



**California Children's Services (CCS) Redesign
Redesign Stakeholder Advisory Board (RSAB)**

Meeting #1 Summary

Tuesday, December 2, 2014

Sacramento, California

Members

in Attendance:

Families / Advocates: Juno Duenas, Family Voices; Devon Dabbs, Children's Hospice & Palliative Care Coalition of California; Kelly Hardy, Children Now; Tony Maynard, Board Member of the Hemophilia Council of California. Plan Representatives: Maya Altman, Health Plan of San Mateo; Abbie Totten, California Association of Health Plans; Jennifer Kent, Local Health Plan Association. County Representatives: Chris Dybdahl, Santa Cruz County; Judith Riegal, County Health Executives Association of California; Katie Schlageter, Alameda County. Hospital Representatives: Arlene Cullum, MPH, Sutter Hospitals; Domonique Hensler, Rady Children's Hospital - San Diego; Tom Klitzner, UC Medical Centers; Ann Kunhs, California Children's Hospital Association. Provider Representatives: Nick Anas, Children's Specialty Care Coalition; Kris Calvin, American Academy of Pediatrics; Richard Chinnock, MD, California Specialty Care Coalition; John Patrick Cleary, California Association of Neonatologists. Foundation Representatives: David Alexander, Lucile Packard Foundation for Children's Health. CCS Executive Committee Representative: Dyan Apostolos, Monterey County; Edward A. Bloch, MD, FAAP, Los Angeles County; Susan Mora,



Riverside County; David Souleles, Orange County. Other Stakeholders: Jennifer Kent, Local Health Plan Association; Laurie Soman, Children's Regional Integrated Service System; Amy Westling, Association of Regional Center Agencies.

DHCS Staff

in Attendance:

Dr. Jill Abramson, Chief Medical Policy and Consultation Section; David Banda, CCS Program Consultant; James Delgado, Chief, Dependent County Operations Section; Dr. Robert Dimand, CCS Chief Medical Officer; Anastasia Dodson, DHCS Associate Director; Annette Lee, Chief, Waiver and Research Section; Louis Rico, Chief, Systems of Care Division; Kimberly Steele, Chief, Waiver Implementation Unit

UCLA Staff

in Attendance:

Dylan Roby, Jessica Padilla, Michaela Ferrari, Nathan Moriyama, Moira Inkelas, Neal Halfon (via conference call)

Audience Members:

Teresa Anderson, Marie Barrett, Larisa Beckwith, Patty Chan, Janis Connallon, Kara Corches, Tim Curley, Adam Dorsey, Lakshmi Duidanda, Roger Dunstan, Erin Fisher, Kirsten Halstead, Anna Hasselblad, Terri Cauger Hill, Erin Kelly, Sandy King, Jeffrey G. Lobas, Anna Long, Pip Marks, Doreen Moreno, Karen Morris, Tederick Myles, Jaime Ordonez, Mia Orr, Pamela Patterson, Margaret Pay, Chris Perrone, Jennifer Ramirez, Pamela Sakamoto, Lisa Schoyer, Tim Shannon, Martha Sherkerberg, Kathryn Smith,



Aaron Starfire, Paula Villescaz, Tina Vora, Al Warmerdam,
Nicole Wordelman, Steven Yedlin, MD

Meeting Summary

1. Welcome and Purpose Statements

PowerPoint slides for this portion of the meeting can be found [here](#).

- a. Dylan Roby, Assistant Professor and Program Director at the UCLA Center for Health Policy Research, opened the meeting. Dr. Roby introduced himself as the Principal Investigator for the CCS Redesign Project and asked RSAB members to introduce themselves. He also gave a brief overview of the meeting agenda and topics to be covered.
- b. Anastasia Dodson and Louis Rico, Department of Health Care Services, Systems of Care Division, reviewed the vision, goals, and groundwork for the stakeholder process.
 - i. There was brief dialogue between presenters and a few RSAB members regarding the goals of the Redesign process and the purpose of the Redesign Stakeholder Advisory Board (RSAB):
 1. Ann Kuhns suggested that the Administration commit from the start to extend the carve-out from managed care.
 2. Ms. Dodson and Mr. Rico indicated that the Department could not commit to that at this time, but that the Administration does not have a predetermined outcome for the stakeholder process, and the statutory expiration of the managed care carve-out does not mean that CCS would necessarily or immediately be transitioned to managed care upon expiration of the carve-out. All options were currently up for discussion and DHCS would consider all possible

models. They also indicated that the Redesign process did not need to work within the timeline for the Medicaid Section 1115 waiver renewal.

