

California Children's Services Redesign

Data and Quality Measures
Technical Workgroup Webinar

December 4, 2015

9:00am – 10:30am

Agenda

- **Welcome, Introductions, and Purpose of Today’s Meeting**
 - Anastasia Dodson, Associate Director for Policy, DHCS
 - **CCS Performance Measures and Comments Received**
 - Linette Scott, MD, Information Management Deputy Director and CMIO, DHCS
 - **Efforts to Develop Indicators for Outpatient Care for Children with Special Health Care Needs & Follow-up to the October 21 Advisory Group Discussion – At Least One Outpatient Visit after Hospitalization**
 - Lee M. Sanders, MD, MPH, Stanford Center for Policy, Outcomes and Prevention
 - **Overview of Data Requests Received and Status of Requests**
 - Lee M. Sanders, MD, MPH, Stanford Center for Policy, Outcomes and Prevention
 - Brian Kentera, Chief of CMS Network Branch, DHCS
 - **Wrap-up and Next Steps**
 - Linette Scott, MD, Information Management Deputy Director and CMIO, DHCS
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Welcome, Introductions, and Purpose of Today's Meeting

Anastasia Dodson

Associate Director for Policy, 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.
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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

CCS Performance Measures and Comments Received

Linette Scott, MD

Information Management

Deputy Director and CMIO, DHCS

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>

CCS County Measure 1

Examples of SurveyMonkey Comments

- NICU – Challenge to identify a PCP for NICU infants.
 - Define and monitor Medical Home (MH) – Child should have a MH (could be specialist) responsible for addressing preventative care and ensuring access to appropriate acute and/or chronic care. Incorporate 6 components of family-centered medical home.
 - Definition is broad – Define “usual place of business”. Change “addresses” to “provides oversight and SCC referral for subspecialty care”. Add “appropriate access” to designated physician. Distinguish levels of care: preventative, acute, and chronic.
 - SCC and families should be included.
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CCS County Measure 2

Definition	<p>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:</p>
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	<p>Number of unduplicated new referrals to the CCS program in each county assigned a pending status in the last fiscal year.</p> <p>* The denominator should be adjusted to exclude children who are determined ineligible.</p>

CCS County Measure 2

Examples of SurveyMonkey Comments

- This is solely a process measure and not a quality of care.
- Length of time should be provided. Financial clearance needs to be acquired before medical clearance which may cause delay.
- Define who will measure compliance in dependent counties where medical eligibility is determined by DCOS.
- In the Whole-Child Model, eligibility determination remains with County CCS. It would be difficult for health plans to be responsible for these guidelines.
- Include more detail as to how eligibility is determined and communicated.
- Clinical eligibility assessment should be guided by an objective set of guidelines (including specific diagnosis) and reconciled.

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.

CCS County Measure 3

Examples of SurveyMonkey Comments

- This is solely a process measure and not a quality of care.
 - Insert timeframe for referral.
 - Lists of ICD categories requiring SCC referrals, SCCs, and paneled subspecialists.
 - Changed language to: "Clients enrolled in CCS, in the identified ICD 10 categories, will have a referral to a designated Special Care Center and receive risk appropriate care including, at a minimum, an annual SCC Team Report."
 - Add measure - appropriate designated Specialty Care Center, what the purpose and impact of the report is, how will it be used, and measure of care coordination or family centered care or family satisfaction.
 - Measure is difficult to count and time consuming to evaluate.
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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

CCS County Measure 4

Examples of SurveyMonkey Comments

- Define “health care transition planning”.
 - More specifics on what should be documented, goals, and timeframes.
 - This is a process measure – what is needed is outcomes measure such as did the youth successful transfer to adult care.
 - Develop a Transfer FORM constant for all transitions/referrals that includes pertinent information; optimally, this could be done electronically
 - Suggest two performance measures: One for the CCS general program at 18 and 20 years of age, and another for the MTP patients at 16, 18 and 20 years.
 - There should be a standardized approach to transition planning and specific goals that are met before the transition occurs.
 - Transition should begin at 12 or 14, per national guidelines.
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CCS County Measures

