Q5 CCS County Measure 1 Definition: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.Provide recommendation to CCS County Measure 1 and/or enter your comments.

Answered: 38 Skipped: 0

#	Responses	Date
1	It is challenging to identify a true primary care physician for NICU infants, since the parents often have not made a decision when we receive the referral to CCS. I think this measure should include all clients in CCS except for NICU infants.	11/24/2015 4:50 PM
2	The Special Care Centers provide this already.	11/24/2015 2:33 PM
3	"Addresses preventative, acute and chronic care" is a bit confusing. Is this measure really to determine that each child has a medical home? Acute and chronic care for many CCS children are not handled by PCPs, but by the specialist/SCC, but the child still should have a medical home (which also could be the specialist). I recommend clarifying the language so that the data provided will refer to the presence of a medical home that is responsible for addressing preventive care and ensuring that access is obtained to appropriate acute and/or chronic care, both for the CCS condition and possible non-CCS conditions.	11/24/2015 1:57 PM
4	The measure is very broad, we would need more details, numerator/denominator etc.to determine if we have any comments to make.	11/24/2015 12:03 PM
5	This definition is problematic because the primary care physician is not equipped to address the acute subspecialty needs (eg child with CF needing acute care). The word "addresses" perhaps should be changed to "provides oversight and Special Care Center referral for subspecialty care."	11/24/2015 9:39 AM
6	This would be an ideal solution to coordinate and oversee care for the whole child no matter who is paying for services and care. PCPs are not equipped with time and staff to do this fully and there is great variability amongst them in how much they are willing to take that role on, even if the CCS program authorizes them to participate in caring for the CCS eligible conditions. That is where finding ways to pay extra for Medical Home Services needs to be a priority for such patients. However, should infants fall off current NICU criteria, CCS is no longer involved. Under the whole child model, this will be easier to do.	11/24/2015 9:14 AM
7	This looks to me to be about ensuring that CCS clients have an effective medical home, which I applaud. Is there discussion somewhere about QA/QI (carrots/sticks) in terms of the quality of preventive/acute and chronic care support?	11/23/2015 6:23 PM
8	Identified Special Care Centers should be included.	11/23/2015 4:32 PM
9	This could be difficult to measure when the NICU's or CCS provider is not located in the counties where the child resides or received primary care. A health plan can encourage it and facilitate the providing of information but if they do not include notes in the young child's chart, the plan should not be penalized.	11/23/2015 4:25 PM
10	who addresses (add) and coordinates preventative, acute, ... If it isn't coordintated between clinics it is difficult to navigate	11/23/2015 3:02 PM
11	Children with medical complexity need a medical home -- to support care coordination and connectivity to community resources -- not just a designated physician. There should be a companion measure of families who measure the quality of receiving these services as well.	11/23/2015 12:27 PM

