

April 14, 2015

The Honorable Diana Dooley
Secretary, California Health and Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

Dylan Roby, PhD
Professor, UCLA Center for Health Policy Research
10960 Wilshire Blvd, Suite 1550
Los Angeles, CA 90024

Dear Secretary Dooley and Dr. Roby,

Thank you for the opportunity to participate on the CCS Redesign Stakeholder Advisory Board (RSAB) and to provide comments on the various proposals to redesign California Children's Services (CCS).

Sutter Health has a deep interest in the modernization of the CCS Program and the future of Medi-Cal in California. Sutter serves nearly 1 in 4 Medi-Cal beneficiaries in Northern California, more than any other provider in our region and 1 in 5 babies born in California are delivered at a Sutter hospital. Sutter Health's Sutter Medical Center, Sacramento and California Pacific Medical Center, are CCS-designated tertiary hospitals-the same designation as Children's hospitals-and have long served as critical regional access points for high quality, specialty care and primary care services for CCS eligible children throughout our region.

Sutter Health shares the Department's goals of revamping the CCS program and transitioning CCS to organized delivery systems of care that are family-centered, cover both primary and specialty care services to treat the whole child, improve efficiency and maintain the quality of care established by the CCS program. We believe that an integrated, coordinated approach to care can improve quality, enhance affordability, and increase access for our state's most vulnerable children.

We believe these goals can best be achieved if they are based on the principal of inclusivity-- versus exclusivity-- to ensure that relationships between children with special health care needs (CSHCN) and their providers are preserved and existing as well as new organized systems of care can continue to evolve and innovate to create patient-centric medical homes for CCS children.

Sutter Health applauds the State for its thoughtful approach in evaluating various models and ensuring stakeholder input is carefully considered in crafting the best outcome for the CCS program. We offer the following comments and observations (see attachment) for your consideration and look forward to participating in helping to shape the future care model for our CCS patients.

Thank you again for the opportunity to provide input to and participate in the RSAB and CCS redesign effort.

Sincerely,

ORIGINAL SIGNED BY ARLENE CULLUM

Arlene Cullum, MPH
Director, Women's and Children's Ambulatory Services

cc: Pat Fry, President and CEO, Sutter Health
Carrie Owen Plietz, CEO, Sutter Medical Center, Sacramento

CCS Redesign

Models Sutter Health

Commentary

General Comments

1. Models Presented Should Have Consistent Key Components of a System of Care for Children with Special Health Care Needs (CSHCN).

All models presented for review should include the following key elements:

(1) A strong regionalized system of pediatric specialty care that is anchored by a CCS Tertiary hospital with a coordinated linkage to Special Care Centers to meet the continuum of pediatric specialty needs, (2) A risk assessment system to continually assess the acuity of the child in the context of the family and allocate appropriate resources, (3) A patient navigator system to assign eligibility, assure on-going access to care, and coordinate difficult to access services, (3) State CCS responsibility for paneling providers and assuring availability of providers, and (4) a robust quality and evaluation component that measures practice change outcomes (i.e. use of home care or telemedicine) as strategies to improve compliance, patient satisfaction, and quality.

2. Standardized Definitions for Care Coordination versus Case Management

The definitions of case coordination and case management *are not consistent with CCS standards, nor all practices*. The definition of Care Coordination provided in the CCS Redesign definitions (from Massachusetts Consortium) includes care plan development. The definition for Case Management also in the same document is used to describe eligibility determination, authorizations for care and sometimes coordination of care at the County level. In all of the CCS Special Care Centers, there is a requirement for case conferences to review the treatment care plan which includes child and family needs, strengths and concerns, medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health and wellness outcomes.

The difference in these functions is that the care plan developed within the Special Care Center includes the medical treatment plan of care as well as all of the other domains. I do not understand how or why a care plan could be developed at the County and/or Health Plan level with caseloads of 250-650+ when these nurses are not specifically trained in the specialized care needed for specific diagnoses.

The care provided at the County level and/or Health Plan by a nurse should be termed "Care Navigator" function to include eligibility determination, assurance of access to care, assurance of timeliness to care, and ombudsman responsibility.

The care provided by the Primary Care Provider should be termed "Care Coordination" to include referral to the appropriate Special Care Center and/or other community referrals (MTU, Regional Center, etc).

The care provided at the Special Care Center should be termed "Case Management" to include medical treatment care plan development to include medical, social, developmental, behavioral, etc needs with strong linkage to the Primary Care Provider. In cases where the primary care provider is also the Specialty Care Provider, these functions can be merged.

