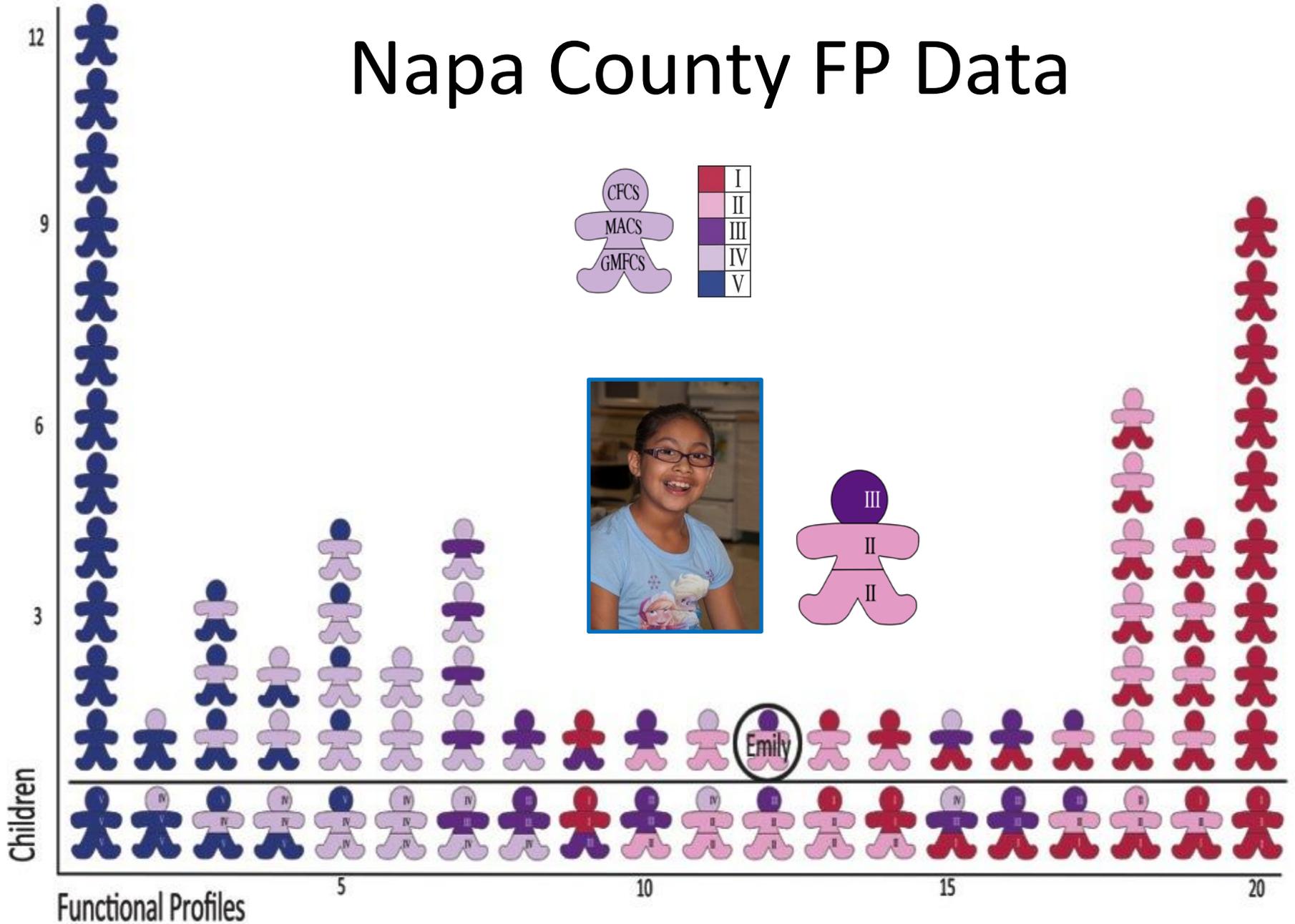
Functional Profiles (FP)

- o Cerebral Palsy is the most common diagnosis in the MTP
- o Approximately 45% to 55%
- o Functional Profiles
 - o 5 levels for each scale
 - o 125 possible different functional profiles
 - o Gross Motor Function Classification System (GMFCS)
 - o Manual Ability Classification System (MACS)
 - o Communication Function Classification System (CFCS)