Examples of SurveyMonkey General Comments

- Discussion about possible quality measures that can be assessed from data currently collected at the state and county levels.
 - Need more details on each measure with numerators and denominators.
 - There is a need to track denied referrals, as the fear with the proposed transition is that the network available to children and youth with special health care needs will be narrowed.
 - There is a need for care coordination, family involvement, and family centered care measures.
 - Given the potential for measures to be influenced by reporting artifacts, recommend analyzing ways to accurately capture these measures.
 - Special requirements and protections needed: 1. Access to subspecialty care. 2. Access to other services (e.g, home nursing, DME). 3. Quality of care to meet the special requirements of the CCS population.
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Efforts to Develop Indicators for Outpatient Care for Children with Special Health Care Needs

Follow-up to the October 21 Advisory Group Discussion – At Least One Outpatient Visit After Hospitalization

Lee M. Sanders, MD, MPH
Stanford CPOP

Candidate Quality Indicators from CCS Paid-Claims Data: The Example of “Outpatient Care after Hospitalization”

Lee Sanders, MD, MPH



Lucile Packard
Children's Hospital
Stanford



Quality Indicators for Outpatient Care of Children with Special Health Care Needs

Most quality indicators for children have been adapted from adult-care **inpatient-care** indicators and validated among children. (AHRQ 2015)

Few quality indicators for child **outpatient care**.

- No indicators derivable from administrative data.
- None specific to children with special needs (CSHCN)

Objective

To identify quality indicators, **derivable from administrative data**, that may assess appropriate **delivery of outpatient care for CSHCN.**

Methods

Systematic literature review

- Identify all published expert guidelines and nationally endorsed quality metrics for outpatient care of CHSCN.
- From these, propose a subset of “candidate indicators” that may be derived from administrative (paid-claims) data.

Modified Delphi Process (2014-15)

- Focus groups (8): Expand list of candidate indicators
- Surveys (3): Identify the most “appropriate” indicators
 - 17 stakeholders (MD + non-MD)
 - Each indicator rated 0 (least appropriate) to 9 (most)

Results

48 candidate indicators across 5 domains

- Access to Medical Home Services
- Access to Pharmacy Services
- Access to Outpatient Care
- Ambulatory-Sensitive Hospitalization
- Home Health and Outpatient Therapies

19 indicators were deemed “most appropriate”

(mean appropriateness score >7)

Most Appropriate Indicators

Access to Medical Home Services

1. **Regular Primary Care Visits** (age <24 months: at least 2 visits per year; age \geq 24 months: at least 1 visit per year)
2. **Regular Subspecialty Care** (at least 1 visit per year)
3. **Regular Dental Care** (age \geq 24 months: at least 1 visit per year)
4. **Usual Source of Care (Physician):** Same Physician seen at least once per year for multiple years in a row
5. **Usual Source of Care (Clinic):** Same Clinic visited at least once per year for multiple years in a row
6. **Care Coordination:** At least 1 visit coded for “care coordination” or “case management” per year.

Access to Pharmacy Services

7. **For children with medication-dependent conditions:** No episode of $>$ 90 days between prescription refills

Most Appropriate Indicators

Ambulatory Sensitive Hospitalization

8. No unplanned 30-day re-admission to hospital

9-15. No hospitalization for one of the following primary acute conditions: Dehydration, Urinary Tract Infection, Asthma, Impaction or Constipation, Anemia, Diabetic Ketoacidosis (except at time of initial diagnosis of diabetes), Feeding-tube complication

Access to Outpatient Care

16. For children who are hospitalized: At least 1 outpatient visit of any type (MD, RN, diagnostic, other) during the 30 days prior to hospitalization

17. For children who are hospitalized: At least 1 outpatient visit of any type (MD, RN, diagnostic, other) during the 30 days after hospital discharge

Home Health and Outpatient Therapies

18. For children with DME: At least 1 home health visit per year

19. For children with neurologic impairment: At least 1 PT visit per year

Most Appropriate Indicators

Ambulatory Sensitive” Hospitalization

8. **No unplanned 30-day re-admission to hospital**

9-15. **No hospitalization for one of the following primary acute conditions:** Dehydration, Urinary Tract Infection, Asthma, Impaction or Constipation, Anemia, Diabetic Ketoacidosis (except at time of initial diagnosis of diabetes), Feeding-tube complication

Access to Outpatient Care

16. **For children who are hospitalized:** At least 1 outpatient visit of any type (MD, RN, diagnostic, other) during the 30 days prior to hospitalization

