

# California Children's Services Redesign

Data and Quality Measures  
Technical Workgroup Webinar

February 3, 2016

10:30am – 12:00pm

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# Welcome, Introductions, and Purpose of Today's Meeting

**Anastasia Dodson**

Associate Director for Policy, DHCS

# Agenda

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- **Welcome, Introductions, and Purpose of Today’s Meeting**
    - Anastasia Dodson, Associate Director for Policy, DHCS
  - **Status Update on Comments Received for the County Measures**
    - Linette Scott, MD, Information Management Deputy Director and CMIO, DHCS
  - **Analysis of CCS Administrative Data: “Policy Briefs”**
    - Lee M. Sanders, MD, MPH, Stanford Center for Policy, Outcomes and Prevention
  - **Wrap-up and Next Steps**
    - Linette Scott, MD, Information Management Deputy Director and CMIO, DHCS
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# Status Update on Comments Received on CCS County Measures

**Linette Scott, MD**

Information Management

Deputy Director and CMIO, DHCS

# CCS County Measure 1

<b>Definition</b>	<b>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.</b>
<b>Numerator</b>	The total number of unduplicated active children with a Medical Home address in the addressee tab of CMS Net Registration with the Provider Type field identifying a Certified Nurse Practitioner or Physician. A blank Medical Home or another Provider Type in the field will be designated incorrect and not counted.
<b>Denominator</b>	The total number of unduplicated active children enrolled in the local CCS county program.

# Measure 1

## SurveyMonkey Snapshot

SurveyMonkey Questions/Comments	DHCS Response
NICU – Challenge to identify a PCP for NICU infants.	<b>Revision to be made</b> - Update definition to include “...including NICU infants <u>at the time of discharge to home...</u> ”
Define and monitor Medical Home (MH) – Child should have a MH (could be specialist) responsible for addressing preventive care and ensuring access to appropriate acute and/or chronic care. Incorporate 6 components of family-centered medical home.	<b>Revision to be made</b> - Comment to be incorporated.
Definition is broad – Define “usual place of business”. Change “addresses” to “provides oversight and SCC referral for subspecialty care”. Add “appropriate access” to designated physician. Distinguish levels of care: preventive, acute, and chronic.	<b>Revision to be made</b> - Comment to be incorporated.
SCC and families should be included.	<b>Agree</b> - family role needs to be identified and defined.



# Measure 1

## Webinar Questions/Comments Snapshot

December 11 Webinar Questions/Comments	DHCS Response
<p>Medical home definition comment: How would the state go about capturing the data on an on-going basis? Would the state expect the counties to capture it the way they are now or through a different system?</p>	<p><b>Included in measure.</b> CMSNet will register the number of active children with a medical home. (Please see numerator in Plan and Fiscal Guidelines - CCS Performance Measure 1.)</p>
<p>Why is it a challenge to identify a PCP for NICU infants? I don't think this is challenging as identifying a PCP in a NICU is low hanging fruit.</p>	<p>This varies by location. In some geographic areas, it is difficult for physicians to follow some of the issues of complexly ill NICU grads compared with following uncomplicated newborns.</p>
<p>This looks similar to current CCS standards. The traditional way of monitoring a medical home is site visits and selected chart review of the notes to show communication, etc. Has this site visit mechanism been discussed at all for determining if everyone is complying with measures?</p>	<p><b>Under DHCS review.</b></p>



# CCS County Measure 2

<b>Definition</b>	Children referred to CCS have their initial medical and program (financial and residential) eligibility determined within the prescribed guidelines per California Codes of Regulations (CCR), Title 22, and according to established CCS policy and procedures*. Counties will measure the following:
<b>Numerator</b>	<ul style="list-style-type: none"> <li>a. Medical eligibility is determined within seven calendar days of receipt of all medical documentation necessary to determine whether a CCS-eligible condition exists in the last fiscal year. (CCR, Title 22, Section 42132; CCS N.L. 20-0997) Measure number of days between the referral date and the last case note within the reported Fiscal Year with a type of “Medical Documentation Received”.</li> <li>b. Residential eligibility is determined within 30 calendar days of receipt of documentation needed to make the determination in the last fiscal year. (CCR, Title 22, Section 41610) Measure number of days between the referral date and the last case note within the reported Fiscal Year with a type of “Residential Documentation Received”.</li> <li>c. Financial eligibility is determined within 30 calendar days of receipt of documentation needed to make the determination in the last fiscal year. (CCR, Title 22, Section 41610). Measure number of days between the referral date and the last case note within the reported Fiscal Year with a type of “Financial Documentation Received”.</li> </ul>
<b>Denominator</b>	<p>Number of unduplicated new referrals to the CCS program in each county assigned a pending status in the last fiscal year.</p> <p>* The denominator should be adjusted to exclude children who are determined ineligible.</p>



