



**Department Of Health Care Services
California Children's Services (CCS) Advisory Group (AG) Meeting**

**October 21, 2015
10:00am – 3:00pm**

MEETING SUMMARY

Members Attending: David Alexander, MD, Lucile Packard Foundation for Children's Health; Maya Altman, Health Plan of San Mateo; Nick Anas, MD, CHOC Children's Hospital; Steven Barkley, MD, Santa Barbara Cottage Hospital; Edward A. Bloch, MD, Children's Medical Services, LA County; Kris Calvin, American Academy of Pediatrics, CA; Richard Chinnock, MD, California Specialty Care Coalition; John Patrick Cleary, MD, California Association of Neonatologists; Arlene Cullum, Sutter Health; Juno Duenas, Family Voices; Michelle Gibbons, California State Association of Counties; Kelly Hardy, Children Now; Tom Klitzner, MD, California Children's Services, UCLA; Ann Kuhns, California Children's Hospital; Susan Mora, Riverside County Department of Public Health; Tony Pallitto, Kern County Public Health Services Department; Richard Rabens, MD, The Permanente Medical Group / Kaiser Permanente Northern California; Judith Reigel, County Health Executives Association of California; Katie Schlageter, Alameda County; Laurie Soman, Children's Regional Integrated Service System; David Souleles, Orange County Health Care Agency

Members not attending: Dyan Apostolos, Monterey County Health Department; Amy Carta Santa Clara Valley Health & Hospital System Representing: California Association of Public Hospitals and Health Systems; Athena Chapman, California Association of Health Plans; Stuart Cohen, MD, American Academy of Pediatrics, Devon Dabbs, Children's Hospice & Palliative Care Coalition of CA; Karen Dahl, MD, Valley Children's Hospital; Chris Dybdahl, Santa Cruz County; James Gerson, MD, HealthNet; Domanique Hensler, Rady Children's Hospital – San Diego; Ed Schor, MD, Lucile Packard Foundation for Children's Health, Abbie Totten, Health Net, Inc.; Amy Westling, Association of Regional Center Agencies

Members attending by phone: Tony Maynard, Hemophilia Council of California

DHCS Staff: Jennifer Kent, Anastasia Dodson, Louis Rico, Sarah Brooks and Brian Kentera.

Facilitator: Bobbie Wunsch, Pacific Health Consulting Group

Guests: Peggy Hoover, Partnership Health Plan; Michael Harris, CenCal Health; Dr. Mary Doyle, Los Angeles County CCS; Terri Stanley, Cal Optima; Kathy Neal Central CA Alliance.

Follow-Up from Previous Meeting, Key Updates, AB 187, and Future Meetings'

Topics/Goals

Jennifer Kent, Director, DHCS

Anastasia Dodson, Associate Director for Policy, DHCS
Sarah Brooks, Deputy Director of Health Care Delivery Systems, DHCS

Presentation slides available at:

http://www.dhcs.ca.gov/services/ccs/Documents/AGMeetingPPFINAL10_19_15.pdf

Jennifer Kent opened the discussion by acknowledging the Governor's signing of AB187 that extends the date for sunset of CCS carve-out to no earlier than January 2017. The signing message signals the continued desire of the Administration to improve the program and recognizes that the bill is a sign of good faith in wanting to work together with stakeholders to find a thoughtful way forward.

Questions and Comments

Ann Kuhns, California Children's Hospital: We very much appreciate the signature and working together going forward.

Juno Duenas, Family Voices: Thank you on behalf of families.

Tony Maynard, Hemophilia Council of California: We also appreciate the symbolic nature of signature and look forward to working together on a solution that everyone is satisfied with.

Richard Chinnock, MD, California Specialty Care Coalition: I want to add our thanks.

Anastasia Dodson, DHCS offered brief updates since the July meeting. There were two technical work group meetings: the Data and Quality Measures Workgroup and the Care Coordination/Medical Home Workgroup. We are trying to drill down on issues identified over the past meetings and assign them to a technical work group. We want to list out the topics, put them in context of relevance for all counties vs counties targeted for the Whole-Child model and develop the right timing for discussion. We are confirming common language and definition of the topics; working through the substance of the issues; what is the state's role; as well as other input helpful to the issue identified. We are using this to structure productive meetings. In terms of designing today's agenda, we are mapping topics for the series of meetings through 2016 based on where there is a need to address gaps and resolve concerns.

Questions and Comments

Bobbie Wunsch, Pacific Health Consulting Group: One additional item about the meetings. Based on conversations by advisory group members with Secretary Dooley, about six weeks ahead of each meeting going forward, there will be an agenda prep call to gather your input and topic ideas for the agenda. In this way, we can organize agendas based on both DHCS input and advisory member input.

David Souleles, Orange County Health Care Agency: I have a question that is not on the agenda. In terms of the Whole-Child model, is the state still committed to this and can you comment on the timeline? I think this will happen in parallel to these meetings?

Jennifer Kent, DHCS: You are right to call it a parallel process. We want to continue to work with counties and plans already implementing the Whole-Child model with the timeline identified. Nothing will begin before January 2017. However, there are program improvements that should occur statewide such as care coordination and data. And, we will continue to work

on the Whole-Child model preparation: plan readiness, transition issues, data, care continuity, etc.

Laurie Soman, Children's Regional Integrated Service System: There is an issue that came up in the previous RSAB group – that we should expand family representatives. Juno Duenas participates but families are a diverse community and it would be a good idea to have additional representation.

Jennifer Kent, DHCS: We are always interested in diverse representation and can take suggestions if there are names for consideration. It is not a lack of interest on our part but an understanding that the time commitment and travel can be hard for family representatives.

Bobbie Wunsch, Pacific Health Consulting Group: We invited representatives of the five County Organized Health Systems to sit at the table, not as members of the Advisory Group. We want them to join the conversation when appropriate and answer questions about how issues play out at the plans.

Katie Schlageter, Alameda County: I support what Laurie is saying about additional family representatives. Alameda County has seven families participating in a local mental health committee. I also appreciate the idea of planning six weeks in advance to get input on the agenda ahead

Ann Kuhns, California Children's Hospital: Perhaps at a future meeting, can we run through the DHCS proposed legislation section by section - where it originated, why it is there, etc.?