17. **For children who are hospitalized:** At least 1 outpatient visit of any type (MD, RN, diagnostic, other) during the 30 days after hospital discharge

Home Health and Outpatient Therapies

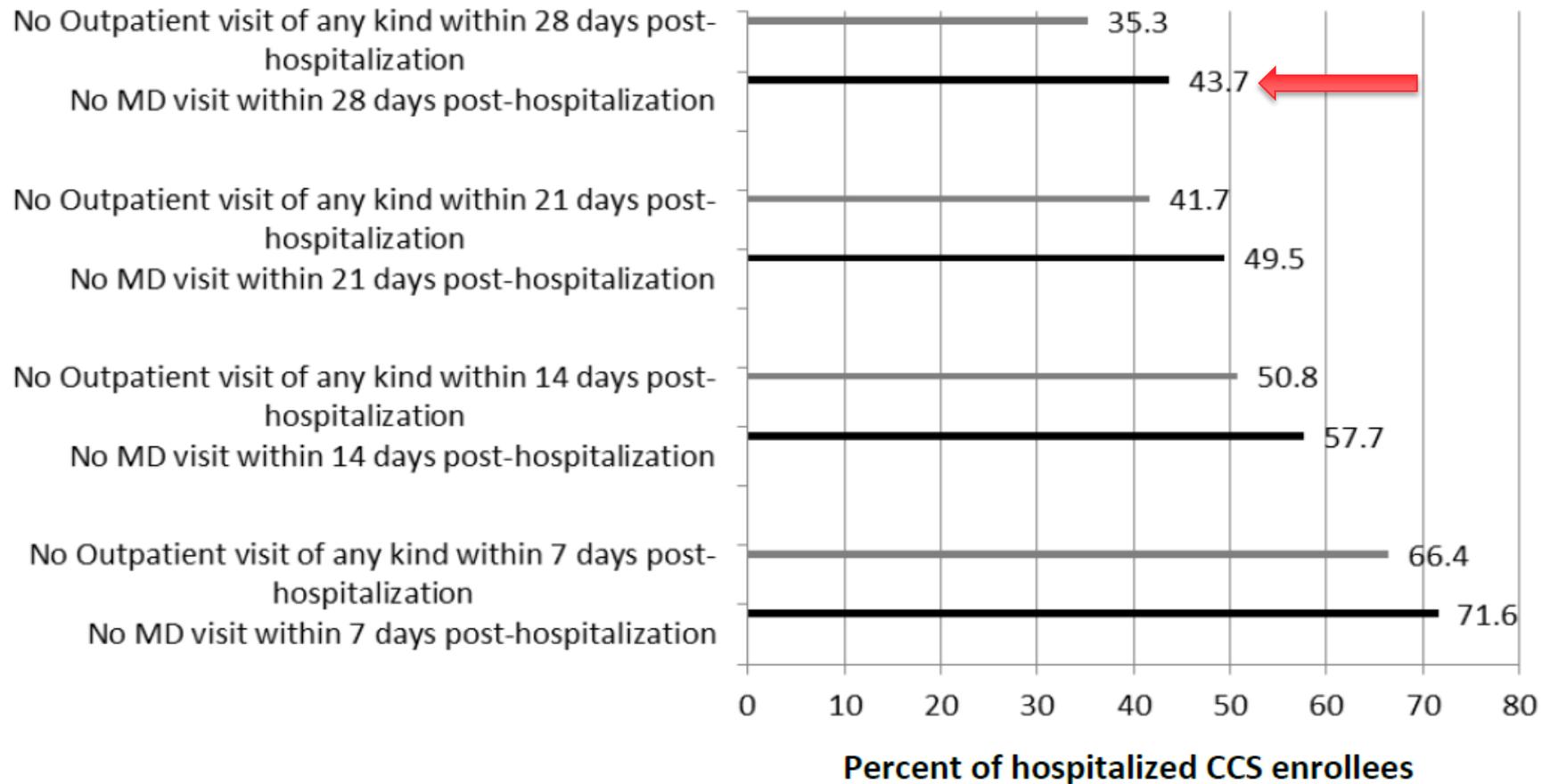
18. **For children with DME:** At least 1 home health visit per year

19. **For children with neurologic impairment:** At least 1 PT visit per year

Outpatient Care After Hospitalization

10.9% of children were readmitted in 28 days.