# Measure 2

## SurveyMonkey Snapshot

SurveyMonkey Questions/Comments	DHCS Response
<p>This is solely a process measure and not a quality of care measure.</p>	<p><b>Agree</b> - The CCS County Measures discussed are process measures. DHCS does have outcome/quality measures. Both are necessary.</p>
<p>Length of time should be provided. Financial clearance needs to be acquired before medical clearance, which may cause delay.</p>	<p><b>Under DHCS Review.</b> The proposed change would display the average time to determine eligibility, which could be provided in addition to percent of cases determined within required timeline.</p>
<p>Define who will measure compliance in dependent counties where medical eligibility is determined by DCOS.</p>	<p><b>Agree - under DHCS review.</b></p>
<p>In the Whole-Child Model, eligibility determination remains with County CCS. It would be difficult for health plans to be responsible for these guidelines.</p>	<p><b>Agree - under DHCS review.</b> DHCS will continue to monitor county activities.</p>
<p>Include more detail as to how eligibility is determined and communicated.</p>	<p><b>Agree - under DHCS review.</b></p>



# Measure 2

## Webinar Questions/Comments Snapshot

December 11 Webinar Questions/Comments	DHCS Response
Should add family input component to PM2. Is it there and if not, why not?	<b>Agree</b> - Family input on this is captured through the Title V survey.
These are measures to be reported by local CCS program. The information and documentation will only be as good as the information they receive by the provider or family. The local CCS program is only as good as what they get and it won't always be in a timely manner.	<b>Agree - under DHCS review.</b>

# CCS County Measure 3

<b>Definition</b>	Clients enrolled in CCS, in the identified ICD categories, will have a referral to a designated Special Care Center and an annual SCC Team Report.
<b>Numerator</b>	<p>Number of clients in CCS, with a medical condition in the following ICD categories, who actually received an authorization for SCC services in the last fiscal year:</p> <ol style="list-style-type: none"> <li>1. Cardiac Defect: 745. or any 5-digit 745. code Cardiac Anomalies: 746. or any 5-digit 746. code</li> <li>2. Cystic Fibrosis: 277. or any 5 digit 277. code Respiratory Failure: 518. or any 5-digit 518. code</li> <li>3. Diabetes Type I: 250. or any 5-digit 250. code</li> <li>4. Factor Disorder: 286. or any 5-digit 286. code Leukemia: 204. or any 5-digit 204. Code Sickle Cell: 282.62 or .63 or .64 or .68 or .69</li> <li>5. Post-Transplant: 33.50, 33.51, 33.52, 33.6, 37.5, 37.51, 41.01, 41.02, 41.03, 41.04, 41.05, 41.06, 41.07, 41.08, 41.09, 46.97, 50.51, 50.59, 52.80, 55.61, 55.69</li> </ol>
<b>Denominator</b>	Number of unduplicated CCS clients in each category and subcategory who should receive an authorization for SCC services in the last fiscal year.