2. Developing a Roadmap for the CCS Redesign Process

PowerPoint slides for this portion of the meeting can be found [here](#).

- a. Dr. Roby began presenting an overview of the [Redesign Partners and Stakeholders Blueprint document](#), the guiding principles of the Redesign, and the stakeholder input process and expectations.
 - i. Dr. Roby stated that there are multiple partners involving in facilitating the Redesign process, including Stanford's Center for Policy, Outcomes, and Prevention (CPOP), Harbage Consulting, and the Lucile Packard Foundation for Children's Health.
 - ii. Dr. Roby described the key goals of the project, which are to improve care and outcomes for children and youth with special health care needs (CYSHCN) and also to identify indicators that will measure quality to improve care for these children and their families.
 - iii. Dr. Roby mentioned that the entire process will take place during the next six to seven months in order to make sure that the CCS program is working well to satisfy its patients and their families.
 - iv. Dr. Roby then went on to explain the guiding principles for the CCS Redesign, as well as the RSAB expectations and commitment as described in the Blueprint document.
 - v. Dr. Roby then began to discuss DHCS and RSAB activities for the CCS Redesign process before handing the mic over to Dr. Neal Halfon, who was present via phone.

- b. Neal Halfon, from the UCLA Center for Healthier Children, Families & Communities, presented on the process of developing a roadmap for the CCS Redesign and facilitated discussion on RSAB members' perceptions of the CCS program.
- i. Dr. Halfon began by describing the process to create a successful roadmap for the Redesign, and gave an overview of the subsequent series of meetings that will build that roadmap. This first introductory meeting is meant to give a general overview of the process and overall vision, as well as do some "information gathering" and begin to discuss what RSAB members' vision of success is.
 - ii. The second meeting will be the actual "road-mapping" meeting to study current trends in CCS, what stakeholders want to keep, what needs to be repaired or fixed, what needs to be improved and transformed, , and how to move forward in making that happen.
 - iii. The third meeting will include looking at specific models and innovations in California and other states.
 - iv. The fourth meeting will focus around technical issues (i.e., financing, delivery system issues etc.) that are identified by the RSAB members as needing attention.
 - v. The fifth meeting will be a design meeting to take everything from previous meetings and engage in a re-engineering exercise to see what options or elements to consider based on the views and values of the RSAB members.

3. Facilitated Discussion on RSAB Perceptions of the CCS Program

- a. Ms. Kuhns commented that it is important to understand how success is measured, to establish a baseline before changes are made, to have a clear idea of exactly what the problems are in order to work towards improvements, and to identify outcomes and goals.
- b. Laurie Soman asked for a clearer articulation from DHCS of the current CCS program's problems that need to be fixed, changed, or redesigned.
 - i. Ms. Dodson responded that there is no set list of problems, but rather overall population quality goals and a desire for more coordination.
- c. David Souleles commented that financing is more than just a technical issue; it's a very complicated funding structure that we have gotten tripped up on in previous redesign efforts. He also asked about the timeline for the Medicaid Section 1115 Waiver, and if DHCS is making any efforts to include anything CCS-related in the waiver.
 - i. Ms. Dodson responded that the CCS Redesign is not bound by the 1115 Waiver timeline.
- d. Tom Klitzner commented that in order to move forward, the board must have some idea of DHCS' restraints regarding cost and financing.
 - i. Mr. Rico responded that the goal is not to save money, but that they do need to be budget neutral. The Redesign should be issue-driven, not financial, though financing is both important and complicated. The goal is to have the stakeholders drive the process and determine the key issues.
 - ii. There was some discussion between RSAB members and DHCS regarding where any money saved in redesigning the CCS program would go, and if it would go back into providing care for children in California.

