

# California Children's Services (CCS) Redesign

Health Homes, Care Coordination, and  
Transitions Technical Workgroup (TWG)

Kick-off Webinar

Thursday, March 26, 2015

9-11am PST

# Webinar Agenda

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- Welcome and introductions, roll call
  - Overview of goals and purpose of TWG
  - California Health Homes Program presentation (Brian Hansen)
    - Presentation Q&A (Brian Hansen & Hannah Katch)
  - Title V Needs Assessment presentation (Jillian Abramson, MD)
    - Presentation Q&A (Jill Abramson, MD)
  - Discussion of TWG members' goals and priorities
  - Data Request Form overview
  - Next steps and items for follow-up
  - Closing remarks
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# Health Homes, Care Coordination, and Transitions TWG Members

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**Co-chairs:** Hannah Katch (DHCS), Jill Abramson, MD (DHCS), Jessica Schumer, MD (UCLA)

**Members:** Richard Chinnock, MD (California Specialty Care Coalition); Juno Duenas (Family Voices); James Gerson, MD (HealthNet); Domonique Hensler (Rady Children's Hospital – San Diego); Kris Calvin (American Academy of Pediatrics, CA); Erica Jewell (Miller Children's Hospital/Long Beach Memorial Medical Center); Susan Mora (Riverside County Department of Public Health); Amy Westling (Association of Regional Center Agencies); Katie Schlageter (California Children's Services Administrator, Alameda County); Brian Hansen (DHCS); Christopher Wecks (parent representative)

Please email recommendations for parent members to: [michferrari@ucla.edu](mailto:michferrari@ucla.edu)

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# Goals and Purpose

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The task of this workgroup is to develop specific recommendations for implementing health homes and improving care coordination and transition planning for CCS enrollees. In particular:

- What are the essential elements of a medical/health home for children with CCS eligible conditions, and what are the considerations for location of those homes (in specialty vs. primary care clinics, in urban vs. rural locations, etc.)?
- How should the MTP and specialty care centers be included in the redesign efforts?
- What are the essential elements of a transition plan, and what entity(ies) should be responsible for their creation?

# TWG Tasks and Deliverables

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- Provide feedback on Packard’s “Standards for Systems of Care for Children and Youth with Special Health Care Needs” and the 2011 CCS Pilot RFP sections on care coordination and Medical Homes.
- Feedback on structuring care coordination based on complexity/risk stratification.
- Make revisions to relevant terms in CCS Redesign Definitions Document, to come to consensus on what each means specifically for the CCS population.
  - All three documents were emailed to TWG members on March 25, 2015. Feedback is requested by **Friday, April 3, 2015**, and should be sent to: [michferrari@ucla.edu](mailto:michferrari@ucla.edu) and [chpr\\_ccs@em.ucla.edu](mailto:chpr_ccs@em.ucla.edu)
- **Final Deliverable:** Consensus-based document produced by TWG detailing essential elements of and recommendations for care coordination, health homes, and transition in an organized system of care for CCS.



# Health Homes for Patients with Complex Needs

Information from the November 17, 2014,  
DHCS Concept Paper

# CA HHPCN Policy Goals

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## Better Care

- Improve care coordination
- Integrate palliative care into primary care delivery
- Strengthen community linkages within health homes
- Strengthen team-based care, including use of community health workers/promotores/other frontline workers

## Better Population Health

- Improve the health outcomes of people with multiple chronic diseases

## Lower Cost

- Achieve net cost savings (avoidance) within 18 months

# Additional Medi-Cal Objectives

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1

- Ensure sufficient provider infrastructure and capacity to implement HHPCN as an entitlement program

2

- Ensure that health home providers appropriately serve members experiencing homelessness

3

- Increase integration of physical and behavioral health services

4

- Create synergies with the Coordinated Care Initiative (CCI) in the eight participating counties

5

- Maximize federal funding while also achieving fiscal sustainability after eight quarters of federal funding

# ACA Section 2703

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Creates the new **health home** optional Medicaid benefit:

- For intensive care coordination for people with chronic conditions
- The new benefit includes a package of six care coordination services, but does not fund direct medical or social services
- 90% federal funding for eight quarters, and 50% thereafter

# AB 361 – enacted in 2013

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- Authorizes implementation of ACA Section ( § ) 2703:
  - Provides flexibility in developing program elements
  - Requires DHCS complete a health home program evaluation within two years after implementation
  - Requires that DHCS implement only if no additional General Fund moneys will be use.
- Requires inclusion of a specific target population of frequent utilizers and those experiencing homelessness
- For the target population, the program must include providers with experience serving frequent hospital/ED users and homeless members

# The Health Home Population

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- AB 361 and the DHCS proposal focus on:
  - Frequent utilizers of health services
  - Chronic conditions that are likely to be responsive to intensive care coordination
  - Goals of reducing inpatient stays, ED visits, and negative health outcomes, and improving patient engagement
- Regardless of the specific chronic conditions that are selected:
  - A large percentage of enrollees with SMI and SUD, and who are homeless will be included
  - Whole-person care will include coordination of behavioral health (BH) services and includes linkages to social services, such as supportive housing

# HHPCN Target Population

<b>Chronic Conditions</b>	
<b>Physical Health</b>	<b>Behavioral Health</b>
Asthma /COPD	Substance Use Disorder
Diabetes	Major Depression
Traumatic Brain Injury	Bipolar Disorder
Hypertension	Anxiety Disorder
Congestive Heart Failure	Psychotic Disorders (including
Coronary Artery Disease	Schizophrenia)
Chronic Liver Disease	Personality Disorders
Chronic Renal Disease	Cognitive Disorders
Chronic Musculoskeletal	Post-Traumatic Stress
HIV/AIDS	
Seizure Disorders	
Cancer	

# HHPCN Target Population

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- Acuity will also factor into eligibility determination process
- All full scope Medi-Cal enrollees who meet the eligibility and target geography criteria will be included
- Patient acuity and intensity of service needs will inform tiering of services and payments
- Health home-eligible individuals who are also chronically homeless will have specific care management requirements in addition to those who are already stably housed

# What are Geographic Considerations

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- Health homes may be statewide or limited to a smaller geography within the state
- States may utilize a phased approach to strategically roll out across target regions
- Each new geographical area requires a new state plan amendment (SPA), and will be allowed a 90% federal match for the first eight quarters
- CA must have adequate provider infrastructure to serve the target population in the selected geographies
- CA could leverage previous care coordination improvements, such as the CCI, to give the health homes program every chance for success

# HHPCN Geographic Phasing

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- State intends to start with the Coordinated Care Initiative (CCI) counties as readiness allows beginning in January 2016
  - Dually eligible beneficiaries are already in managed care
  - Providers more likely to have experience with enhanced coordination requirements
- Remaining CA counties as readiness allows starting in July 2016

# CA Health Home Network

## LEAD ENTITY: *QUALIFYING MEDICAL MANAGED CARE PLANS*

- Maintains overall responsibility for the health home network, including administration, network management, health information technology and exchange (HIT/HIE)
- Receives health home payment from the state and flows to partners



## COMMUNITY-BASED CARE MANAGEMENT ENTITIES: *Sample orgs could include: FQHCs, hospitals, clinics, IPAs, behavioral health providers*