# Measure 3

## SurveyMonkey Snapshot

SurveyMonkey Questions/Comments	DHCS Response
This is solely a process measure and not a quality of care.	<b>Agree</b> - The CCS County Measures discussed are process measures. DHCS does have outcome/quality measures. Both are necessary.
Insert timeframe for referral.	<b>Agree - under DHCS review.</b>
Lists of ICD categories requiring SCC referrals, SCCs, and paneled subspecialists.	<b>Included in measure.</b> ICD-9 categories are listed in the measure and will be cross-walked with ICD-10. (Please see denominator in Plan and Fiscal Guidelines - CCS Performance Measure 3.)
Changed language to: “Clients enrolled in CCS, in the identified ICD-10 categories, will have a referral to a designated Special Care Center and receive risk appropriate care including, at a minimum, an annual SCC Team Report”.	<b>Under DHCS review.</b>
Add measure - Appropriate designated Specialty Care Center, what the purpose and impact of the report is, how will it be used, and measure of care coordination or family centered care or family satisfaction.	<p><b>Under DHCS review.</b> DHCS will look at ways to improve the measure to be more useful as a basis for program improvement.</p> <p><b>Under DHCS review.</b> DHCS will review a family satisfaction measure.</p>



# Measure 3

## Webinar Questions/Comments Snapshot

December 11 Webinar Questions/Comments	DHCS Response
<p>This is an important measure as it measures access. As we move to managed care that this is an important way to evaluate the extent to which transition to managed care doesn't impede access. Good measure to ensure people get their referrals.</p>	<p><b>Under DHCS review.</b> DHCS will look at ways to improve the measure to be more useful as a basis for program improvement.</p>
<p>I think this is an important measure and epitomizes the process vs the outcomes measures in a value based payment system. Especially part 2 of the measure - SCC provide an annual team report – In current FFS system there is a financial incentive to do that. You get paid for the report and second the client stays on centered care if appropriate only when the reports are filed. How to substitute for that in a value based system might be capitation in which actually there is possibly not even a financial incentive to the plan to refer to CCS, which there is now. I think some of the county medical directors who have faced this kind of problem and know the data capabilities and ability to monitor this sort of thing might be consulted offline how to make sure that these two important aspects are continuing to be met when we change to value based care.</p>	<p><b>Under DHCS review.</b> DHCS appreciates the comment and will review for further discussion.</p>

# CCS County Measure 4

<b>Definition</b>	The percentage of youth enrolled in the CCS program 18 years and older identified by ICD Categories in Performance Measure 3 who are expected to have a chronic health condition that will extend past their 21 <sup>st</sup> birthday will have CMS Net case notes documentation of health care transition planning.
<b>Numerator</b>	The number of youth enrolled in the CCS program who are 18 years and older identified in the denominator below who have documentation in either the <u>Transition Planning Required</u> Case Note or the <u>Transition Planning Not Required</u> Case Note identified during the Annual Medical Review for each client.
<b>Denominator</b>	<p>Number of clients in CCS, age 18 through 20, with a medical condition in the following ICD-9 categories:</p> <ol style="list-style-type: none"> <li>1. Cardiac Defect: 745. or any 5-digit 745. code Cardiac Anomalies: 746. or any 5-digit 746. code</li> <li>2. Cystic Fibrosis: 277. or any 5 digit 277. code Respiratory Failure: 518. or any 5-digit 518. code</li> <li>3. Diabetes Type I: 250. or any 5-digit 250. code</li> <li>4. Factor Disorder: 286. or any 5-digit 286. code Leukemia: 204. or any 5-digit 204. Code Sickle Cell: 282.62 or .63 or .64 or .68 or .69</li> <li>5. Post-Transplant: 33.50, 33.51, 33.52, 33.6, 37.5, 37.51, 41.01, 41.02, 41.03, 41.04, 41.05, 41.06, 41.07, 41.08, 41.09, 46.97, 50.51, 50.59, 52.80, 55.61, 55.69</li> </ol>

# Measure 4

## SurveyMonkey Snapshot

SurveyMonkey Questions/Comments	DHCS Response
Define “health care transition planning”.	<b>Revision to be made</b> - Comment to be incorporated.
More specifics on what should be documented, goals, and timeframes.	<b>Revision to be made</b> - Comment to be incorporated.
This is a process measure – what is needed is outcomes measure such as did the youth successful transfer to adult care.	<b>Under DHCS review.</b> DHCS is taking this under advisement.
Develop a Transfer FORM constant for all transitions/referrals that includes pertinent information; optimally, this could be done electronically.	<b>Under DHCS review.</b> DHCS is taking this under advisement.
Suggest two performance measures: One for the CCS general program at 18 and 20 years of age, and another for the MTP patients at 16, 18 and 20 years.	<b>Under DHCS review.</b> DHCS is taking this under advisement.
There should be a standardized approach to transition planning and specific goals that are met before the transition occurs.	<b>Under DHCS review.</b> DHCS is taking this under advisement.
Transition should begin at 12 or 14, per national guidelines.	<b>Under DHCS review.</b> DHCS is taking this under advisement.



