

LESSONS LEARNED FROM PREVIOUS TRANSITIONS: DHCS STRATEGIES FOR IMPROVEMENT

FOR CONSIDERATION IN TRANSITION TO CCS WHOLE CHILD MODEL

Lesson Learned	Strategies for Improvement
Plans need beneficiary data in advance to improve plan readiness and care coordination.	<ul style="list-style-type: none">• Provide CCS identification data at least 30 days prior to transition.• Provide utilization data and Service Authorization Request (SAR) data for transitioning beneficiaries at least 45 days prior to transition.
Notices should be clear and timely.	<ul style="list-style-type: none">• Develop notices and informing materials with stakeholder input.• Notices and informing materials should include the timing of the transition, how the change affects the child and family, and additional resources for information and questions.• Provide multiple notifications to inform families of the transition (i.e., at 30, 60, and 90 day intervals).
Beneficiary outreach is most effective at the provider level.	<ul style="list-style-type: none">• Hold informational webinars with the plans and providers.• Develop a Continuity of Care flyer that explains how continuity of care works with the intent of disseminating to provider offices.
Help beneficiaries understand they have the right to continuity of care.	<ul style="list-style-type: none">• Provide for an automatic continuity of care provision that requires plans to enter into a continuity of care agreement with the child's/families existing provider as long as certain conditions are met.• Include continuity of care information on child / family notices.• Update DHCS guidance to the plans on automatic continuity of care via an All Plan Letter• Develop a Continuity of Care webpage to improve awareness about continuity of care rights for ongoing care with the child's / families existing health care provider(s), as well as continuity with prescription medications, treatment/surgery, and other care facilities.• Develop a Continuity of Care flyer that explains how continuity of care works with the intent of disseminating to provider offices.
Transitions generate a greater need for care coordination.	<ul style="list-style-type: none">• Issue a Memorandum of Understanding (MOU) template that outlines roles and responsibilities for care coordination between the plans and local CCS counties.• Review the plan's policies and procedures for care coordination to ensure processes are in place• Work with the plan to address any deficiencies.• Require the plan to correct any deficiencies prior to the transition.• Monitor the plans' administrative readiness, including staffing, training and education.• Hold regularly scheduled meetings with the plans to discuss care coordination, among other topics.
Capitalize on improving the beneficiary experience.	<ul style="list-style-type: none">• Plans are to embark on a call campaign to welcome transitioning members and their family and respond to questions and/or concerns on the transition.• Provide Frequently Asked Questions to the plan call centers, Health Care Options (HCO), local county CCS program and State CCS program to assist with providing consistent and accurate information.