Jennifer Kent, DHCS: Yes, there is also a Stakeholder Advisory Committee (SAC) formed around the 1115 waiver. Jim Watkins presented to SAC on children's data. It was not CCS specific however it was high cost focused so many CCS children we identified in the data. He was able to tease out mental health services in the population that may be of interest. There is significant amount of mental health in CCS that has not been detailed. We can send out the slides for your review. He looked at top conditions, not county data but it does indicate high cost conditions and other specific categories of mental health cost and what services.

Katie Schlageter, Alameda County: We would be very interested in that data. We are trying to get baseline data right now in Alameda. We show that on the medical therapy program (MTP) kids, 80 of 900 kids accessed behavioral health services and many were severe, inpatient stays. We were not previously aware of this.

Jennifer Kent, DHCS: I want to add that Children's Hospital Orange County (CHOC) has an expansion for mental health beds and treatment capacity currently underway. There is the mental health condition and the co-occurring physical health conditions as well.

Kelly Hardy, Children Now: Can you briefly talk about the purpose of this reconvened advisory group and today's meeting objectives?

Jennifer Kent, DHCS: The agenda reflects the interest in an ongoing dialog about the Whole-Child model; and how readiness, preparation by plans, CCS specific clinical issues need to be detailed. This is a parallel discussion to the overall program and improvements across all counties. The focus here is all about CCS broadly – not solely Whole-Child model. Talking about care coordination, the medical home and how to use data in each of these topics.

Bobbie Wunsch, Pacific Health Consulting Group: We want to have a discussion at each meeting about what data is available to provide input to the agenda topics. We will generally start with data. Lee Sanders is traveling and not available until later in the day for this particular meeting.

Care Coordination / Medical Home / Provider Access Technical Workgroup Update

Anastasia Dodson, Associate Director for Policy, DHCS

Dr. Mary Doyle, Associate Medical Director, Los Angeles County CCS

Peggy Hoover, Senior Director Health Services, Partnership Health Plan

Presentation slides available at:

http://www.dhcs.ca.gov/services/ccs/Documents/AGMeetingPPFINAL10_19_15.pdf

Ms. Dodson reviewed the October 9th webinar meeting of the technical workgroup. It was very helpful to have input from various parts of the health care system. The workgroup has four goals, including consultation on implementing the Whole-Child model; ways to improve care coordination between all partners in all counties; explore new, innovative models of care that will increase care coordination and care quality; discuss provider standards and access requirements; and, improve transitions for youth aging out of CCS. There are many additional topics proposed such as medical therapy, durable medical equipment (DME), telehealth, mental health and more. Based on input from the meeting, we will restate the goals from the perspective of family and youth. We will set a regular meeting schedule. It is a challenge combining three separate groups and we need your input about working with a small group. The webinars will be open to all.

Questions and Comments

Laurie Soman, Children's Regional Integrated Service System: These goals are very ambitious for one workgroup to take on. The more report backs the whole group receives, the more we can get feedback to you even if we can't participate on a webinar. One comment on DME. CHRISS just completed a survey that was a follow up on access to DME from counties, hospitals and families. The data is just as bad as it was in 2007, the last time the state reviewed this. We have a brief summary I will forward and would like the information built into the discussion. It does not offer solutions but it does offer feedback on the status of access. Hospitals are out of pocket but families are out of pocket as well – just to get children out of the hospital – that's not ok. On goal 3, can you clarify whether this is in the context of the department's model?

Anastasia Dodson, DHCS: I was thinking of it in relation to Whole-Child model but perhaps it should be thought of more broadly to link to other topics like youth transitions, which is statewide.

Jennifer Kent, DHCS: Another context is to think of it for those in inpatient, out-of-home settings that needed to be transported to a specialty care site out of their home community for treatment. How do we consider continuity of care when they return home? It is also in this step-down situation.

Juno Duenas, Family Voices: Are we talking about the Whole-Child model and also thinking about CCS as whole?

Anastasia Dodson, DHCS: Yes, definitely.

Arlene Cullum, Sutter Health: I am concerned that given the periodicity of meetings suggested and the breath of the topics, I think there would be relevance to have subcommittees. Volunteers could join a subcommittee. It is extra work, but just considering one topic of provider standards, this is a large topic and may not be able to be handled in the timeline you outlines.

Katie Schlageter, Alameda County: It would be good to have longer in person meetings not phone meetings.

Juno Duenas, Family Voices: I agree.

Susan Mora, Riverside County Department of Public Health: I agree and welcome a fixed set of dates. I would be willing to join in person.

David Alexander, MD, Lucile Packard Foundation for Children's Health: On goal 3, there are universal provider standards and there are specific issues with transition to managed care around continuity that I hope will not get lost in a broad discussion.

Bobbie Wunsch, Pacific Health Consulting Group: The point you are making is important. We have parallel and intersecting issues and we need to retain a focus on both.

Kris Calvin, American Academy of Pediatrics: This goes to the heart of our larger agenda and would benefit from more involvement of members. AAP did a survey with a 50% response rate of members. We asked them what they most needed to be a medical home for these children and even higher than reimbursement and other topics, care coordination was the top issue they wanted AAP to focus on.

Anastasia Dodson, DHCS: I didn't hear any concerns, so we will go ahead and choose a small group to plan agendas and set dates.

Los Angeles County Update on Case Management Redesign
Dr. Mary Doyle, Associate Medical Director, Los Angeles County CCS

Presentation slides available at:

http://www.dhcs.ca.gov/services/ccs/Documents/AGMeetingPPFINAL10_19_15.pdf

Ms. Dodson introduced Dr. Doyle to make a presentation on risk stratification discussed at the webinar meeting. Many of the questions from the webinar have been incorporated into today's presentation. She provided a recap on the research and information on some additional projects related to today's agenda. The Medical Therapy Program (MTP) caseload of nurses was very high and there is interest of coming up with a model of care to do high quality care coordination. A pilot was developed based on complexity of case management needs – not the child's medical complexity. There were four models piloted and data was collected in a data software program. The pilot included process measures such as pre and post patient and family satisfaction as well as outcome measures such as identification of a medical home, missed days of school and clinical outcomes. Cases were sorted into standard and complex case management and the pilot confirmed that cases were in the right category. We developed and are now using standardized ICD 10 codes. We are now doing the caseload sorting based on results of the pilot. Nurses prefer a hybrid model of 60% standard and 40% complex cases. We are close to the one year mark and analysis of the findings. Currently, the focus is on refinement of the software and streamlining the process. We are tracking cases into their second year although we have limited the data entered. The medical home questionnaire is almost complete.