# CCS County Measure General SurveyMonkey Comments

SurveyMonkey Questions/Comments	DHCS Response
Discussion about possible quality measures that can be assessed from data currently collected at the state and county levels.	<b>Under DHCS review.</b> Although the CCS measures are process measures, DHCS is reviewing to ensure CCS is incorporated into the quality measures.
There is a need for care coordination, family involvement, and family centered care measures.	<b>Under DHCS review.</b>
Given the potential for measures to be influenced by reporting artifacts, recommend analyzing ways to accurately capture these measures.	<b>Under DHCS review.</b>
Special requirements and protections needed: 1. Access to subspecialty care. 2. Access to other services (e.g., home nursing, DME). 3. Quality of care to meet the special requirements of the CCS population.	<b>Under DHCS review.</b> This is being considered in light of all quality and performance measure discussions.

# **Analyses of CCS Administrative Data: “Policy Briefs”**

**Lee Sanders, MD, MPH**



# Essential Questions

**How do we protect the health and well-being of a large population of children with serious chronic illness?**

- 1.** How do these children **use** health care services?
- 2.** What is the distribution of program **spend** for that care?

# Stanford CPOP Policy Analyses

## Policy Briefs

- [CCS: Enrollment by Diagnosis and Over Time](#)
- [CCS: Annual Spending, by Region](#)
- [Two More Years: What Does Continued CHIP Funding Mean for California?](#)
- [CCS: All Inpatient Paid Claims by Site of Care](#)
- [Variation in Specialty Care Hospitalizations for Children with Chronic Conditions in CA](#)
- [Regionalized Pediatric Specialty Care for California's Children](#)
- [Quality of Care: Outpatient Care Before Hospitalization](#)
- [Quality of Care: Outpatient Care After Hospitalization](#)
- [The Cost of Care for Children Enrolled in CCS](#)
- [Care Use by "High-cost" Children Enrolled in CCS](#)
- [Health Care Use Varies by Diagnosis among CCS Enrollees](#)
- [Health Care Use Varies with Age among CCS Enrollees](#)

## Peer-Reviewed Manuscripts

- Outpatient Pharmacy Expenditures (JAMA 2015)
- Health Care Use and Costs for Diabetes (J. Peds 2015)
- Use of Outpatient Care among VLBW Infants (submitted)
- Outpatient Care Patterns as Predictors of Diabetic Ketoacidosis (submitted)

<https://cpopstanford.wordpress.com/reports-and-policy-briefs/>

# New Policy Briefs

- 1. Enrollment Periods:** How long do CCS-enrolled children **stay enrolled**?
- 2. Distribution of Spend:** What is the distribution of program **spend** by care category and by proportion of children?

# Analytic Design

Retrospective, population-based analysis of all paid claims for the CCS Program (2007-2012)

Total capture of all care episodes

Inpatient bed days

Outpatient visits (primary, subspecialty, non-MD)

ED visits

Home health and Durable Medical Equipment (DME)

Residential care

Pharmacy

Total capture of all CCS-related costs

Partial capture of non-CCS-related costs (FFS)

**N = 323,922 children**

# Data Source

All paid claims for all CCS enrollees, 7/1/2011 to 6/30/2012, abstracted from the state's Management Information System/Decision Support System (MIS/DSS).

“Total spending per child” includes all paid claims for children enrolled in fee-for-service Medi-Cal and all condition-specific claims for children enrolled in Managed Care Medi-Cal.

# Definitions

**CCS enrollee:** Any child enrolled in California Children's Services from 7/1/2011 to 6/30/2012. Data pulled January 2013.

<http://www.dhcs.ca.gov/services/ccs>.

**Types of Care:** Broad categories based on claim type: Inpatient, Residential Facility, MD visit, Pharmacy, DME, Home Health, ED visit, Dental, Other Outpatient.