- Responsible for providing the core health home services:
  - ✓ Comprehensive care management
  - ✓ Care coordination (physical health, behavioral health, community-based LTSS) and health promotion
  - ✓ Comprehensive transitional care
  - ✓ Individual and family support
  - ✓ Referral to community and social support services
  - ✓ Use of HIT/HIE to link services
- Dedicated care manager is located within this entity
- Entity receives payment for health home services via a contract with the plan
- Makes referrals to community partners for non-Medicaid funded services



## COMMUNITY AND SOCIAL SUPPORT SERVICES: *Sample organizations could include supportive housing providers, food banks, employment assistance, social services*

- Provides services that meet the enrollees' broader needs (e.g. supportive housing services, social services and supports)
- May not necessarily receive health home funding

# Federal Health Home Service Requirements

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- Each state defines the core services:
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care
  - Individual and family support
  - Referral to community and social support services
  - The use of HIT/HIE to link services, as feasible and appropriate
- Definitions are in the DHCS Concept Paper

# Health Home Services

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- DHCS is assessing the care coordination MCOs currently provide
  - What would have to be added to complete the health homes benefit
  - There can be no duplication of care coordination services
- In addition to medical coordination, other potential focus areas are:
  - Mental health and substance use disorder services
  - Services for homeless members, including linkages to supportive housing
  - Coordination and referral for palliative care services

# Quality Measures and Evaluation

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- CMS established a recommended core set of eight health care quality measures that align with existing core sets for adults and children
- States are encouraged to also develop state-specific quality measures
- CMS also identified three utilization measures to assist with the overall federal health home evaluation
- California will also conduct a state specific evaluation of the health home initiative
- DHCS requests stakeholder input on state-specific quality measures and evaluation plans

# Payment Methodology

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- Payment method will likely be a per member per month (PMPM) carved in to the managed care plan capitation payment
- Payment methodology intended to include tiering based on patient acuity
- Payments would flow through the lead entities to qualified care management entities via a contract
- DHCS will further develop the health home payment methodology once the target population, geographic area, network partner standards and service definitions have been finalized

# Timeline

<b>9/14 – 1/16</b>	
<b>Design &amp; Decision Making</b>	
9/14 – 7/15	Ongoing program design. Solicit, evaluate, and incorporate stakeholder as needed.
4/15-7/15	One time required consult with Substance Abuse and Mental Health Services Administration (SAMSHA)
4/15 – 7/15	CMS consultation on coverage issues and reimbursement model
8/15 – 1/16	Ongoing stakeholder communication and early preparations
8/15	Formal SPA submission to CMS
1/1/16	CMS approval of 2703 SPA
<b>7/15 – 7/18</b>	
<b>Implementation &amp; Provider Technical Assistance</b>	
7/15 – 12/15	Begin to provide TA, build health home networks, and prepare for program implementation
1/16	Begin operating health homes (SPA effective date for enhanced match purposes)
12/17	End of enhanced match for first 2703 health home SPA
1/18	Completion of initial AB 361 evaluation timeframe

# Four Additional Items of Interest

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- **Concept Paper 2.0:**
  - Targeting April for public release of more detail.
- **Beneficiary Outreach and Provider Technical Assistance:**
  - Still a focus area; exploring possibilities in lieu of CalSIM funding.
- **Behavioral Health (BH) and California Children's Services (CCS):**
  - Engaging with stakeholders regarding a BH model and watching the CCS redesign process closely.
- **Engaging with our Plan partners very soon:**
  - To assist in technical aspects of model development.

# Stakeholder Engagement

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- We received great stakeholder input from our Nov. webinar and concept paper release; and
  - We have been meeting with various stakeholders on specific areas of Health Homes for the last several months.
- DHCS is targeting an April stakeholder event and release of expanded concept paper for review and feedback; and
  - As noted in our timeline, we will continue with stakeholder events between April and SPA submission in August to solicit feedback on the program evolution.

# Stakeholder Engagement Contacts

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- Visit the DHCS Health Home web page <http://www.dhcs.ca.gov/provgovpart/Pages/HealthHome.aspx> for:
  - The DHCS Concept paper;
  - A recording of the Nov. 17 Webinar
- Please contact us via the DHCS Health Home mailbox [HHP@dhcs.ca.gov](mailto:HHP@dhcs.ca.gov) to:
  - Send comments/questions or to ask to be included in future notices of stakeholder engagement opportunities

# Health Homes Presentation Q&A

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Questions?