Questions and Comments

Laurie Soman, Children's Regional Integrated Service System: Can you clarify the case numbers? The figure of 827 cases in standard case management and only 14 were eligible for CCS after a year? Could you talk about where they fell out based on your criteria?

Dr. Mary Doyle, Los Angeles County CCS: They are cared for in CCS-approved, excellent NICUs. They may be avoiding major complications. Some of the complex cases developed chronic lung disease and were oxygen dependent; some were discovered to be eligible based on a condition they didn't previously know about and also there were newborns in metabolic screening where a positive screen happened.

Edward A. Bloch, MD, Children's Medical Services, LA County: To clarify, newborns who come in with conditions like respiratory failure, NICU criteria is not required and it is in the regs as an eligible condition. Those tend to be sickest; they were not part of 827 cases. Those with severe congenital heart disease are not part of 827. I want to emphasize that point.

Dr. Mary Doyle, Los Angeles County CCS: If they were screened as eligible, they automatically went into the complex group.

John Patrick Cleary, MD, California Association of Neonatologists: This uncovers details we need to uncover. Outside the hospital, case management can be limited only because CCS standards create far more support for families. The way CCS approves NICU function, CCS says you must do x, y and z. The burden on case management in the medical home is reduced because there other systems like CCS High risk is in place. The broad CCS effect must be accounted for in this discussion.

Dr. Mary Doyle, Los Angeles County CCS: One of the CCS functions is to panel and certify qualified MDs. I know that some submit data and we may be able to discover who does become eligible for CCS for some other reason.

Arlene Cullum, Sutter Health: Did you say once have metabolic diagnosis, they no longer qualify? That was a rationale for reducing caseload?

Dr. Mary Doyle, Los Angeles County CCS: They are example of automatic CCS and move to complex case management. They would move from NICU acuity-only to CCS eligible and complex.

Susan Mora, Riverside County Department of Public Health: Do you have data on the number of contacts between nurses and families in the two categories of case management?

Dr. Mary Doyle, Los Angeles County CCS: We are able to pull that out. We were concerned that sending a letter would generate calls from families due to confusion and that did not happen routinely. There were very few calls and almost no complaints. And, in many cases, the type of contact was sibling support or other needs – not CCS related.

Katie Schlageter, Alameda County: Of the complex cases, are you saying they do intensive case management for all kids on their caseload?

Dr. Mary Doyle, Los Angeles County CCS: Yes, they make an initial assessment, make the quarterly calls and based on what is needed, they may or may not contact the family again depending on what is needed.

Katie Schlageter, Alameda County: We are doing something related and want to learn. Alameda nurses have taken on a caseload of ten intensive care coordination cases; they prepare a care plan, make monthly calls for six months and case conferences. We have a core team of nurses, social workers and family navigators. We can't seem to get beyond the ten caseload level so we hope to learn from you about dropping some of the intensity as they stabilize.

Dr. Mary Doyle, Los Angeles County CCS: It is great you have navigators. It is one of my asks that we remove clerical duties from nurses; remove the items that don't require nurses; move family support to a more appropriate level.

Katie Schlageter, Alameda County: We have had family navigators for 20 years. Four are in-house to work on these teams and it is wonderful for the families and the team.

Juno Duenas, Family Voices: A program we are pushing is partnership between CCS and Family Resource Centers (FRC) so there is parent to parent help negotiating all the systems. It is not just medical needs for navigation. In the long run, the FRC help families understand how to advocate themselves and their kids.

Dr. Mary Doyle, Los Angeles County CCS: We built in a resource directory for exactly these referrals.

Edward A. Bloch, MD, Children's Medical Services, LA County: I want to stress that the work shifted for less complex cases is data entry, non-medical issues. It is important to realize how much of the process involves interaction with families – they are central to the process.

John Patrick Cleary, MD, California Association of Neonatologists: On the caseload sorting slide, there were assumptions that CCS or the administration should not accept. Sorting equal numbers of complex cases across staff may just distribute equal reduction of quality across the cases. In the NICU, the caseload ratios are not optional. At this moment of change, the opportunity to identify the right caseloads is critical.

Dr. Mary Doyle, Los Angeles County CCS: I appreciate that. The issue for us is that when faced with the caseload, we are doing the best we can, but I agree with you. This will require more refinement, in particular among the complex group. This is the first step toward optimal case management and understanding what modifications we can make.

John Patrick Cleary, MD, California Association of Neonatologists: My respect to those on front line. I am advocating for more resources.

Edward A. Bloch, MD, Children's Medical Services, LA County: The ratios that Mary referred to are federal guidelines for Title V: 1 nurse to 400 cases.

Maya Altman, Health Plan of San Mateo: Are you planning to continue using the software? Do staff use both CMS and this – do double entry?

Dr. Mary Doyle, Los Angeles County CCS: Yes, for the pilot, nurses were working in both systems. The data entry is time consuming. We are modifying the platform and working on what we can migrate in from CCS and what can be carried over between systems.

John Patrick Cleary, MD, California Association of Neonatologists: Following up on high risk infant follow up, we should be considering whether the right number of infants are heading to the program?

Susan Mora, Riverside County Department of Public Health: Do you have outcomes data available for pre and post pilot phase?

Dr. Mary Doyle, Los Angeles County CCS: We are in the process of writing up the data. The satisfaction was high among families and staff. We are pleased about staff satisfaction because we want to retain highly skilled, trained staff. I don't yet have patient health outcome data.

Tom Klitzner, MD, California Children's Services, UCLA: The value of this good work is becoming apparent. The development of complex care programs have their own coordinators and they do complementary work to what you are describing. Might there be value in combining what is happening at complex care programs so we only have 1-2 people to go to for care coordination? As we develop relationships with your nurses, we are able to facilitate good care.