**Counties, County Groups and Regions:** County defined as place of child's residence at enrollment. County groups (3) defined by DHCS CCS Redesign Plan. Regions (5) defined by California Department of Social Services.

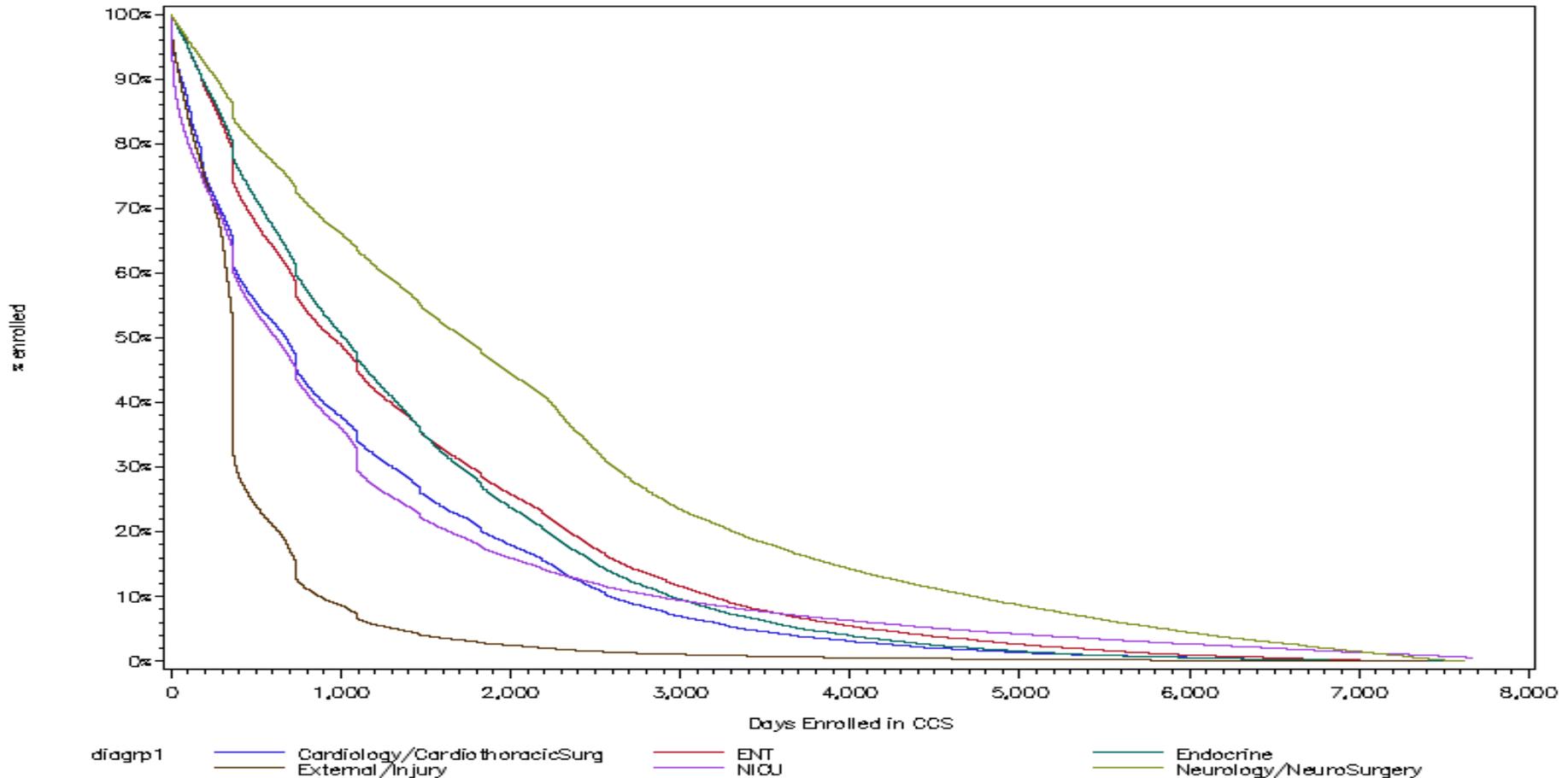
# Child Enrollment Period

## **Objective:**

To describe the distribution of CCS-program enrollment period (in days) for all children (2009-2012), by diagnostic category and by region.