Brian Hansen, DHCS

Hannah Katch, DHCS

# 2015 Title V Needs Assessment for CA CSHCN

Jill Abramson, MD, MPH

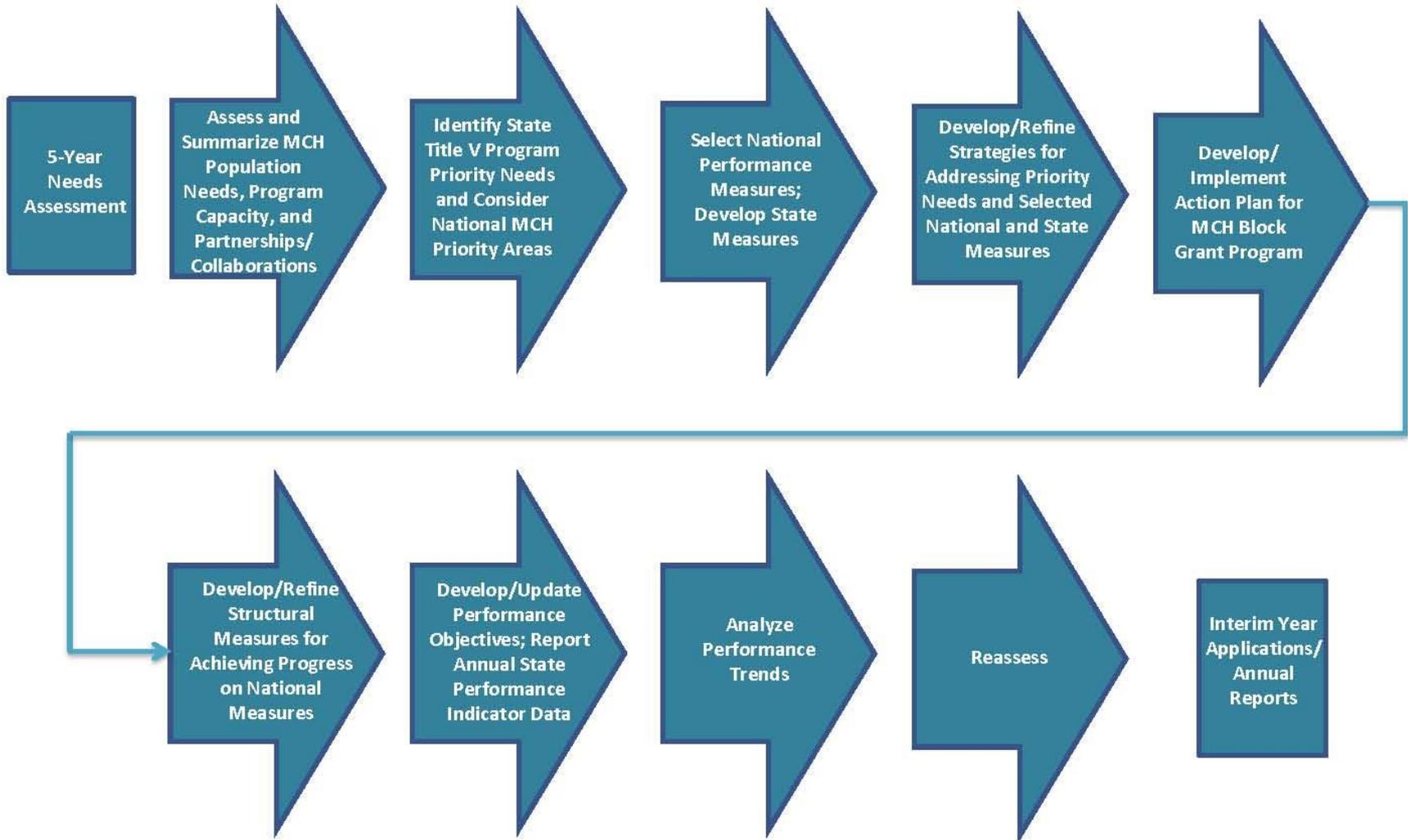
# Title V Needs Assessment Purpose

Assess state CSHCN systems and health care needs, then what the Title V role is in addressing those needs

Assesses state CSHCN program needs/capacity in meeting the six CSHCN Core Objectives

- 1. Families of CSHCN are partners in decision making at all levels and are satisfied with the services they receive**
- 2. CSHCN receive coordinated ongoing comprehensive care within a medical home**
- 3. All CSHCN will be adequately insured for the services they need**
- 4. Children are screened early and continuously for special health care needs**
- 5. Services for CSHCN will be organized so families can use them easily**
- 6. All youth with special needs will receive services needed to support the transition to adulthood**

# TITLE V MCH BLOCK GRANT NEEDS ASSESSMENT FRAMEWORK LOGIC MODEL



# CCS Needs Assessment – How it was Done

## Select Contractor

## Key Informant Interviews (16)

## Collection/analysis of CCS program data

### Surveys

- Family Survey (N = 4065)
- Physician Survey (N = 130)
- CCS Administrators/Medical Consultants survey (N = 82)

### Focus Groups

- 6 focus groups were conducted in November and December 2014
- CCS families (3 groups)
- CCS providers (1 group in Southern CA)
- CCS administrators and other managed care administrators (2 groups)

### Other

- NSCHCN , CMS Net client and paneled provider data

**Meet with Title V Stakeholder group initially at end to select priorities, develop Action Plan, goals, objectives**

# Stakeholder Group and Key Informants

- Stakeholders representative of key interest groups: Families, CCS County Programs, Professional and Advocacy Organizations, Managed Care Plans, other State Departments, and Academic Researchers
- Stakeholder subcommittees provided key input for surveys and focus groups
- Sixteen Key Informant Interviews provided general guidance for remainder of process

# CCS Family Survey

- Collaborative effort with State CCS, stakeholders, parents
- Administered by CCS counties at the time of annual medical renewal or at MTU
- Goal – survey 5% of caseload
- Survey period 7/6/14 - 11/15/14

# Family Survey :

## Region and Survey Methods

Region	N	%
North Mountain	354	9
Bay Area	554	14
Sacramento	66	2
Central Coast	404	10
San Joaquin	1,025	25
Los Angeles	195	5
Orange	527	13
San Diego	493	12
Southeast	447	11

Methods of Survey Completion	N	%
CCS annual paperwork	932	23
Specialty Care Center	161	4
Phone - someone called	1,492	37
Computer - Survey Monkey	561	14
Smartphone - Survey Monkey	91	2
Other	642	16
Missing	186	5

# Physician Survey Highlights – Practice Setting of Respondents

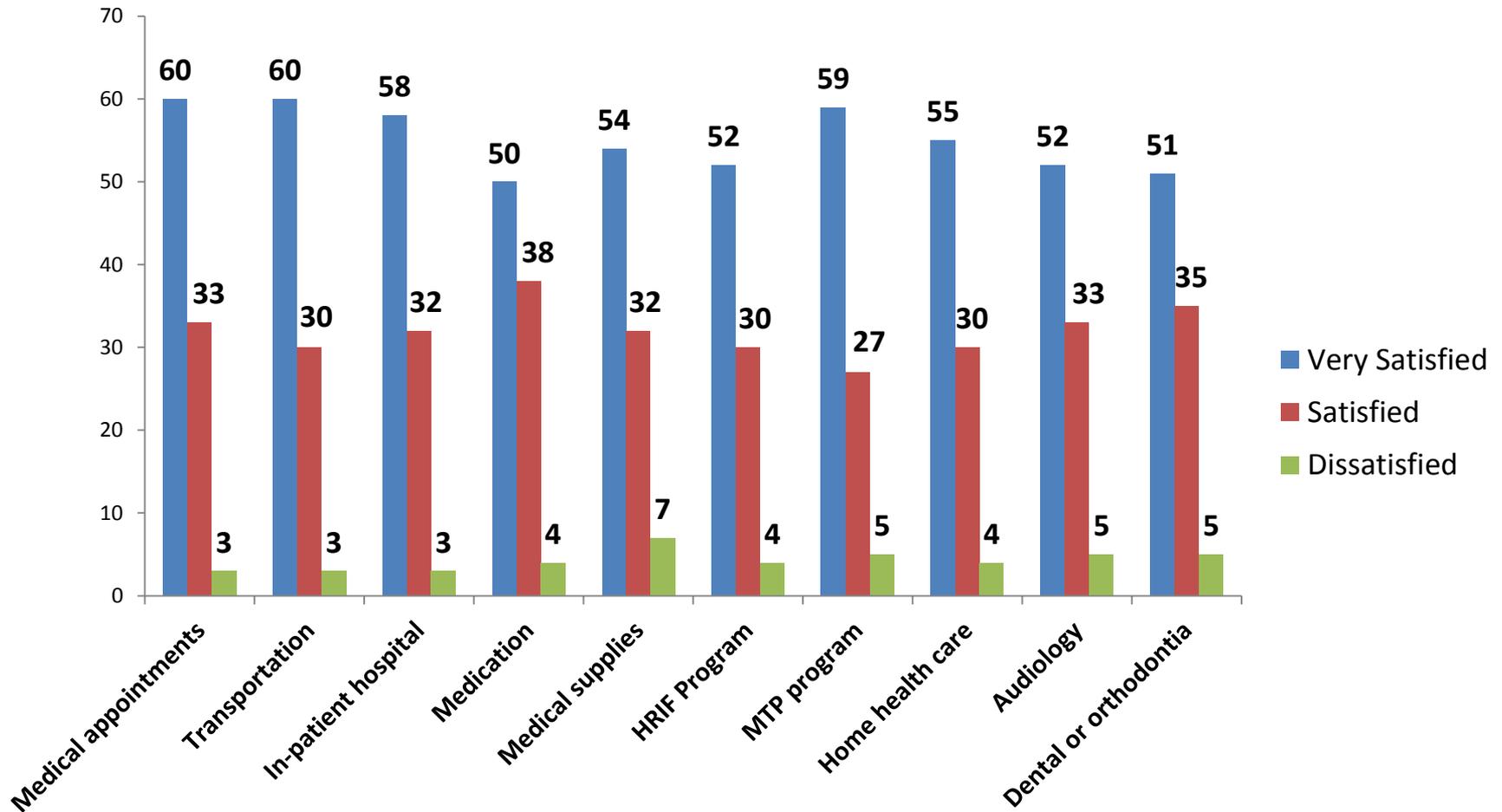
Practice Location	Response	%
Tertiary Medical Center (Non-Kaiser)	83	67%
Kaiser Tertiary Medical Center	1	1%
Stand alone specialty clinic	6	5%
Primary care practice (private)	12	10%
Primary care practice (public)	2	2%
Federally Qualified Health Center (FQHC)	14	11%
Other	6	5%
Total	124	100%