Dr. Mary Doyle, Los Angeles County CCS: This is an excellent point. We have similar complex care programs and additional medical home programs where they are assigning the same hospitalist each time they are admitted. We did a match between our programs and more than 75% of children overlap. We are working to develop such a liaison system to improve and streamline care coordination.

Richard Chinnock, MD, California Specialty Care Coalition: I was thinking along the same lines. We have a care coordinators in multiple places.

Juno Duenas, Family Voices: It is interesting to listen to how hard it is to figure out the care coordination in the health care system. For families, there is also school, regional center and others and they change all the time. The parent is the primary care coordinator. How can we provide the family the support they need?

Dr. Mary Doyle, Los Angeles County CCS: Points well taken. Parent are important care coordinators and we need to incorporate the family and navigator into care teams and offer them what they need.

Partnership Health Plan of California Care Coordination
Peggy Hoover, Senior Director Health Services, Partnership Health Plan of CA
Presentation slides available at:
http://www.dhcs.ca.gov/services/ccs/Documents/AGMeetingPPFINAL10_19_15.pdf

Ms. Hoover reviewed background on Partnership Health Plan (PHP) and programs offered to CCS eligible children. The structure and requirements for PHP CCS model are still in development. Most children are already enrolled in the health plan because it is a single plan, a County Organized Health System model. PHP is in 14 counties and are there because the county invited the plan to serve their geography. We work county by county on CCS because there are differences in how each county is organized relative to CCS. In the carved-in model, county CCS staff is responsible for authorization of services for CCS conditions; PHP is

responsible for all claims (CCS or non-CCS); care coordination is shared collaboratively between county and PHP; and, PHP authorizes and coordinates care and services for treatment not related to a CCS eligible condition. In the carved-in model, there are Independent Counties where county CCS determines eligibility and completes authorizations and there are Dependent Counties where county CCS determines financial and residential eligibility and State CCS determines medical eligibility and completes Service Authorization Requests. We bring all the care coordinators together to share information and learn. There are a number of other programs and initiatives through the health plan for chronically ill, complex patients such as Seniors and Persons with Disabilities, Growing Together high risk pregnancy; Palliative Care Pilot; and, Managing Pain Safely. Should the Whole-Child model continue, we will be looking at our network adequacy to ensure we have the right providers, including single case contracts. There are many unknowns as the model is still under development.

Questions and Comments

Edward A. Bloch, MD, Children's Medical Services, LA County, Children's Medical Services, LA County: On the opioid program, do you assess the outcomes of the pain management? Was it assessed objectively?

Peggy Hoover, Partnership Health Plan: We are looking at emergency department utilization, we have not done a patient survey. We are moving methodically. First, we are educating providers to decrease the number of prescriptions and limit to the prescription to one month. This is an ongoing project.

David Souleles, Orange County Health Care Agency: We have been discussing in Orange County the need to develop a joint list of issues to be worked through between CCS and health plans as part of the transition. This is an intensive process to understand the networks, the financing, the structure of transitions, etc. To the extent DHCS can offer best practices, it would be useful to be sharing between different jurisdictions. Just to confirm carved-in, you are referring to a situation of the financing – paying the CCS medical expense? When we talk about carved-in in for the Whole-Child model, it is several steps beyond what you have?

Peggy Hoover, Partnership Health Plan: Yes

Jennifer Kent, DHCS: We are looking at convening plans and counties involved in Whole-Child models. There are best practices and you each have list of issues locally. DHCS can bring a list of readiness from plan and state perspective to share best practices throughout the year.

Laurie Soman, Children's Regional Integrated Service System: There is a need to identify all the issues to be addressed. The transition is fraught with risk. The issue is not health plan intent – no plan would set out to do anything dangerous - it is a question of expertise. CCS has deep expertise as part of the current situation. When I look at statistics from PHP, the experience is primarily with adults because there are higher numbers. You have had the benefit of CCS to manage kids. If you do not plan to contract back with CCS, what will be the plan to ensure the pediatric expertise?

Peggy Hoover, Partnership Health Plan: It is too early to say we are not contracting with counties. As to pediatric expertise, we have neonatologists and other well qualified staff to handle the cases. We also go to outside agencies to get whatever expertise is needed. We may tap CCS expertise as well.

Jennifer Kent, DHCS: Some counties in PHP geography are “dependent” which means the state is doing authorizations. PHP has both independent and dependent status counties.

Laurie Soman, Children’s Regional Integrated Service System: Yes, but even dependent counties have local staff familiar with the situation.

John Patrick Cleary, MD, California Association of Neonatologists: The life planning you mention is very important work. On the carved-in counties, can you say you break even?

Peggy Hoover, Partnership Health Plan: I can’t say overall one way or the other.

Maya Altman, Health Plan of San Mateo: There are 3 plans with this situation with a carve-in for 25 years, including San Mateo. In any given year, we may not break even. Does that matter to the plan in any given year? CCS is a very small number. Our rates build in the experience and there are fluctuations from year to year, so there is an accommodation.

Terri Stanley, Cal Optima: In reference to cost drivers, the difference in a COHS is that we tend to bring the providers to the table and talk about how to deal with issues rather than issuing an edict. We have involved providers with criteria sets, financial situations and others because we are the only plan in the county,

Michael Harris, CenCal: What has been said is really important. There are certainly fluctuations year to year but it doesn’t impact care because it will show up in the rates. We recognize the value of local providers and parents. We have a high interest in best practice sharing.

Sarah Brooks, DHCS: Even when there are changes in rates or when plans experience fluctuations, there is not a change in requirements. The plan has to figure out how to structure itself to meet the needs based on their contracts.

Michelle Gibbons, California State Association of Counties: What does DHCS want to see from plans in structuring Whole-Child model? What are the considerations from the plans?

Sarah Brooks, DHCS: From DHCS perspective, we will have a robust readiness process. We are seeking input from this group about the specifics but high level items include network adequacy, care coordination structure, continuity of care requirements, internal monitors, patient materials and call center scripts. We also work with DMHC on this process.

Michael Harris, CenCal: *Health* From the plan perspective, most discussions focus on ensuring continuity of care, seamlessness between families and plans and that we have expertise in-house. It’s not yet clear whether it is in-house or external through contracting.