- e. Dr. Roby summarized that this is a process and that all of the answers will not be reached in a single meeting. Thus reinforcing the need for the road-mapping strategy that is being laid out, and noting that “homework” will sometimes be required of RSAB members in between meetings.
- f. Juno Duenas requested to be on a committee to create definitions of key terms and issues to help steer the process and keep everyone on the same page.
- g. Mr. Souleles noted that Ed Schor and the Lucille Packard Foundation created national standards for systems of care for CYSHCN that may be used as one of the ways to establish a baseline. This publication can be found [here](#).
- h. Ms. Soman seconded Ms. Duenas nomination for writing definitions, and commented on the fact that previous stakeholder processes have taken place for the CCS program but the results of those processes were not implemented. She wants to know how DHCS will measure success this time, to ensure that the results of this process will be implemented.
 - i. Mr. Rico clarified that although improved health outcome is always a goal, improvements to the CCS program are not one size fits all and therefore there is no strict definition of success.
- i. Domonique Hensler suggested that it is up to the stakeholders to recommend and determine what issues need to be addressed and to be open to broad options for the program as a whole.
- j. Ms. Kuhns noted that many of the stakeholders have already been meeting informally and have produced a document which was submitted to California Health and Human Services Secretary Diana Dooley.
 - i. Dr. Roby confirmed that this document would be posted on the UCLA and DHCS website as a resource for the RSAB. He also suggested that this is not the end of the process and that despite previous stakeholder processes, this one would be starting with a

blank slate but at the same time taking into consideration previous research and findings, and continuing the conversation in between meetings.

- k. RSAB member commented that aside from specialists, the primary care physicians (pediatricians) and their input should be considered.
- l. RSAB member commented that focus should be directed towards the goals for the Redesign process.
 - i. Dr. Roby responded that goals will be assessed and that surveys for the RSAB members will be forthcoming. He also brought the group to the conclusion of the Q & A session by saying that these issues will be addressed in between meetings and in future meetings. The first meeting is to lay out the process and get everyone's broad perceptions of the CCS program.
- m. A commitment was made to conduct a survey of stakeholders regarding goals for redesign and plans for a data workgroup.
- n. The Q & A session was closed by Dr. Roby, thanking Dr. Halfon for his presentation and releasing the group to a lunch break.

4. Lunch Break

5. Current Trends in CCS: Update on Title V Needs Assessment

PowerPoint slides for this portion of the meeting can be found [here](#).

- a. Dr. Roby called the session back to order and introduced Dr. Jill Abramson of the Department of Health Care Services, lead on the recent pediatric palliative care waiver program, and the current Title V needs assessment process.

- b.** Dr. Abramson announced that the presentation will give an overview of Title V and the needs assessment process, share preliminary results and preliminary ideas on changes that might be considered.

 - i. Title V background information was given: Otherwise known as the “block grant,” Title V is the Maternal and Child Health Bureau’s program for mothers, children, CSHCN, and women. It has existed since 1935 and is the nation’s oldest federal-state partnership blending national needs for maternal health with the unique needs of MCH populations in different states. It seeks to improve access to quality of care and is currently undergoing a transformation. The mandate is to provide family centers, community based systems of coordinated care, and to facilitate the development of these systems.
 - ii. Every 5 years Title V does a needs assessment which addresses the system, the capacity, the healthcare needs, identifies partnerships and collaboration, assesses Title V’s role in addressing those needs, and finally develops and implements an action plan.
- c.** Dr. Abramson explained that in California, the needs assessment is being conducted with the Family Health Outcomes Projects from the University of California, San Francisco, and gives an overview of the steps in the process.

 - i. The timeline is set such that stakeholders begin the process in January of 2015 and the action plan is developed through June of 2015.
 - ii. Preliminary results are based on a survey of 4500 CCS families. A small fraction of 180,000 CCS clients or 140,000 CCS clients who might have chronic conditions.