# Focus Groups

- ▶ 6 focus groups conducted in November and December 2014
  - **CCS families**
    - 2 groups in Southern CA with a total of 14 participants
    - 1 group in Northern CA with 12 participants
  - **CCS providers**
    - 1 group in Southern CA with 6 participants
  - **CCS administrators and other managed care administrators**
    - 1 group in the Central Valley with 8 participants
    - 1 group in the San Francisco Bay Area with 6 participants

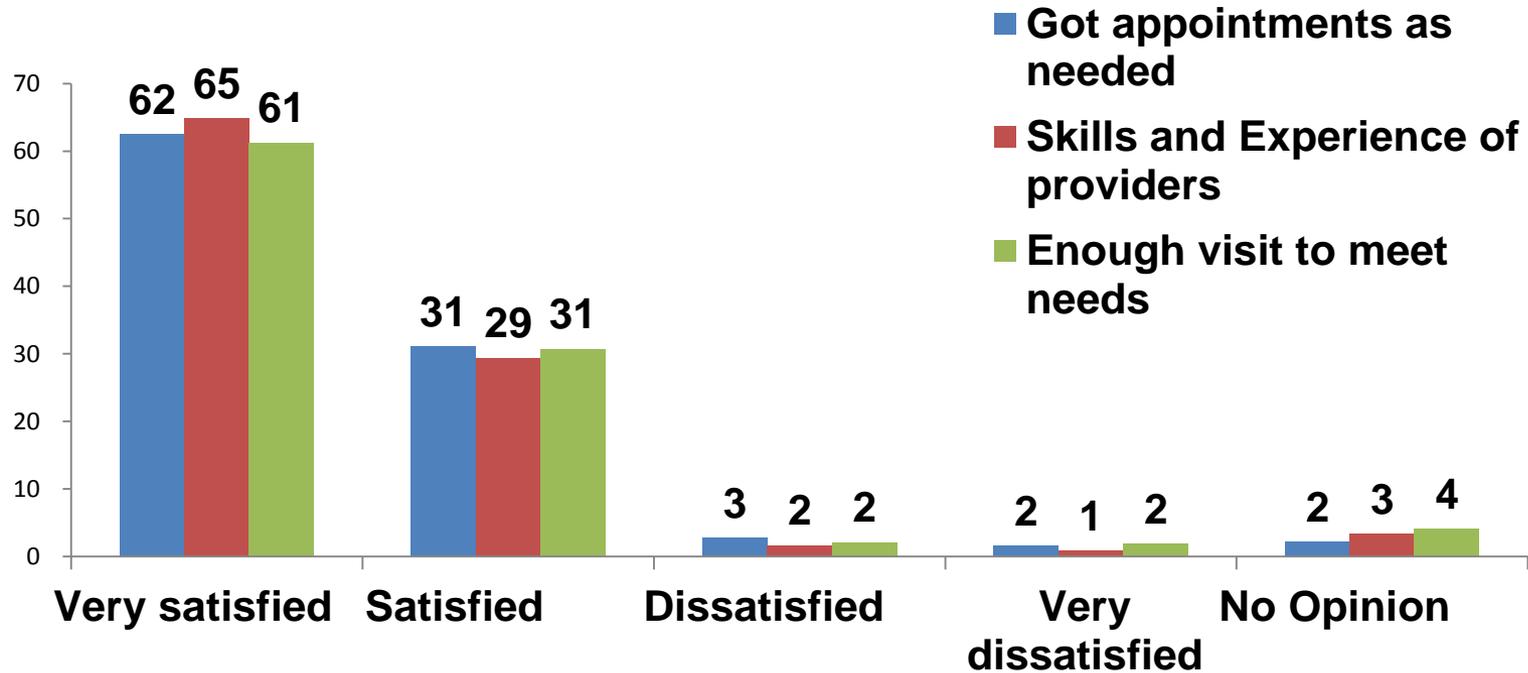
# Results

# Family Satisfaction with Services (Title V family survey)



# Satisfaction with Special Care Centers

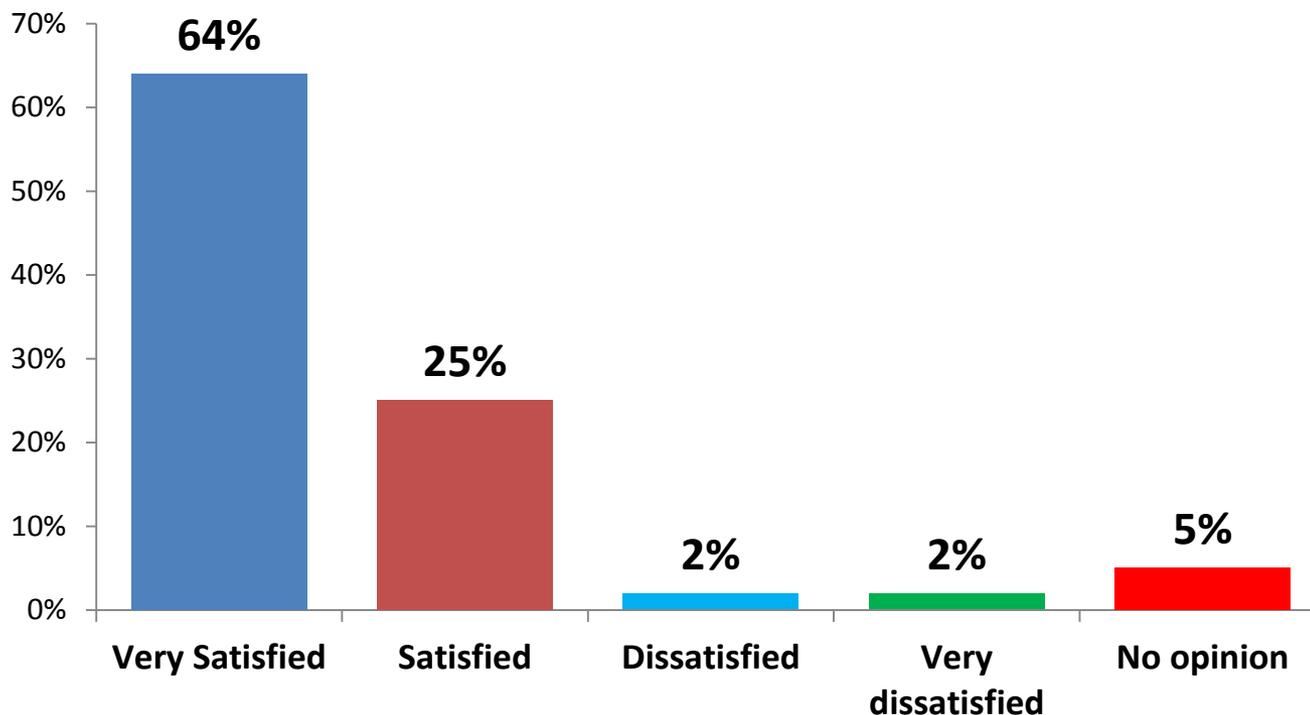
(Title V family survey)