Terri Stanley, Cal Optima: We have discussed this preliminarily with the county and also internally. What does CCS network look like? It may look different than our current network. We are working closely with CHOC of Orange County. For example, there has been a need to develop a specific child health risk assessment. We thought the majority would be in SPD aid category. There are only 60% are SPD aid code, although 85% of regional center clients are SPD. It is important to include the regional center in these discussions. We have networks to meet the needs and we have delegated models that we need to review. We are involving stakeholders from provider and patient sides and pulling in advisory committees.

David Souleles, Orange County Health Care Agency: The county issues are significant, the financing issues and labor issues are significant. There will be ripple effects for this transition that need to be worked through depending on how it goes forward. For clarification, for the 3 plans with costs carved in, do you have a separate rate for CCS kids?

Sarah Brooks, DHCS: Only for San Mateo Health Plan.

Jennifer Kent, DHCS: We have not discussed this with Mercer yet. Rates are generally done in-house but we are discussing how to accomplish this. Currently, for other plans it is included with child/family rates.

Michael Harris, CenCal Health: Even if we did start with a special rates, within several years it will be rolled into overall rates.

David Souleles, Orange County Health Care Agency: Is it worth a conversation about whether the eligibility conversation still needs to occur?

Jennifer Kent, DHCS: Eligibility has its own set of complexity. Not every CCS child is a Medi-Cal child.

David Souleles, Orange County Health Care Agency: I think it is important to have this on the table for discussion.

Ann Kuhns, California Children's Hospital: Having a distinct rate for CCS is important because it is difficult to hold plans accountable when it is part of overall rates. I would like to have plan readiness reviewed at one of these meetings. Also, it would be useful to review the plan-county MOUs. It might allay concerns to see how this is worked out. Then we can identify gaps and have a construction dialog. Finally, we need the regional centers to participate because it is my understanding is that the regional center is payer of last resort for items not covered by anyone else.

Edward A. Bloch, MD, Children's Medical Services, LA County, Children's Medical Services, LA County: Regional Centers only pay for non-medical services.

Juno Duenas, Family Voices: They do pay for DME which feels like it is medical.

Bobbie Wunsch, Pacific Health Consulting Group: There is a regional center member who couldn't be here today. Thanks to Peggy and Mary.

Data & Quality Measures Technical Workgroup Update, Available Statewide Data, and County CCS Measures

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention

Brian Kentera, CMS Network IT Section Chief, DHCS

Sarah Brooks, Deputy Director of Health Care Delivery Systems, DHCS

Presentation slides available at:

http://www.dhcs.ca.gov/services/ccs/Documents/AGMeetingPPFINAL10_19_15.pdfBrian

Brian Kentera reviewed the first webinar for the Data and Quality Workgroup, including the charter and goals. Goals include: supporting data needs of the CCS Advisory Group; establishing CCS performance and quality measures, for demographics, process, and

outcomes; assessing data gaps and needs; and informing the evaluation process for the Whole-Child model.

Lee Sanders introduced definitions, categories for data measures and described the methodology for a retrospective analysis of 323,922 children in CCS from 2007-2012. For much of the analysis, the focus is data from 2012. Total spending includes all claims for managed care and fee for service Medi-Cal. Some data is county specific and some is regional. CCS enrollment demographics, conditions, hospital services and home health services data were presented and discussed.

The key questions for the data review are:

1. How do these children use health care services?
2. What may be proxies for quality of care that can be derived from existing administrative data?
3. What is the distribution of program spend for that care?

Questions and Comments

Ann Kuhns, California Children's Hospital: Do we know why the carve-in counties have less home health?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: In sharing data with colleagues, I have developed a hypothesis that it may be about the availability of home health. This is a good area for further inquiry.

Edward A. Bloch, MD: To what extent does hemophilia being treated in home situations contribute to the higher rates? Home health has been approved at the state level and CCS would not be authorizing.

Maya Altman, Health Plan of San Mateo: To what extent is this home health services vs other home services? This was all authorized by the state until recently. The carve-in counties are quite disparate to draw conclusions about availability.

Jennifer Kent, DHCS: Does the data set include IHSS claims? Is IHSS included in home health?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Yes, we defined home health as all services delivered by home health agency or with home in the title. We can go back and check this.

Brian Kentera, DHCS: IHSS is in the data set so the answer to the question is in the definition of what was included in this reported data item.

Arlene Cullum, Sutter Health: Under therapeutic interventions, does this include special care centers; what exactly is the definition here? Where do special care center interventions show up on the graph?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: This includes physical therapy and occupational therapy and they are delivered by any Medi-Cal provider.

Ann Kuhns, California Children's Hospital: It seems the slide delineates inpatient or outpatient throughout. CCS specialty care centers are not broken out.

Laurie Soman, Children's Regional Integrated Service System: Can you describe what is in large HMO vs other?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Other includes community hospitals. The large HMO is a familiar integrated health system.

Arlene Cullum, Sutter Health: Are you referring to Children's Hospitals as the freestanding children's hospitals? Sutter and some of the UCs are nationally designated children's hospitals. Using Children's Hospitals could lead to erroneous assumptions.

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Yes, it is free-standing hospitals that are referred to. It is a way of identifying use of sub-specialty care but I agree we do need to be careful about the way definitions are classified. I will review the definitions and we welcome input on this.

David Alexander, MD, Lucile Packard Foundation for Children's Health: Could we present the data by designated children's hospitals, UC and other?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Yes, good suggestions.

David Alexander, MD, Lucile Packard Foundation for Children's Health: Is this all outpatient data including primary and specialty?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Yes.

Tom Klitzner, MD, California Children's Services, UCLA: How do you define CCS vs non-CCS site?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: We reviewed every site and provider listed on any claim and paired them to include every provider including private physicians who is CCS.

Brian Kentera, DHCS: We used a comprehensive list of CCS panel providers and approved facilities for this comparison.

Edward A. Bloch, MD, Children's Medical Services, LA County: There are whole categories of providers who can't be designated as CCS-approved panel, such as podiatrist and chiropractor.

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: I will make sure we include that as we move forward.

Brian Kentera, DHCS: On the claim detail, there is a referring provider and a rendering provider. The data is the rendering provider in the metrics presented so it could be a CCS approved referring provider to a non CCS rendering provider.

Ann Kuhns, California Children's Hospital: Given the complexities, what can we draw from this?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: This is a way to identify what care is delivered by CCS providers or not.