# CCS Program Enrollment (Days), By Diagnostic Category

Enrollment Lengths. Children enrolled 7/1/2009–6/30/2012  
by diagnostic group



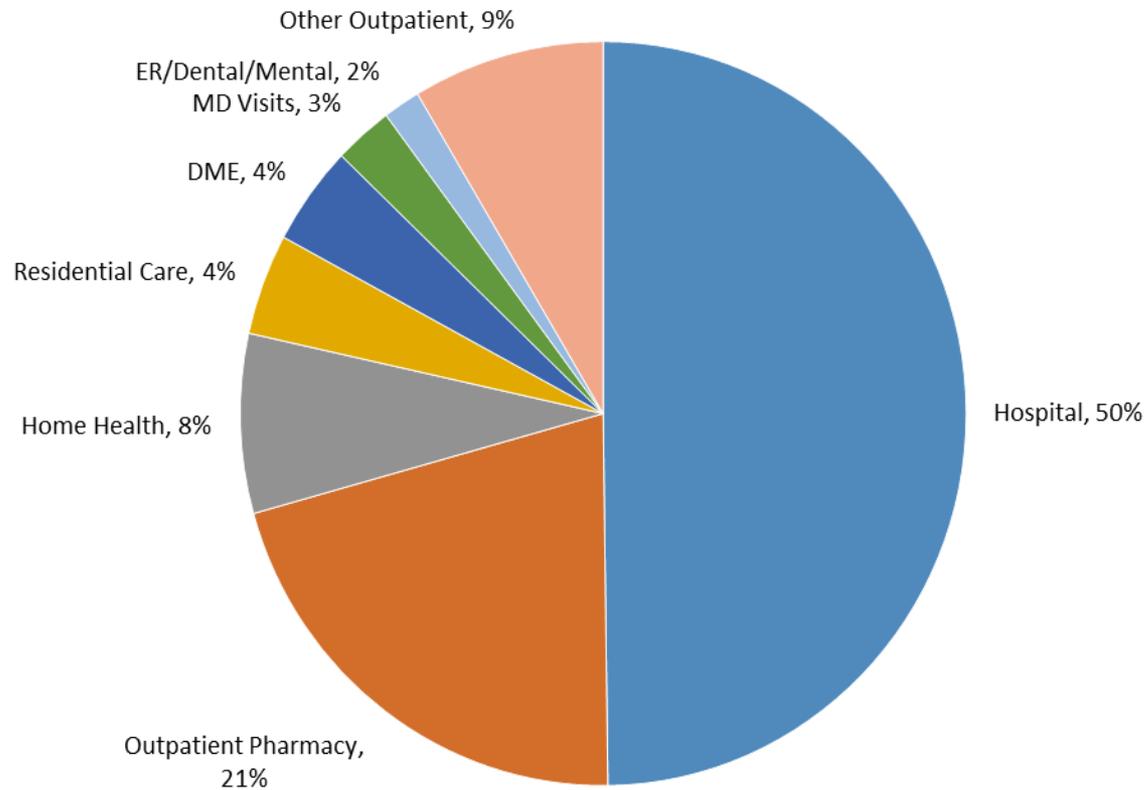
# Child Enrollment Periods: Policy Implications

- Anticipating differential enrollment periods by diagnosis may help stratify and improve **care coordination**.
- Regional differences in enrollment periods suggest opportunities for cross-regional **learning partnerships**.