# Knowledge of and Satisfaction with CCS Case Managers (Title V family survey)

- 68% of respondents to the Family Survey said their child had a CCS Case Manager

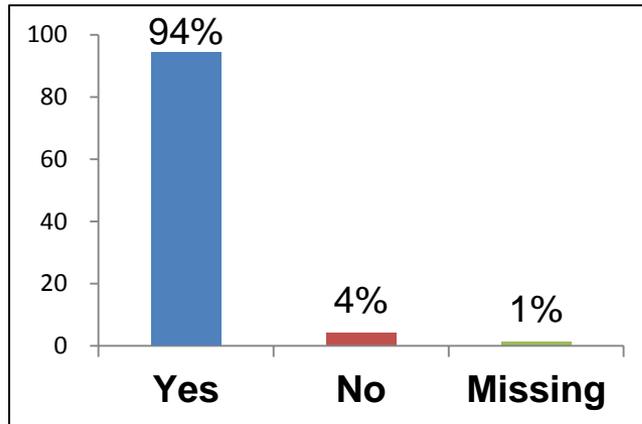
Satisfaction with Case Manager



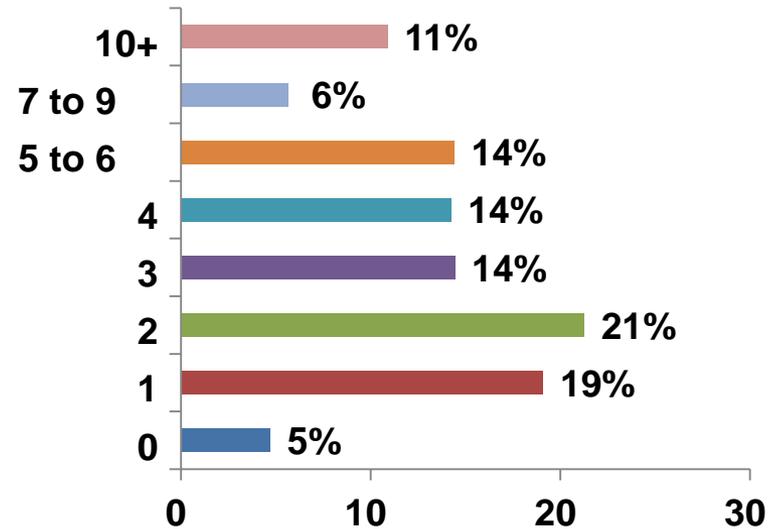
# Medical Home: PCP and Referral

(Title V family survey)

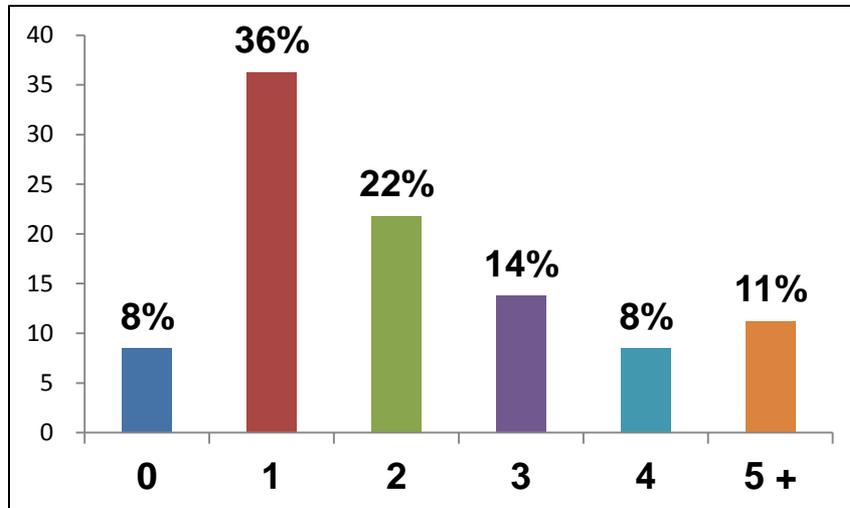
Have a primary care provider?



Number of specialist visits in last year?



Number of specialist seen in last 12 mos.



# Medical Home: Referral

*From the National Survey of CSHCN 2009/2010*

- CSHCN needing a referral for specialty care and having difficulty getting it: 33.9% in CA vs. 23.4% Nationwide

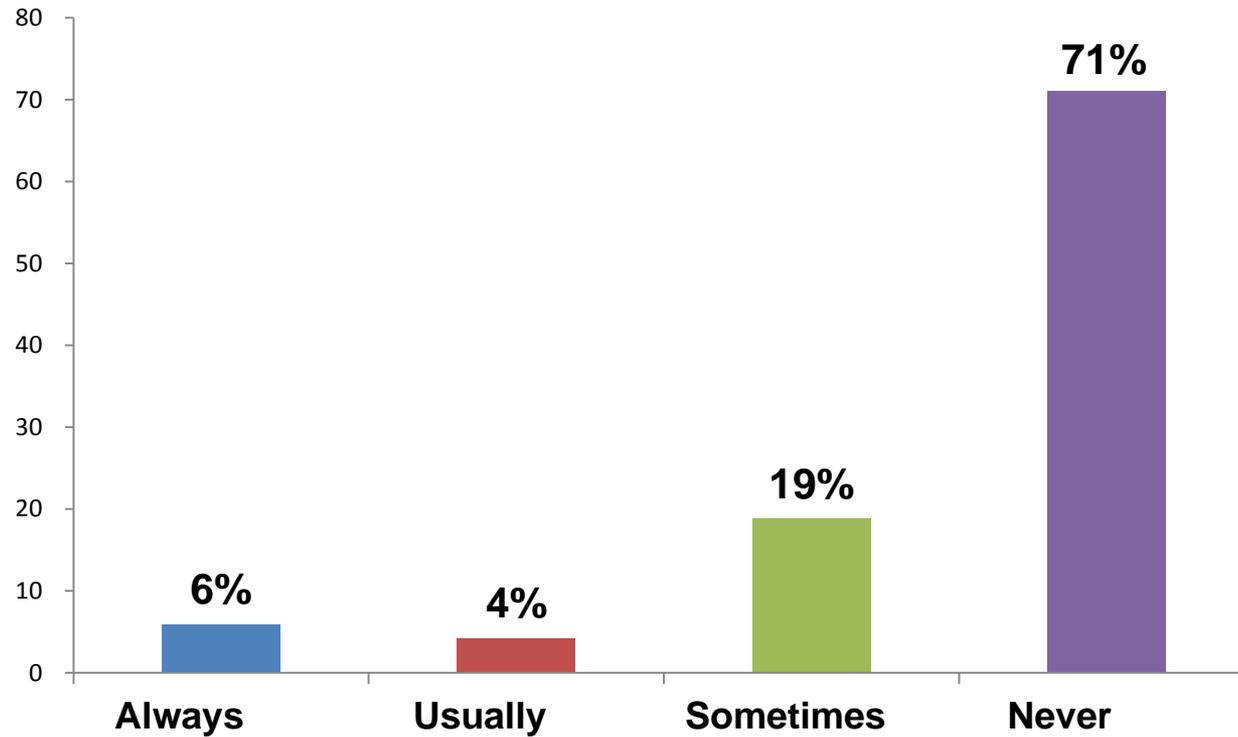
*From the CCS Family Survey*

- Saw specialist when needed 71%
- Specialist always coordinated with PCP 58%
- Had delays with referrals to specialists 29% (always /usually 10%)