Maya Altman, Health Plan of San Mateo: I was struck that there is not much variability by geography across the state. Why is this by geography rather than county classification?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Yes, we do have the data by type of county and there was no variation.

Susan Mora, Riverside County Department of Public Health: Is this all diagnoses, not just CCS diagnoses?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Yes

Ann Kuhns, California Children's Hospital: The outpatient care patterns confirms that CCS has sustained a regionalized network of specialty providers.

David Alexander, MD, Lucile Packard Foundation for Children's Health: Does this include all visits to all providers? It would be interesting to look at all visits for CCS kids.

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: This data is visits to CCS providers so it is likely mostly reporting data about specialty services. It does confirm there is greater use of services in a small number of providers.

Tom Klitzner, MD, California Children's Services, UCLA: We see no difficulty getting kids to primary care visits inside the complex care clinics. They have frequent visits with us and may prefer to get primary care at the same time and place. What you are seeing in the data may include some primary care.

Edward A. Bloch, MD: In the previous slide, it seemed that primary care is being delivered by non-pediatricians; non CCS-panel physicians

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: We can do that analysis but it is not able to be extrapolated from this data.

Tom Klitzner, MD, California Children's Services, UCLA: I am interested in the kids not going to CCS providers who should be. We know there are kids who receive care from non-CCS providers and we need to analyze that.

Juno Duenas, Family Voices: Who are the types of providers who are non-CCS?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: I have a list. Most are the providers commonly known; subspecialty care centers developed over the years.

Laurie Soman, Children's Regional Integrated Service System: On the data related to visits post hospitalization, since this is based on paid claims, is it possible the contact post-hospital was phone contact?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Yes, and we don't know what the right threshold number for post hospital contact should be, however, it does

seem that some contact within 28 days would be expected. I am interested in other physician comments.

Richard Chinnock, MD, California Specialty Care Coalition: Yes, I am shocked. I asked because I was surprised that we have a large pediatrician group that is not CCS approved because they don't want to deal with the paperwork.

Steven Barkley, MD, Santa Barbara Cottage Hospital: I am shocked also. Could it be because they are going to a hospital that is a long distance away and they just don't go the follow up?

Ann Kuhns, California Children's Hospital: Could there be an accuracy issue if the physician is capitated given you are looking at claims? For the most part, kids are in managed care so if the discharge is to check in with primary care and they are capitated, it may explain the data. There is more margin for error about the data from claims in a capitated situation.

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: That is a great point and it is a good idea to separate this by managed care but my thought is that it won't change significantly. I was surprised by this so I have looked into the claims. I do believe this is an area to dig into if we want to improve care. I use this as a proxy for looking at the inpatient-outpatient transition.

David Alexander, MD, Lucile Packard Foundation for Children's Health: I agree this may be an artifact of encounter vs claims data. It is interesting to look at given the trend although if possible, we should not limit this to an in-person visit. In today's world, a telephone call may be a good follow up. We should figure out a way to measure the transition from hospital to home. As we think about setting up data going forward, the issue is contact between primary care home and family not encounter or claim.

Tom Klitzner, MD, California Children's Services, UCLA: I am equally dismayed and I don't think any of our comments explain away this data. How are readmissions accounted for? We are publishing a paper on readmits within 28 days. One of the risk factors for readmission was having a medical home. If you see your doctor, you are more likely to be readmitted. If that is true, it means more people are excluded from your data who actually did see a physician. So readmissions may be more likely to have received follow up. I don't know that this would change the take-away of the data.

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Children readmitted within 28 days were removed from the data.

Terri Stanley, Cal Optima: Did you include CHDP services? If they wanted to include the preventive services, perhaps it was billed as CHDP when they were seen for follow up.

John Patrick Cleary, MD, California Association of Neonatologists: A small aspect is that some sub-specialty physicians have follow up much more than 28 days because of the availability of the specialist. If you can look at this by specialty it might be useful. If complex care programs were determined to be a good thing, would they be possible to have them as a medical home in the context of managed care? What would that look like if they were the medical home and if that seemed to be a plus?

Tom Klitzner, MD, California Children's Services, UCLA: There are areas where the standards can be an issue. Plans worry about time/distance and complex care centers don't. We know

people are willing to travel long distances for primary care for complex care but this crosses up into access standards.

Jennifer Kent, DHCS: When we assess networks, they have to meet time and distance standards.

Maya Altman, Health Plan of San Mateo: That is an overall assessment of the network. Patients can choose to go any distance they want to. We have to make primary care available within time and distance standards. They are not required to go a particular primary care home or specialist. We are starting to have conversations with complex care centers about being a medical home.

Katie Schlageter, Alameda County: Is there significant variability by county so we can learn from those doing this well?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: That is a good idea. There is some variability. Once we define quality metrics we agree on, we can look at county and regional variability but it is not readily available right now.

Ann Kuhns, California Children's Hospital: On the issue of confounding issues, some chart review may be needed to dig into certain cases. Is this partly due to inability to get an appointment? Unless it is an emergency, they may be scheduled out.

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Yes, we are measuring use, not access. We can do more data analysis and interviews to explore the data more deeply.

Ann Kuhns, California Children's Hospital: What is the standard for wait times? Is that reported?

Maya Altman, Health Plan of San Mateo: It is 10 days for primary care.

Jennifer Kent, DHCS: It is a Knox Keene standard and we require the same for the COHS. We report the COHS because they are not Knox Keene and DMHC reports all Knox Keene plans.

Juno Duenas, Family Voices: My daughter was really ill, we used the emergency room as primary care. Eventually we found a neurologist available and this allowed us to stop using the emergency room.

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: We can't capture phone calls and lots of other case management that is not documented. We don't know the right number here for contact with a physician but it does seem care can be improved if we drill into this. We will never be able to get to all the nuance.

Maya Altman, Health Plan of San Mateo: All the plans have transitions of care programs for those coming out of the hospital. We focus on ensuring they see a physician and we have transition coaches that make rounds in the hospital and offer a home visit. There is a HEDIS measure in mental health that might help us. The encounter data may be an issue but this is a big, big gap in care.