12	Currently the CCS system has a field for a "Medical Home Provider". Many of my families have advised me they are the "Medical Home Provider as they need to track client 24-7 and make referral connections with specialists. The State needs to clearly define the term for CCS staff completing the field. If we are saying for quality standards the medical home is an MD, NP, PA, or SCC-MD who provides preventive, acute, and chronic care, then the field needs to accommodate that and be locked to allow no other data entries. A baseline data run should be done and each county advised of their results. Then for continued evaluation on success rate of increasing documented medical home of record the report should be available monthly. In Solano there is a report available through Business Objects, and we review the data monthly (we are also able to identify and target clients with no medical home of record to educate and encourage the family to choose one) .	11/23/2015 11:35 AM
13	I would recommend that we initiate performance measures (similar to HEDIS) to document performance and perhaps develop incentive payments based on this performance	11/23/2015 11:34 AM
14	Is it necessary to include NICU infants in the statement due to the variance in medical conditions, length of stay, and discharge needs. It can solely read clients enrolled in CCS which includes NICU.	11/23/2015 11:17 AM
15	All CCS clients MUST ALSO be designated to an existing CCS Special Care Center (SCC), and all SCC recommendations must be fully implemented and reimbursed to the SCC. The SCC must retain authority for determining what is medically necessary (including prevention education) if the patient's care is co-managed by a Managed Medi-Cal Health Plan. We have collaboration models that work in Hemophilia. Please contact me.	11/23/2015 10:57 AM
16	Will this be run as the BO medical home report? Will CMSNet be updated to allow medical home provider to be an FQHC since these clients do not see the same doctor?	11/23/2015 10:43 AM
17	We are unclear on the intent of this measure. Terms such as, "usual place of care", and "where care is provided normally" are vague. Is the intent to associate the child with a non-CCS-paneled provider who provides non-CCS services and potentially life-term care, or a CCS-paneled provider? If there is a measure, what's the measure of success given the CCS parents' and providers' concerns?	11/23/2015 10:41 AM
18	We are concerned that for the NICU population, entering the name of the SCC medical director does not reflect who will follow these children after they leave the NICU.	11/23/2015 10:27 AM
19	1. NICU infants are often not enrolled in Medi-Cal initially. Without enrollment, in Medi-Cal or MMCP how would these infants be connected to primary care? Also, we have had difficulty with hospital social workers assisting families apply for SSI on infants who meet presumptive eligibility for SSI.	11/23/2015 8:35 AM
20	I agree	11/23/2015 8:28 AM
21	These comments reflect the consolidated feedback from all CCHA member hospitals: (1) A team or practice should also be able to be identified as the medical home designee. (2) This measure seems to be asking if the child is assigned to an available high risk clinic for complex NICU patients and should be re-written to make this more explicit. (3) The measure should specify that clients enrolled in CCS have a designated CCS provider in a usual place of care.	11/20/2015 4:48 PM
22	We support this approach.	11/20/2015 2:27 PM
23	Not all PCP name can be found in CMSNet despite of free texting. NICU babies does not have assigned PCP until discharged from hospital or seen for f/u vaccinations or HRIF. Transfer clients require time to find new PCP. Nurse Practitioners who are PCP are not CCS paneled.	11/20/2015 2:11 PM
24	As a General Pediatrician with many CCS patients, even though I am the child's PCP, CCS will not allow me to write orders for tests or prescriptions for medications as I am not a sub specialist. This often delays care for the child as the family cannot contact the specialist, who is 150 miles away in a timely manner. I feel CCS often gets in the way of my provision of care for my patients just because we do not reside in a large urban center. Merging CCS with MediCal would greatly increase my ability to get the children the medications they need.	11/20/2015 3:26 AM
25	Clients enrolled in CCS, including NICU infants, will have APPROPRIATE ACCESS TO 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.	11/19/2015 10:00 PM
26	Absolutely necessary to have this medical home. Included in this should be assurance of an initial and annual assessment, a care plan, and linkage to behavioral health and developmental services.	11/19/2015 11:31 AM
27	As an FQHC, we already are the medical home for a great number of the CCS children in our County as we have over two-thirds of the pediatricians. We support the move to integrating CCS with Partnership Health Plan and continuing to be the primary care medical home for these children.	11/18/2015 4:32 PM
28	Parents should be able to name their own physician	11/17/2015 8:54 PM
29	The specialists and other healthcare providers must have special training for caring for children with chronic illnesses, fully understand the meaning of "The Whole Child" Model that requires that the family be included as a main partner in the 'Team.'	11/17/2015 3:31 PM

30	Mono County is very rural and pediatricians are not able to address specialty care for CCS children, which is most needed. Immunization and routine care are addressed but transition is lacking.	11/16/2015 4:53 PM
31	NICU infants may not have a designated physician until they are ready for discharge, maybe reword, that hospitalized patients have upon discharge- that way if a new client is enrolled the CCS program will work to get them one upon discharge.	11/16/2015 2:34 PM
32	Agree	11/16/2015 11:45 AM
33	Standards for designation of an "appropriate" Medical Home, that can address particularly chronic care coordination, need to be included.	11/16/2015 9:25 AM
34	Medical Services rendered by physician or nurse practitioner should be located in the CCS office. Recommendation include transforming CCS offices into Medical Clinics to attend all county CCS clients.	11/16/2015 9:17 AM
35	It is important to distinguish the levels of care: primary care medical home, specialist, specialty care center. Clients should be matched with the appropriate level of care and definitions for what constitutes preventative, acute, and chronic care should be monitored.	11/16/2015 8:55 AM
36	- This measure should be made more fully consistent with all 6 components of the family-centered medical home (including 24/7 access, comprehensiveness, cultural competence). - This measure should be assessed by both subjective (parent survey) and objective (observation, admin) metrics.	11/16/2015 8:42 AM
37	This is definitely the ideal. However in the current access-challenged environment (for the Medi-Cal population), I would guess the greatest majority of our CCS children are assigned to FQHC, RHC or other look-alike clinics. Can it be verified with Managed Care if children in these clinics are assigned at the physician-level or clinic-level? Otherwise, Counties compelled to meet the measure, may assign a physician in the clinic just to have a "designated physician" that will count toward that measure.	11/13/2015 5:31 PM
38	1. A number of NICU infants discharge without further CCS eligibility. During the time they are CCS elig, their care is primarily with the NICU. It appears to me the goal of the measure is to assess assignment and access to a Primary provider and Medical Home after discharge for CCS elig children. Therefore I propose adding after "including NICU infants" the phrase "at the time of discharge". 2. Should be we using the phrase "will have" or "have"?	11/13/2015 5:00 PM