# Referrals to Specialists

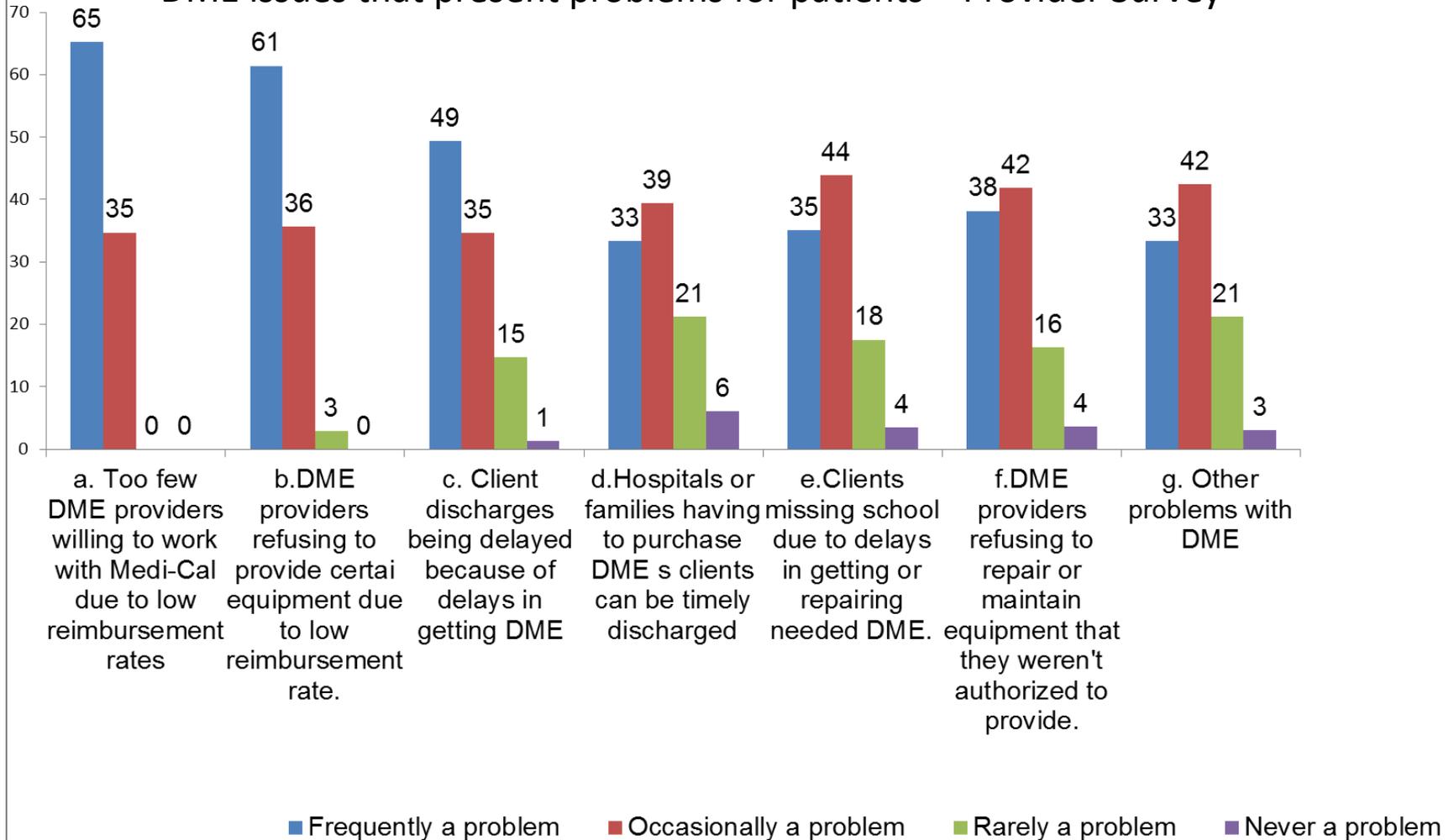
(Title V family survey)

Delays or problems getting referrals to CCS Specialists?



# Medical Home: DME

DME issues that present problems for patients – Provider Survey



# Medical Home: Access

(Title V provider/administrator focus group themes)

- Provider Access
  - Lack of paneled primary care providers in rural areas
  - Delays accessing specialty care
  - Lack of available specialists
  - Lack of paneled mental health providers
- Use of ER services because of lack of access to timely care
- DME Access
  - DME delays lead to delayed discharges
  - DME providers do not provide certain equipment due to low rates

Source – FHOP Title V 2015 focus groups

# Medical Home Challenges

(Title V focus group themes and quotations)

- Poor communication and coordination between primary and specialty care providers from the parent perspective
- Parents playing a big role in coordinating care for their child
- Many barriers to physician participation in CCS – delays in payments, complex paper work, challenges dealing with Medi-Cal Managed care plans

# Medical Home challenges

## CCS providers stated in focus groups:

“How can you ask a Medi-Cal provider, being paid \$20/visit, to manage all of the care? Some do it on their own time. It would require caring for the whole child [and be]...incentivized.”

“Generally speaking, no true adherence to the medical home concept. We are never going to control cost and guarantee quality until we understand the need to do this.”

“It [no medical home concept] is an enormous failing of the current system.”

“If [we] try to do this for CCS kids, CCS will be out of business in two years. The idea is unrealistic given the current financing and program structure. Everyone wants to do it, but no one can do the financing.”

# Transition to Adulthood

- MCHB Core Outcome #6: Youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

# Transition to Adulthood: The Family Perspective

NS-CSHCN - 37% of youth in CA achieved this outcome

From CCS Family Survey

- 34% of the respondents have a child 14 or older
  - 28% of report providers talking to them about how their child's health care needs will be met when he/she turns 21
    - 15% report CCS helping to find an adult provider
    - Of those reporting CCS help finding an adult provider, 80% were successful

From Family Focus Group

- *"I am terrified of what's coming when my daughter turns 20...it's an extreme problem that no one is telling anyone how to do it."*
- *"I'm nervous because I'm afraid of all of the things I am going to lose. Just because they've aged, their medical needs haven't changed."*

# Transition to Adulthood: Provider Perspective

## *From Physician survey*

- 63% who worked with transition age youth report it is very hard to find a new PCP
- 69% who worked with transition age youth report it is very hard to find a new specialty care provider

## From Physician focus group

- Very hard to find a provider to see CCS clients as they age out
- Lack of transition planning
- No organized system of care for YSCHN to transition into
- Lack of insurance coverage a major problem
- *“Unmitigated disaster...there is a no transition, your services end on your birthday”*
- *“Adolescents who “age out” of CCS usually have NO WHERE TO GO. We know of no private-practice adult neurologists willing to take on multi-handicapped young adults or adults with intractable epilepsy on Medi-Cal. The only source of care for our 21 yo former patients is LAC USC or Harbor UCLA, and there is NO coordinated multispecialty care available anywhere for them”*

# Transition to Adulthood: Parent/Administrator Perspective

From CCS Administrators

- *“We've augmented our annual transition fair to a transition conference, which entails transitioning into and out of CCS.”*
- *“We have a parent liaison that works closely with our families and helps them with any problems they may experience in finding community resources. She also attempts to contact each young adult who is transitioning out of CCS to assist them with any transitioning problems or questions they may have.”*
- Having a list of qualified physicians for the family and young adult to choose from. Young people with physical along with developmental problem need assistance with all types of needed services.
- MSWs have been best resource for assisting families with transition and coordinating care related to transition. Lack of MSWs severely impacts client, family and program.