Kathy Neal, Central CA Alliance: We also have an active transition of care program. One thing we are seeing is an access issue in the rural communities. We are incentivizing physicians to see patients within 28 days. It has been hard to administer but important to us.

Michael Harris, CenCal Health: We are working on what Juno mentioned. We also fund incentives to get people back into primary care and we work with those using the emergency room frequently. How can we get you into primary care for better quality?

Peggy Hoover, Partnership Health Plan: We also have an incentive program as well. We were using readmission but now we are using being seen within 7 days post discharge as the measure.

Terri Stanley, Cal Optima: In our model of care, we look at key events including hospitalization. However, we have no way of knowing with CCS kids because we don't have the data. This is a good measure to follow once the data is integrated.

Jennifer Kent, DHCS: What is a residential stay?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Residential is any overnight stay that is not hospital.

Richard Rabens, MD, The Permanente Medical Group / Kaiser Permanente Northern California: Does the data include all NICU and hemophilia patients?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: There are two skewing patterns. NICU and diagnostic category. Both hemophilia and neurology are high cost items.

Tom Klitzner, MD, California Children's Services, UCLA K: This data is very helpful. Many of our children who are persistently high cost are NICU-gone bad. This is the group to focus on for health plans. We have models for lowering cost through complex care models. Our program can't know if someone is hospitalized in another hospital but the plan does know. I think there is potential to increase value through increased coordination with plans and complex care coordination.

Laurie Soman, Children's Regional Integrated Service System: My concern is that CCS kids are too small a group to warrant a drill down by the plans. To what degree are pharmacy costs driving cost? Could you call that out in the slide?

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Most of the costs are outpatient-related. They are pharmacy, physician and home health.

Maya Altman, Health Plan of San Mateo: Generally in health plans, we do look at high cost, high utilizer consumers and we spend time figuring out who needs complex care. This kind of information is invaluable so that we know where to focus. Pharmacy is a big driver for us. We have not drilled down on CCS in this way because it is early and we are still working on internal procedures.

Peggy Hoover, Partnership Health Plan: Pharmacy is a primary driver. I am surprised by home health being a big driver.

Jennifer Kent, DHCS: Are you including shift nursing as home health? IHSS is not expensive. It will help if you explain the specifics here because most of us think IHSS as home health.

Terri Stanley, Cal Optima: shift nursing is EPSDT service. Part of the value of Whole-Child model going forward is that we won't have these different boxes of information.

Maya Altman, Health Plan of San Mateo: We do have high costs for shift nurses.

Bobbie Wunsch, Pacific Health Consulting Group: This is good clarification so we can drill into the cost drivers as we go forward.

Tony Maynard, Hemophilia Council of California: The high cost pharmaceuticals are a huge issue in our community. We want to be sure that care is not compromised because of the high costs. There are some hemophilia patients who develop immunity to medications and they are extremely high cost. It might be useful to look at that data separately. There is only so much that can be done to lower cost.

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention: Yes, I agree there are high cost, efficacious treatments.

Anastasia Dodson, DHCS: We have a process from you to request next steps. We will have a workgroup webinar every six weeks open to all.

Ann Kuhns, California Children's Hospital: Can we consolidate all the information in one website location?

Juno Duenas, Family Voices: We need the dates of all meetings way ahead.

Tom Klitzner, MD, California Children's Services, UCLA: Returning to the issue of plans attending to CCS. Of the Medi-Cal spend overall, how much is CCS?

Jennifer Kent, DHCS: Plans pay attention to all high cost issues; it doesn't matter if this is a CCS child, adult or other category. In the fee for service data I mentioned previously and we will send, the total for CCS was \$2B and high cost children was \$11B. Just like other high cost populations, until plans have full responsibility, there are costs hidden.

Laurie Soman, Children's Regional Integrated Service System: The question is whether there are population based programs within the plans. CCS has been the population based program. There are very few children and the numbers are not large enough to come to attention.

Maya Altman, Health Plan of San Mateo: We are very much focused on CCS, their family and other issues. My comment was that high cost is not driving our current work. I don't believe CCS children will be lost inside managed care health plans. Our focus was on workflows within the CCS program; member priorities; operational issues.

Terri Stanley, Cal Optima: I think the concern is valid. We do stratify populations – much as CCS separates high and low complexity. Plans need all the data to know where to pay attention. From this presentation, my take away is that we have persistently high costs in CCS. Many populations are high cost for a short duration and they naturally go back to the mean. This population does not return to the mean.

Maya Altman, Health Plan of San Mateo: The health risk assessment is to establish the case management need – it is not just cost.

Data & Quality Measures Technical Workgroup Update, Available Statewide Data, and County CCS Measures

Lee M. Sanders, MD, Stanford Center for Policy, Outcomes and Prevention

Brian Kentera, CMS Network IT Section Chief, DHCS

Sarah Brooks, Deputy Director of Health Care Delivery Systems, DHCS

Presentation slides available at:

http://www.dhcs.ca.gov/services/ccs/Documents/AGMeetingPPFINAL10_19_15.pdf

Brian Kentera returned to a review of the Data and Quality Workgroup and introduced a discussion of county data measures. He walked through an example of data DHCS can provide related to the CCS Program statewide. He asked for comments on example measures related to Medical Home; Timely Eligibility Determination; Referrals to Specialty Care Centers and Annual Assessments; and, Health Care Transition Planning. Each example of the definition and measures were discussed. Data reported on the slides is just a placeholder until clarity on definitions and instructions is final.

Questions and Comments: Medical Home Measure

Ann Kuhns, California Children's Hospital: Will these be the same performance measures for the whole state – not just Whole-Child model Counties?

Jennifer Kent, DHCS: Yes

Anastasia Dodson, DHCS: We are still refining the instructions to the county about how to define the data.

Edward A. Bloch, MD: On Measure 1 related to Medical Home, the instructions allow for a parent to identify any primary care physician to be the medical home. They may not be a board certified pediatrician. It is overly permissive at the moment.

Ann Kuhns, California Children's Hospital: We need to be clear and consistent about what is medical home. We support a robust version of medical home but unless we capture lots more data, we won't know what is included as a medical home. Is this just meant to include a primary care physician or can a specialty care center function as the medical home? Does this data capture NICU as medical home for babies? We need to be clear about the denominator – only CCS; third party coverage CCS?