# Distribution of CCS Program Spend

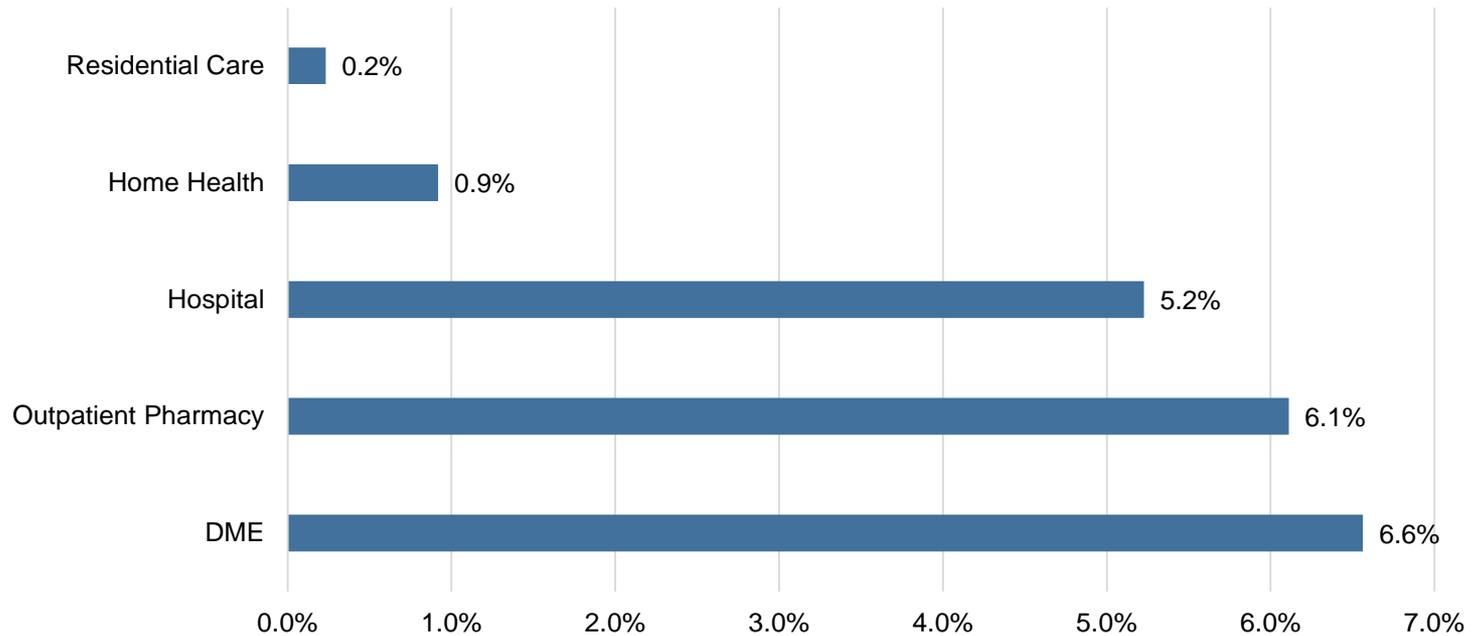
**Objective:** To assess the leading drivers of CCS program spend (2012), by health-service category and by proportion of children.

# CCS Program Spend, by Health Service Category



# CCS Program Spend, by Proportion of Children

Percent of Children Responsible for >80% of CCS Program Spend in Each Service Category



# Distribution CCS Program Spend:

## Policy Implications

- **Across the entire CCS population**, preventing hospitalizations or reducing hospital length of stay may provide opportunities for cost savings.
- **For targeted subpopulations (<5% of children responsible for >80% of spend)**, there may be opportunities for more efficient use of home health, especially in residential, home health, and pharmacy services.

# Wrap-up and Next Steps

**Linette Scott, MD**

Information Management

Deputy Director and CMIO, DHCS

# CCS Stakeholder Meeting

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- **CCS Advisory Group Stakeholder Meeting**

**When: Wednesday, April 6, 2016**

10:00am – 3:00pm

**Where: Sacramento Convention Center**

1400 J St, Sacramento

# Information and Questions

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- Advisory Group data requests, email:
    - [CCS-AdvisoryGroupDataRequests@dhcs.ca.gov](mailto:CCS-AdvisoryGroupDataRequests@dhcs.ca.gov)
  - For Data Request Form and CCS Redesign information, please visit:
    - <http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx>
  - Please contact the CCS Redesign Team with questions and/or suggestions:
    - [CCSRedesign@dhcs.ca.gov](mailto:CCSRedesign@dhcs.ca.gov)
  - If you would like to be added to the DHCS CCS Interested Parties email list, please send your request to:
    - [CCSRedesign@dhcs.ca.gov](mailto:CCSRedesign@dhcs.ca.gov)
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