# Cultural Competency

- AMCHP System Outcome #7: All CYSHCN and their families will receive care that is culturally and linguistically appropriate (attends to racial, ethnic, religious, and language domains).

# Cultural Competency: The data

## Access to Interpretation Services

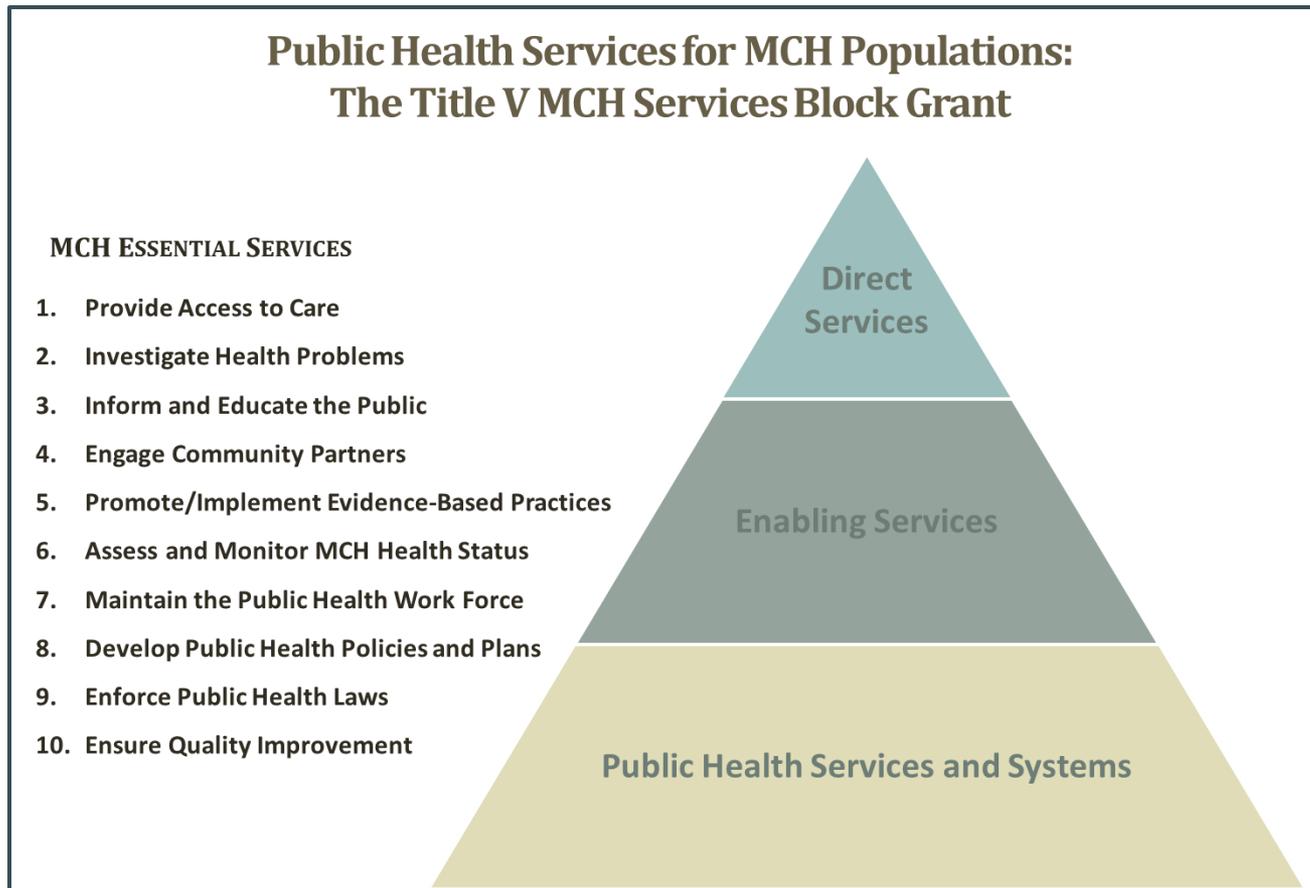
- 23% of families reported needing interpretation services to communicate with their child's medical provider always or usually in the last 12 months
- 76% of families report that an interpreter is usually or always available when they saw a CCS specialist in the last year
- 18% report interpreter being only sometimes available, and 6% report never available

# Positive Comments from Parents

- *“CCS has always been supportive and hardworking when it comes to the needs of my child”*
- *“CCS has been amazing! They have provided vital services and care to my child - they have been flexible and accommodating. They have helped with problem solving difficult medical situations regarding my child. They have been supportive but informative, being honest about what can or should happen in various situation.”*
- *“CCS has been helping our family since my son was an infant 6 years ago. The PT and OT therapy have been extremely effective that helped my son tremendously. It's hard to imagine what life would be if we hadn't had CCS.”*
- *“CCS has been the greatest use of tax payer money .We are grateful for the therapy services they are A-1. Kid is leaving for college doing well.”*
- *“CCS is a miracle. Helps make kids productive and they are always taking care of their kids. Grateful and appreciative. Everyone is sincere and truly giving. A support group would have been great. CCS should never be cut off. The program is extremely necessary and not a waste. Please keep this program it is a tremendous help.”*