- d. An RSAB member asked for Dr. Abramson’s clarification in defining her use of the term “children with special health care needs.”
 - i. Dr. Abramson clarified that the population covered by CCS is much smaller than the total number of CYSHCN needs in California, but that she was referring to the CCS-eligible population.
- e. Dr. Abramson continued by presenting preliminary results of the CCS-relevant portions of the survey conducted as part of the needs assessment:
 - i. 75% of respondents were aware that their child had a case manager.
 - ii. Over 80% of respondents were satisfied with the case managers.
 - iii. Transition is a problem. As children age out of the program, transition is not usually addressed by CCS. However, when it is, they only have a 30% success rate.
 - 1. Dr. Abramson suggests that transition could happen at the clinician level rather than the administrative level, and that connections between pediatric providers and adult providers would help.
- f. An RSAB member commented about the shortage of paneled providers in the Central Valley and rural Northern California.
- g. Dr. Abramson commented on the mental health provider access and the need for a better connection between CCS and the mental health provider community, as well as the lack of telehealth-compatible consultation sites and the fact that CCS code groupings are not available to telehealth.
- h. Dr. Abramson presented a selected few comments from the focus group interviews, then summarized the next steps involved in wrapping up the needs assessment.
- i. Dr. Abramson presented the following opportunities for CCS culled from the information revealed in the needs assessment thus far:

- i. Provider capacity: follow-up visits could be conducted by the primary care provider as long as they are in good communication with and can receive guidance from the specialist.
- ii. Telehealth: minimum requirements for equipment should be clarified for CCS operations to make usage more widespread
- iii. CCS case management could be better if there was a lower caseload. This may be an option if some medical conditions are dropped.
- iv. Clarifying denial letters so parents don't think that their child will not be covered by CCS.
- v. Paneling process is not clear: applications do not continue to be active after a certain time period and providers need to re-apply.
- vi. Make it standard procedure for care plans to be shared with enrollee's family.

6. Current Trends in CCS: Findings from CCS Administrative Data

PowerPoint slides for this portion of the meeting can be found [here](#).

- a. Dr. Roby introduced Dr. Lee Sanders from the Stanford Center for Policy Outcomes and Prevention (CPOP).
- b. Dr. Sanders described his focus as an analysis of CCS paid claims data with the goal of influencing public policy reform to generally improve the health of children with serious chronic illnesses.
- c. Dr. Sanders noted that the analysis is intended to answer three essential questions:
 - i. Who the CCS enrollees are and how they use healthcare services.
 - ii. The quality and appropriateness of care received.
 - iii. The distribution of cost for that care.

- d. Dr. Sanders described the analytic design, which was a retrospective population analysis of all paid claims for all CCs enrollees between 2007 and 2012. He then detailed the population's insurance status, the breakdown of diagnostic categories, patterns of care use, including by characteristics such as age and medical complexity, and their attempt to look at quality indicators by assessing preventable hospitalizations, often for acute issues that occur on top of the enrollee's chronic, CCS-qualifying condition (such as pneumonia), as well as outpatient care after hospitalization.
- e. Dr. Sanders then described the cost of care, noting that 1% of children account for 25% of program cost, and that 85% of enrollees have high-cost, chronic conditions. He also explained that 36% of cost is hospital-based, and 21% of cost is home health. Finally, when looking at children's use of hospital care around the state, free-standing hospitals represent 55% of the cost compared to all other hospital types.
- f. Dr. Sanders noted that the data's implications for reform suggest program reform, care system innovation, enhanced outpatient care systems and regionalized sub-specialty and primary care, improved population health management, tiered care coordination, and public policy and payment reform.