3. Acuity scoring

While we are generally supportive of risk scoring for acuity, special consideration must be given to assessing risk at various intervals for the CCS population. Given the changing risk factors for CSHCN, having risk scoring be included as a one-time function and/or only at specified intervals will not provide an adequate assessment of that child's acuity. Therefore, inherent in any model chosen needs to be a dynamic process to identify acuity changes to ensure appropriate services are delivered in the most appropriate setting and to guard against over-utilization for fiscal gain.

4. Payment Models and Outcomes of Care

Standardized outcome measures should be developed and adopted to include both health and process outcomes, including utilization of care. Some of the models presented have outlined reductions in utilization of care (Alta Med-CHLA), however measures of health outcomes were not shared in relation to reduction in utilization. We do not have agreed upon quality dashboards for many of the Special Care Centers. Some exist including Vermont-Oxford, California Perinatal Quality Care Collaborative (CPQCC), High Risk Infant F/U, and National Cystic Fibrosis Foundation indicators.

5. Transition to Organized Systems of Care Will Take Time

As the State has recognized in their stated goals, let's "learn lessons from past transitions to managed care." "Transitioning" CCS to organized systems of care is a complex endeavor and any effort of this magnitude will take time. Therefore, we strongly recommend that the final plan include an adequate transition period that will allow for this evolution to take place while maintaining systems of care. In addition, a smooth and adequate transition could also provide several opportunities to build out the continuum of care, for example through the expansion of pediatric home health.

Model Specific Comments

1. Bay Area Stakeholder

CCS+: There is wide variation in the service delivery provided at the County level and the functionality of this service. For a few counties, such as Alameda, adding these proposed services may in fact enhance provision of care. In other counties, providing additional responsibilities may be problematic.

CCS Collaborative: This model is interesting in concept and similar to the ACE Kids Network Plan proposed by national Children's Hospital Association. This is a very long term solution, *not one that would be implementable in the next three to five years* given the contracting and legal agreements necessary. This model would allow regional flexibility in that there are varied entities (County, Health Plan, Medical Foundation, other) who could apply. We do not have enough information to know yet how risk-sharing arrangements could be safely made.

2. CCHA-SBS86

- a. **Definition of Children's Hospital**---The current definition allows only the 8 freestanding and the 5 UC's to be included as authorized entities in a future CCS integrated delivery system. There are other children's hospitals in California that have been designated by the national Children's Hospital Association and who carry volumes of CCS children in excess of the thirteen centers included. Sutter Health strongly believes that any future CCS redesign model must include ALL CCS designated tertiary hospitals as components/anchors/leaders of an organized delivery model.
- b. **Poor Measures of Quality:** Belonging to "a" pediatric quality collaborative does not assure quality nor does it allow for common measures of quality across the State. There is much to do to achieve consensus on quality indicators across pediatric specialties, however these exist in some areas, like Cystic Fibrosis (National Cystic Fibrosis Foundation data set).
- c. **Authorization Process and Assurance of Access to Care is Unclear.**
- d. **Readiness to Implement is Only in San Diego.**

3. Los Angeles County Nurse Case Management Model

This model even though it addresses an acuity scale is still a Care Navigator function performed at the County level and does not address the medical case management of care. The development of a system to provide telephone calls based on acuity of patients seems appropriate.

4. Alta Med-CHLA

The Alta Med-CHLA has many elements that poise the system for success:

- a. Pairing with an FQHC to get cost based reimbursement will provide sustainability of model and potential for replication/expansion.
- b. Housing the clinic for CSHCN within an FQHC aligned with a children's hospital is a strong model, however there is a question as to the long term ability for all FQHCs to continue to expand to serve this population.
- c. Tiering the care allows for appropriate allocation of resources.
- d. Patient-centered medical home component seems to provide good coordination of services.

- e. Utilization outcomes are impressive, but would be more impressive if linked with medical outcomes (ie. for pediatric diabetics: rates of readmission for DKA, Ale levels, etc)

5. CARE: System Innovation of Care for Children with Medical Complexity

This model has some incredible merits specifically based upon the 3 Tier approach. While supportive of organizing the services in this manner, we did not receive any substantive information regarding the implementation of this system nor outcomes that could substantiate the results.

6. ACO MODEL

The presentation provided at the second RSAB meeting, *Overview of Accountable Care Organization Demonstration Pilot*, "provided by Dominique Hensler and Erin Fisher, seemed to hold the most promise for CCS Redesign. The Rady model is the only one that has a continuum of health care services to serve the complex needs of CSHCN and the only one that is actively incorporating health care delivery changes (i.e. use of RT in a home setting) and measuring quality outcomes.