Brian Kentera, DHCS: We are working to mature the definition and criteria around the measure.

Ann Kuhns, California Children's Hospital: We will need to have closure on what we are measuring and what we are using as a baseline prior to implementation. From the perspective of what is practical to do, we need to define who can be a primary care provider and then look at what elements of a medical home are being provided through chart review. I don't know how we would measure if everyone is doing all the elements of the medical home. Also, I think we should break out NICU.

Juno Duenas, Family Voices: How are you deciding whether a family has a primary care provider and a medical home – are you asking the family?

Brian Kentera, DHCS: Currently, the data numbers only reflect the fields we have – primary care physician. This comes from county CCS staff.

Edward A. Bloch, MD, Children’s Medical Services, LA County: It is variable and different counties have different processes. Some counties do ask families although the instructions allow for broad interpretation.

Judith Reigel, County Health Executives Association of California: Are these measures from CMS Net (Children’s Medical Services Net)? How much with the performance measures be limited by the data systems we already have?

Brian Kentera, DHCS: Most of the data is, but not entirely. It may be from different sources in different counties. We want to define the data element and we will supplement data from claims data or other systems.

Laurie Soman, Children’s Regional Integrated Service System: In the past, a number of us met with Dr. Dalsey for some time to define children’s medical home and certification. Some of that would require opening up codes for care coordination. There was a draft letter that CCS worked on at the state level defining appropriate medical homes. I can send a draft.

Questions and Comments: Timely Determination Measure

Edward A. Bloch, MD, Children’s Medical Services, LA County: This is also a problematic area. There must be sufficient information in order to make a determination and the dates put into the system doesn’t account for that.

Maya Altman, Health Plan of San Mateo: How does this compare to the Med-Cal eligibility standard for timely determination?

Jennifer Kent, DHCS: Medi-Cal eligibility determination standard is 45 days.

Brian Kentera, DHCS: Thanks for this input. There are refinements we want to make for this measure to work on the three levels of financial, residential and medical criteria.

Questions and Comments: Care Coordination Measure

Anastasia Dodson, DHCS: At the workgroup meeting, Ann suggested that we can connect this data to other measures to see what happened at a referral, tracking.

Ann Kuhns, California Children’s Hospital: On the slide, the age listed is 18-20. Is that the transition age measure?

Louis Rico, DHCS: Correct. That is the age you would begin tracking to identify what has occurred to transition them.

Brian Kentera, DHCS: Ann, you are right that this should be all ages. This slide has an error that it indicates age 18-20.

Bobbie Wunsch, Pacific Health Consulting Group: Can you explain the 95% goal and the number achieved?

Anastasia Dodson, DHCS: The actual data here is not that meaningful at this stage because we are working first to establish the right measures and definitions.

Juno Duenas, Family Voices: What does care coordination mean to you? Are we talking about CCS care coordination? I think this is within CCS, not across all systems.

Ann Kuhns, California Children's Hospital: I was advocating for this to measure ensuring referral and access to special care centers. But it is true, this is not really about care coordination. We should think more about what would report on actual care coordination.

Questions and Comments: Health Care Transition Measure

Anastasia Dodson, DHCS: This data has an advantage of being almost real time data.

Juno Duenas, Family Voices: Age 18 is too late to focus on transition. We should start at 16 or even 14.

Edward A. Bloch, MD, Children's Medical Services, LA County: We tried to use age 14 for engaging families in our transition program. We found it was difficult to get families engaged at the earlier age.

Juno Duenas, Family Voices: I think pairing up families can be helpful here to understand why.

Maya Altman, Health Plan of San Mateo: We have the same difficulty at age 14. Why are we targeting these conditions?

Brian Kentera, DHCS: Primarily, we have focused on these because they are available through a standardized county report. It is a good starting point because they exist today.

Tom Klitzner, MD, California Children's Services, UCLA: Going back to measures 1-3. The special care centers have been the mainstay of the program. If a plan took over the care of kids already in special care centers, is there tension? How would you deal with them needing a primary care home and the special care centers not being considered a traditional primary care home? There is some concern about a negative impact to the special care centers.

Maya Altman, Health Plan of San Mateo: Most, 80% of our kids are seen at Packard. They continued their relationships as they were before they entered the health plan. We will discuss moving to a different reimbursement system over time but they are not ready yet.

Bobbie Wunsch, Pacific Health Consulting Group: That sounds like an issue we should take up in the future, how that integration is going to work.

Tom Klitzner, MD, California Children's Services, UCLA: On the transition issue, there is a separate system element. To identify the provider who will care for the youth after age 21 does begin at age 18. You can't really do that at age 14.

Katie Schlageter, Alameda County: Thank you for looking at this. This is a good time for improving measures.

Group Break-Out Sessions on Specific Topics Bobbie Wunsch, PHCG

a) Transitions for Youth Aging Out of CCS

What standards on transitions for youth should be added to county or managed care requirements?

b) Care Coordination: how various approaches can be applied in managed care for children with CCS conditions

What aspects of CCS care coordination model can be applied to managed care plans?

c) CCS Provider Paneling Standards

How do CCS standards differ from managed care provider standards?

This session was deferred to a later meeting to accommodate a longer discussion of the data.

Public Comments

Bobbie Wunsch, Pacific Health Consulting Group: She invited CCS parents on the phone to make public comments via the member phone line.

Armando Valerio, San Joaquin County: I want to throw the Medical Therapy Program into this discussion because it will be impacted by this transition. We don't have sufficient staff and CCS helps us get needed services. I did analytics based on Dr. Sanders work and was amazed by the needs. I urge you to have MTP in the conversation because we have direct contact with families; families have social issues and we exist over a large geographic area. We need managed care programs to be involved not just from an authorization standpoint but to come to case conferences and assist us in meeting the needs.

Next Steps and Next Meetings

Jennifer Kent, Director, DHCS
Bobbie Wunsch, PHCG
CCSRedesign@dhcs.ca.gov

Jennifer Kent, DHCS: We are committed to working through the process over this year. It is important to families and to children. We want to continue the sharing between programs that we had in today's meeting and look forward to future conversation.

2016 CCS Advisory Group Meeting Dates:

January 6, 2015

April 6, 2016

July 6, 2016

October 5, 2016