7. Q & A Session, moderated by Dr. Roby

- a. Dr. Roby asked Dr. Sanders for his recommendations for evaluation moving forward. Dr. Sanders responded that actively working on quality outcomes (such as process, structure, etc.), particularly for quality of outpatient care, would most likely reduce inpatient burden.
- b. Dr. Klitzner asked if analysis had been done on a county level and if there is any significant variability.
 - i. Dr. Sanders responded that his team is currently working on that analysis, but that the data are not ready for dissemination yet.
- c. John Cleary asked if the data may be applied to measure not just preventable hospitalizations, but also reducing the percentage of babies who qualify for CCS, specifically for conditions such as chronic lung disease and cerebral palsy, by increased maternal management or specific NICU incentives.
 - i. Dr. Sanders responded that they are trying to link data analysis and datasets with CPQCC towards that end. He commented that data for children's first year of life is impaired because the age at enrollment varies across and within counties.

8. 10 Minute Break

9. Existing Models of Care in CCS

- a. Dr. Roby announced that two pilot sites from the Medicaid Section 1115 Waiver demonstration projects (Health Plan of San Mateo and Rady Children's Hospital in San Diego) are here to present. He then introduced Maya Altman, CEO of the Health Plan of San Mateo, to speak.



10. Overview of Full-Risk Managed Care Demonstration Pilot

Slides from this portion of the meeting can be found [here](#).

- a. Ms. Altman introduced the pilot program, which started in April 2013. She described it as an integration of the county CCS program into an existing Medi-Cal managed care plan, called the Health Plan of San Mateo (HPSM). The HPSM sub-contracts with the county CCS program, which serves about 1,500 children, nearly all of whom are also on Medi-Cal.
- b. Ms. Altman clarified that even prior to the pilot, San Mateo was a “carve-in” county, and while the CCS program existed on its own, the health plan had full financial risk, which was not an ideal situation for the plan.
- c. Ms. Altman noted that, anecdotal information indicated that CCS families were experiencing issues with care management, receipt of denial letters, and medication management, so one of the main goals of the pilot was to improve the experience of the family by addressing the “whole child.” She mentioned that additional goals were to preserve the CCS program’s quality of care and specialty networks, improve health outcomes and access, and remain budget neutral.
- d. Ms. Altman noted some strategies used to achieve these goals, namely co-locating CCS at the Health Plan and having CCS nurse managers authorize all services, whether for CCS care or not. In addition, they attempted to simplify the authorization process, have CCS staff administer comprehensive assessments, and provide easier access to the grievance and appeals process.
- e. Ms. Altman noted some of the pilot’s successes, including a reduction in denials, development of a new, CCS-separate, pharmacy formulary, and reducing the number of DME providers to four while increasing their customer service standards.

- f. Ms. Altman noted some remaining challenges and obstacles, including that they were unable to do a formal evaluation of the pilot, the IT system is still fragmented, and the need to increase mental health service utilization among those who are referred.
- g. An RSAB member asked Ms. Altman if the family subcommittee they formed receives stipends.
 - i. Ms. Altman responded in the affirmative, noting that they meet quarterly and are starting trainings for the committee members.
- h. An RSAB member asked how the CCS program is paid for through the demonstration.
 - i. Ms. Altman responded that CCS is paid as a separate plan with capitated payments for members.

11. Overview of Accountable Care Organization Demonstration Pilot

Slides for this portion of the meeting can be found [here](#).

- a. Ms. Hensler introduced herself as an administrator of 17 years working on care redesign and Dr. Erin Fisher as the medical director of Clinical Pathways and the ACO demonstration.
- b. Ms. Hensler gave background on Rady Children's Hospital and San Diego. In 2013, the hospital had 86,000 patient days, 55% of which was Medi-Cal. Of that, 74% are CCS Children. Therefore, 41% of total patient days are CCS.
- c. Ms. Hensler then described the San Diego CCS program's integrated delivery system, which includes the hospital, a convalescent hospital with skilled nursing and sub-acute care, home care agency, palliative care program, patient follow-up after discharge, nurse triage, and medical management services.