# Title V Needs Assessment vs. CCS Redesign

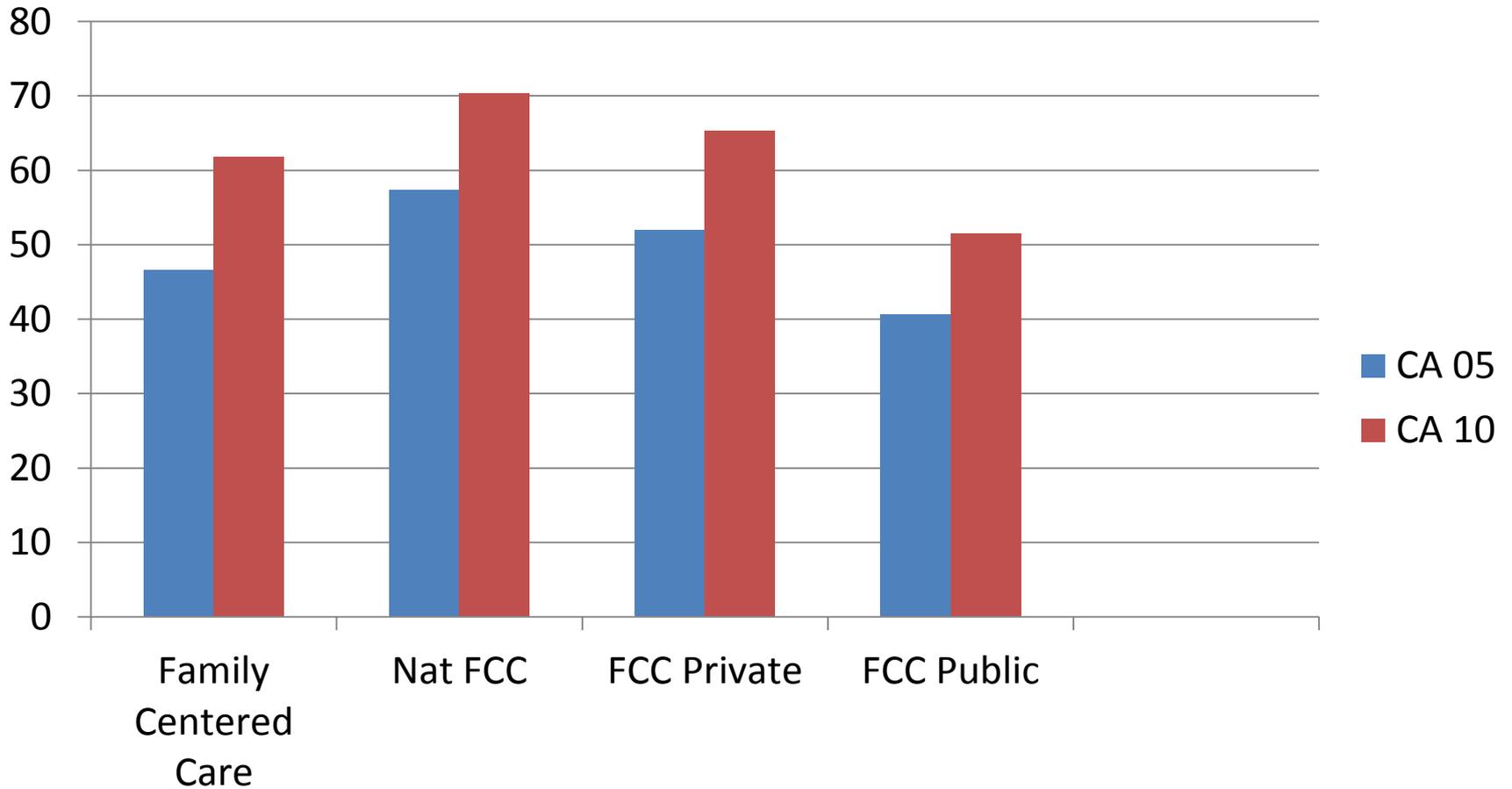
The Mission of Title V is to improve the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs, and their families.



# Thank you

- Family Health Outcomes Project
  - Jennifer Rienks, PhD
  - Ruth Long MA
  - Gerry Oliva, MD MPH
- Systems of Care Division Title V team
  - Robert Dimand, MD
  - Cyd Ramirez, RN
  - Paulette Meeks RN,
  - Laura Whisler, PhD

# Background – Family Centered Care – NSCHN Results



# On-line Surveys

- Families – 4065
  - White 994 (24%)
  - Black 209 (5%)
  - API 313 (8%)
  - Hispanic 2242 (55%)
- Physicians – 130 of which 30 were general pediatricians and the rest sub specialists
- CCS administrator/medical consultants survey – final N for analysis = 82

# On-line Surveys

- Families – 4065
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- Physicians – 130 of which 30 were general pediatricians and the rest sub specialists
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# CCS Needs Assessment – Data Source

## Key Informant Interviews

- 16 Key Informant interviews conducted from July through September 2014

## On-line Surveys

- Family Survey (N = 4065)
- Physician Survey (N = 130)
- CCS Administrators/Medical Consultants survey (N = 82)

## Focus Groups

- 6 focus groups were conducted in November and December 2014
- CCS families (3 groups)
- CCS providers (1 group in Southern CA)
- CCS administrators and other managed care administrators (2 groups)

# CCS Needs Assessment – Data Source

## 2

- NSHCN results
- CMS Net

# Family Satisfaction Results: Services Received and Ratings

Service	Total	Satisfied		Else			Percent	
		V Sat	Sat	Dis	V Dis	No OP	V Sat	Sat
Medical appointments	3,232	1,950	1,019	55	27	181	60	33
Transportation	512	309	139	9	4	51	60	30
In-patient hospital	1,141	664	328	25	12	112	58	32
Medication	2,067	1,035	681	68	19	264	50	38
Medical supplies	1,179	641	336	58	22	122	54	32
HRIF Program	296	154	71	9	2	60	52	30
MTP program	1,211	714	287	53	10	147	59	27
Home health care	310	170	79	8	4	49	55	30
Audiology	478	247	136	22	4	69	52	33
Dental or orthodontia	885	448	267	36	4	130	51	35
No Services	359							

# Medical Home: the data

**How often are the following types of providers lacking for your CCS clients?**

*From the FHOP CCS Administrators/Medical Consultants Survey 2014*

	Never	Occasionally	Very Often	Always	Total N	
CCS Paneled Audiologists	5%	28%	24%	43%	58	
CCS Paneled Physical Therapists	14%	24%	32%	31%	59	
CCS Paneled Occupational Therapists	14%	24%	31%	32%	59	
CCS Paneled Primary Care Providers	21%	35%	30%	14%	57	
CCS Paneled Registered Dietitians	19%	25%	15%	42%	53	
CCS Paneled Respiratory Therapists	32%	16%	12%	40%	50	
CCS Paneled Social Workers	29%	15%	8%	48%	52	
CCS Paneled Orthodontists	17%	21%	17%	45%	53	
CCS Paneled Otolaryngologists	29%	23%	17%	31%	52	
CCS Paneled Pediatric Neurologists	9%	35%	30%	26%	54	
CCS Paneled Endocrinologists	15%	23%	23%	40%	53	
CCS Paneled Plastic Surgeons	16%	33%	22%	29%	51	
CCS Paneled Pediatric Cardiologists	28%	40%	12%	20%	50	
Other CCS Paneled Provider (please specify)	22%	15%	26%	37%	27	

# Title V Needs Assessment Presentation Q&A

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Questions?

Jill Abramson, MD, DHCS

# TWG Discussion

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TWG members' goals and priorities

Hannah Katch, DHCS

Jill Abramson, MD, DHCS

# Data Request Form

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What data will this TWG need to conduct its work?

Please email [michferrari@ucla.edu](mailto:michferrari@ucla.edu) if you did not yet receive a copy of the Data Request Form via email.

# Next Steps and Follow-up

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- Comments on Packard document
- Revisions and suggestions for Definitions Document
- Comments on the CCS pilot RFP.
  - Above three documents were sent to TWG members via email on March 25, 2015. PI
- Suggestions for structuring care coordination based on complexity/risk stratification
  - Feedback is requested by **Friday, April 3, 2015**. Please send via email to [michferrari@ucla.edu](mailto:michferrari@ucla.edu) and [chpr\\_ccs@em.ucla.edu](mailto:chpr_ccs@em.ucla.edu)

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Thank you!