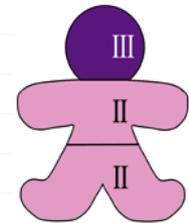
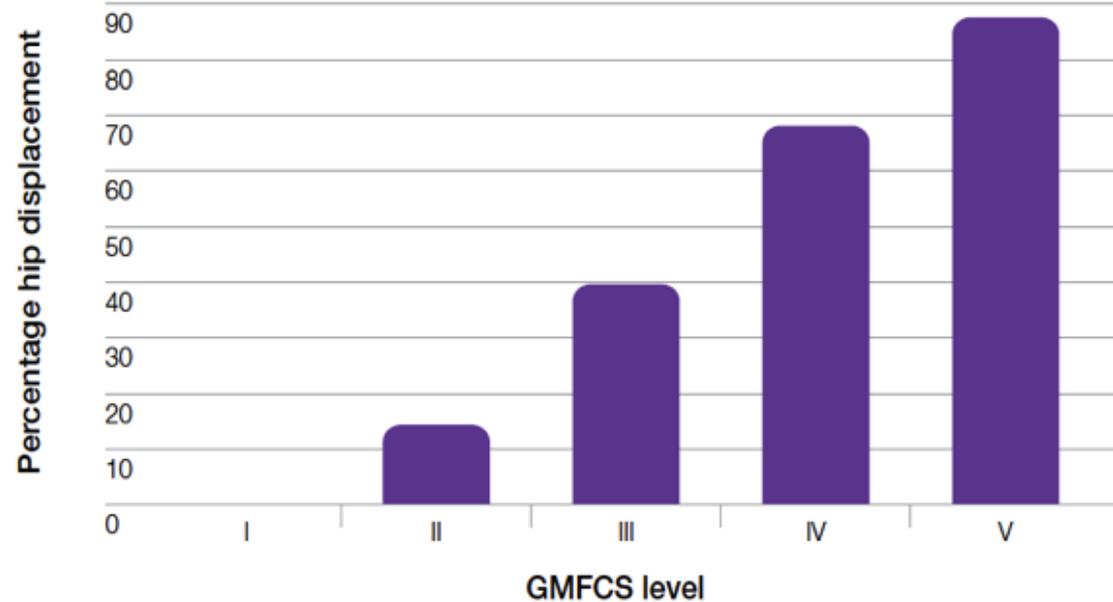
Orange County FP Data

- o Total caseload: 1937
- o Number with CP: 880 (45%)
- o Total Number with complete functional profiles (FPs): 702
- o Number of complete functional profiles represented out of a possible 125: **82**

Napa County FP Data



Hip Surveillance-a new chapter in care coordination



CCS Transition of Care



Collaborative Coordination of Care

Kathy Neal, RN, DNP(c)

Chief Health Services Officer

October 9, 2015

Currently at the Alliance

- Three counties with 333,000 members
- About 6000 members with CCS conditions
- About 4650 open CCS cases on 10/1/2015
- Extensive provider network of about 4700 providers
- Reviewing gap in network; active SCA practice
- UM Staff composed of Medical Directors, RNs, CCS Coordinators

Best Practices

1. All members are assigned to a Patient Centered Medical Home (PCMH)

- Transition from pediatrician to adult primary care
- CCS activity communicated with PCP
- Continuity of Care policy

2. Identification of CCS members

- PEDI (Provider Electronic Data Inquiry) list automated to Care Management system
- Updated monthly
- Members flagged for UM, CM, MS, Pharmacy staff
- Concurrent Review

Best Practices (continued)

3. UM staff trained to identify CCS diagnoses

- Authorization requests
- CCS criteria

4. Collaboration

- UM, Member Services, Provider Services
- County CCS
- Alliance Children's Case Management

Transition Process

1. Starts as early as 18 years old
2. Coordination of care with CCS staff
 - UM and Children's Case Managers have access to PEDI, reads notes for coordination of care
3. Continuity of care
 - Access to care
 - Primary/Specialty Services
 - DME
 - Pharmacy

External Communication

1. County CCS collaboration

- MOU
- Regular communication
- Identified CCS liaisons
- Quarterly in-person meetings

2. Authorization/Referral process

- Provider based

Questions?



kneal@ccah-alliance.org

Wrap-up and Next Steps

Anastasia Dodson

Associate Director for Policy, DHCS



CCS Stakeholder Meeting

CCS Advisory Group Stakeholder Meeting

When: Wednesday, October 21, 2015

10:00am – 4:00pm

Where: Sacramento Convention Center

1400 J St, Sacramento

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