Of those not readmitted ...



Outpatient Care After Hospitalization

- “*Hospitalization*” is defined as the first hospitalization that occurred > 6 months after CCS enrollment.
- “*MD visit*” includes any outpatient visit for MD services – including primary care, subspecialty care, urgent care, EPSDT, dental, and psychiatric visits.
- “*Outpatient visit*” includes all MD visits, plus diagnostic testing and any therapy visit, including physical and occupational therapies.
- This analysis excludes any child with a subsequent hospitalization or LTC claims within 28 days after discharge from index hospitalization.
- “*CCS enrollee*” is any child enrolled in California Children’s Services for >6 months from 7/1/2009 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 Medi-Cal 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 .

Characteristics of Children with No Outpatient Visit After Hospitalization

	Total	No MD Visit after Hospital (N)	No MD Visit after Hospital (%)	No Outpatient Visit after Hospital (%)
TOTAL	29,455	12,864	44%	35%
AGE GROUP (years)				
<1	2,997	889	30%	26%
1 - 2	4,763	1,666	35%	30%
3 - 5	4,176	1,527	37%	28%
6 - 9	4,360	2,006	46%	34%
10 - 14	5,593	2,800	50%	39%
15 - 18	5,452	2,837	52%	44%
19 - 21	2,114	1,139	54%	45%
ETHNICITY				
Hispanic	17,010	7,181	42%	34%
White	5,242	2,474	47%	37%
Black	3,025	1,432	47%	40%
INSURANCE				
FFS only	7,440	3,046	41%	32%
MMC only	17,501	7,228	41%	33%
Mixed / Other	4,514	2,590	57%	50%

Characteristics of Children with No Outpatient Visit After Hospitalization

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- “*Hospitalization*” is defined as the first hospitalization that occurred > 6 months after CCS enrollment and more than 28 days after the start of the fiscal year 2009.
- This analysis excludes any child with a subsequent hospitalization or LTC claims within 28 days after discharge from index hospitalization.
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Characteristics of Children with No Outpatient Visit After Hospitalization

	Total	No MD Visit after Hospital (N)	No MD Visit after Hospital (%)	No Outpatient Visit after Hospital (%)
TOTAL	29,455	12,864	44%	35%
MEDICAL COMPLEXITY				
Non-Chronic	5,037	2,552	51%	44%
Non-complex Chronic	10,667	5,237	49%	41%
Complex Chronic	13,751	5,075	37%	28%
PRIMARY DIAGNOSTIC CATEGORY				
Neurology	7,023	3,157	45%	31%
ENT	3,026	1,638	54%	46%
Orthopedics	1,915	1,261	66%	55%
Endocrinology	2,470	1,241	50%	44%
Hem/Oncology	2,852	967	34%	28%
Cardiology	3,665	956	26%	22%
External/Injury	1,012	608	60%	48%
Urology	960	550	57%	53%
Gastroenterology	1,260	508	40%	35%
Neonatology	884	305	35%	30%
Pulmonology	659	261	40%	35%
Dental	127	101	80%	76%

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- 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.

Regional Distribution of No Outpatient Visit After Hospitalization

	Total	No MD Visit after Hospital (N)	No MD Visit after Hospital (%)	No Outpatient Visit after Hospital (%)
TOTAL	29,455	12,864	44%	35%
REGION				
Bay Area	3,974	1,542	39%	31%
Southern CA, no LA	9,209	4,300	47%	38%
Los Angeles	7,877	3,409	43%	35%
Central California	7,412	3,220	43%	36%
North & Mountain	983	393	40%	32%
COUNTY TYPE				
“Carve-in” Counties	471	241	51%	44%
“Whole-child” Counties	3,938	1,620	41%	27%
Other Counties	24,815	10,922	44%	32%
COUNTY-BY-COUNTY			34% - 57%	
			12 counties > 44%	

Regional Distribution of No Outpatient Visit After Hospitalization

- Region and County Type is assigned based on child's home ZIP code at time of enrollment.
- “*Carve-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.
- “*MD visit*” includes any outpatient visit for MD services – including primary care, subspecialty care, urgent care, EPSDT, dental, and psychiatric visits.
- “*Hospitalization*” is defined as the first hospitalization that occurred > 6 months after CCS enrollment.
- This analysis excludes any child with a subsequent hospitalization or LTC claims within 28 days after discharge from hospitalization.
- “*CCS enrollee*” is any child enrolled in California Children's Services for >6 months from 7/1/2009 to 6/30/2012.
- Most CCS enrollees are enrolled in Medi-Cal 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.

