

**California Children's Services (CCS) Redesign**

**Care Coordination, Medical Homes, and Provider Access Technical Workgroup**

**October 9, 2015**

**Background and Purpose**

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

The Department of Health Care Services (DHCS), in an effort to improve health care and to emphasize quality and coordination of care for Children and Youth with Special Health Care Needs (CYSHCN), initiated the CCS Redesign process in 2014 to work with stakeholders and investigate potential CCS program improvements. Within the Redesign process, DHCS proposed a "Whole-Child Model," an organized delivery system that will provide comprehensive, coordinated services for children and youth with special health care needs in a limited number of counties, no sooner than 2017.

To inform the ongoing CCS Redesign process in all counties, as well as the Whole Child Model implementation, DHCS established the CCS Redesign Advisory Group (AG), composed of individuals with expertise in both the CCS program and care for CYSHCN. In addition, a series of topic-specific technical workgroups are being conducted:

- Data and Quality Measures
- Care Coordination/Medical Home/Provider Access
- Eligible Conditions

**Care Coordination, Medical Homes, and Provider Access Technical Workgroup Goals and Objectives**

- **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.

## **Priorities and Workgroup Activities**

These items will inform the discussion and work of the CCS Advisory Group and other workgroups. Additional issues and/or requirements may arise during the Redesign process and will be added accordingly.

### ***Priorities for 2015-2016***

- Evaluate the roles and responsibilities of “care coordinator” positions in county health systems and health plans as well as necessary background/ qualifications for those positions.
- Attain parent/caregiver perspectives on issues of systems navigation, medication management, and in-home resources to identify areas of need and potential for improvement.
- Identify gaps in availability of care coordination services, specialty care services, self-management services, and education for the CCS Program enrollees.
- Explore existing local resources, efforts, and collaborations that will provide CCS beneficiaries social and support services, complementing CCS’s medical and care coordination services.
- Assess provider access standards to promote continuity of care and ensure CCS beneficiaries have access to adequate provider networks.

### ***Priorities for 2016-2017***

- Develop standardized roles and responsibilities of “care coordinators” and propose strategies to implement the new standards gradually and effectively.
- Propose and implement a strategy to incorporate care coordinators’ roles and responsibilities in CCS Program and the Whole-child Model.
- Propose and implement necessary changes to standards of care and provider network standards appropriately to enhance CCS beneficiaries’ access to primary and specialty care in rural and underserved areas.
- Explore the potential for incorporating telemedicine and home-based health care into enrollees’ care plan for care maintenance.

Please contact [CCSRedesign@dhcs.ca.gov](mailto:CCSRedesign@dhcs.ca.gov) with any questions or comments.