Summary

19 Quality Indicators from CCS Paid-Claims Data

1 of 19 Indicators: “Outpatient Care after Hospitalization”

Of children not readmitted after 28 days ...

- 44% received No Outpatient MD Visit
- 35% received No Outpatient Care of Any Kind

“No Outpatient Visit after Hospitalization” more likely if ...

- Age > 10 years
- Non-complex medical condition

County-level Variation

Independent of case mix (age, medical complexity, diagnoses)

Modified Delphi Process: Other Indicators not assessable by paid claims data

By Parent Survey (examples):

Unmet child health needs.

Satisfaction with care

Reduction or loss of parent income

Family stress / burden

School attendance / absence*

Post-discharge phone calls for follow up*

Timely communication between referrals and medical home*

Availability of 24 hour phone triage by staff experienced with CSHCN*

Regular receipt of multi-disciplinary specialty care services*

For families with LEP, use of interpreter services*

* Identifies indicators that may be captured from existing data sources (including Regional Centers, provider survey, EMRs, patient registry, school district records).

Modified Delphi Process: Other Indicators not assessable by paid claims data

By Provider Survey (examples):

Coordination with non-medical services, including school and regional centers.

Satisfaction with communication from medical and non-medical systems of care.

By electronic health records or registries (examples):

Use of “integrated care plan”*

Regular screening for mental health*

Regular screening for environmental risk (e.g., tobacco smoke, domestic violence)*

Regular assessment of neurodevelopmental function*

Referrals completed (%).

For children with progressive illness, use of pediatric palliative care.*

For rural families, use of telemedicine and home monitoring.*

For adolescents, transition care planning.*

* Identifies indicators that may be captured from existing data sources (including Regional Centers, provider survey, EMRs, patient registry, school district records).

Overview of Data Requests Received and Status of Requests

Lee M. Sanders, MD, MPH
Stanford CPOP
Brian Kentera, Chief
CMS Network Branch, DHCS

Stanford CPOP Policy Analyses

Policy Briefs

- [CCS: Enrollment by Diagnosis and Over Time](#)
- [CCS: Annual Spending, by Region](#)
- [Two More Years: What Does Continued CHIP Funding Mean for California?](#)
- [CCS: All Inpatient Paid Claims by Site of Care](#)
- [Variation in Specialty Care Hospitalizations for Children with Chronic Conditions in CA](#)
- [Regionalized Pediatric Specialty Care for California's Children](#)
- [Quality of Care: Outpatient Care Before Hospitalization](#)
- [Quality of Care: Outpatient Care After Hospitalization](#)
- [The Cost of Care for Children Enrolled in CCS](#)
- [Care Use by "High-cost" Children Enrolled in CCS](#)
- [Health Care Use Varies by Diagnosis among CCS Enrollees](#)
- [Health Care Use Varies with Age among CCS Enrollees](#)

Peer-Reviewed Manuscripts

- Outpatient Pharmacy Expenditures (JAMA 2015)
- Health Care Use and Costs for Diabetes (J. Peds 2015)
- Use of Outpatient Care among VLBW Infants (submitted)
- Outpatient Care Patterns as Predictors of Diabetic Ketoacidosis (submitted)

<https://cpopstanford.wordpress.com/reports-and-policy-briefs/>

Wrap-up and Next Steps

Linette Scott, MD

Information Management

Deputy Director and CMIO, DHCS

CCS Stakeholder Meeting

- **CCS Advisory Group Stakeholder Meeting**

When: Wednesday, January 6, 2016

10:00am – 3:00pm

Where: Sacramento Convention Center

1400 J St, Sacramento

Information and Questions

- Advisory Group data requests, email:
 - CCS-AdvisoryGroupDataRequests@dhcs.ca.gov
- For Data Request Form and CCS Redesign information, please visit:
 - <http://www.dhcs.ca.gov/services/ccs/Pages/CCSStakeholderProcess.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