- d. Ms. Hensler gave an overview of the demonstration pilot, a condition-based capitated full risk model that will launch in 2015. She noted that they are discussing risk-sharing plans with DHCS, and are also developing a 22-metric evaluation for the pilot.
- e. Ms. Hensler also discussed a smaller pilot they had conducted, which moved respiratory therapy for Cystic Fibrosis to the home with great success.
- f. Ms. Hensler then introduced Dr. Fisher to go over the model for the demonstration.
- g. Dr. Fisher noted that the five CCS-eligible conditions were chosen because they are all vulnerable populations with extra risk, and will require extra work to transition to adult care, which is something they hope they can learn from.
- h. Dr. Fisher explained the roles of the Care Navigator and Patient Technician, to facilitate better communication and knowledge of the patient as a whole, and help the family to better navigate the health care system. She stressed that we should deliver evidence-based, coordinated care based on the patient's needs, not the payment model, and have to be open to the idea that better care might cost more.
- i. Dr. Fisher noted that they use risk scoring to assess patient complexity and what areas need more care.
- j. Dr. Fisher discussed some lessons learned in the pilot thus far, including that family behavioral health is critical, getting into the home early on is important, and that literacy does not equal health literacy; most health resources are written at an 8th grade level but should be at 3rd grade level.
- k. Dr. Fisher explained that they are looking at looking at new, effective and efficient ways to use telehealth with families, particularly for palliative care.
- l. Dr. Fisher closed the presentation by noting some of the goals of the demonstration moving forward, including using resources better, getting

better clinical outcomes, keeping children in school and healthier, and overall focusing on patient engagement and delivering better care, rather than saving money.

12. Q&A Session, moderated by Dr. Roby

- a. Dr. Roby moderated a series of questions from the RSAB members to presenters (Ms. Altman from Health Plan of San Mateo, Ms. Hensler and Dr. Fisher from Rady Children's Hospital in San Diego).
- b. A member of the RSAB asked Ms. Altman about how the Health Plan of San Mateo dealt with the increasing workload of county CCS employees, from a financing and staffing perspective.
 - i. Ms. Altman confirmed that it is difficult to handle. She noted that there are union issues that are being worked through, and that attempts are being made to reduce workload in terms of authorizations and paperwork.
- c. Dr. Roby asked if either of the demonstration projects had experienced any difficulty in collecting data from multiple providers, as far as using it for care coordination and tracking metrics.
 - i. Ms. Altman said that they've always had member data for the enrollees, but haven't been able to use it to do risk stratification or prioritization like San Diego had.
 - ii. Dr. Fisher echoed that it is not an easy task, and San Diego had been working on it for about 18 months. She noted that they used Epic, but that they had to re-do a lot of the data, and create some new variables, to get at the measures they were interested in, but that it also is important and difficult to validate the data.
 - iii. Ms. Hensler added that while they have claims data and the EMR, they are working on cloud-based metadata set with balance to be

able to pull in claims data from pharmacy, behavioral health and so on to get a better picture of the utilization pattern of the children in San Diego County and track costs.

- d. An RSAB member asked the Rady San Diego team how quickly they might be able to expand their demonstration to include all CCS eligible conditions, and what they learned from your initial experience?
 - i. Dr. Fisher answered that many of their strategies would be easily replicable in a matter of months, such as the navigator training, which is a 25-hour training over a two week period.
- e. Ms. Soman followed up on a previous question about the planning for the San Diego program, about the commercial pilot and how many kids were involved.
 - i. The San Diego team explained that although there were 18 months involved in planning for the project, it could have been done more quickly. Since the time was allotted to them, they decided to use that time frame to continue learning and also to launch the commercial pilot, which involved 15 children.
- f. Ms. Soman asked to hear more about how Rady will collaborate with CCS and how many enrollees they anticipate for each eligible condition.
 - i. The San Diego team responded that the program is intentionally set up to “break” the system; they chose more high risk patients on purpose to figure out what isn’t working. They mentioned that they have about 600 patients across all five disease-states, all of whom are expected to begin at the same time.
 - ii. In terms of working with CCS, one of the Rady representatives said that they look at it as a partnership – CCS could become employees of Rady, or just have a contact – and that they have had a long-standing relationship with CCS.

- iii. The San Diego team says that the rollout will begin when they are given a “green light” from CMS, but they are thinking the first quarter of 2015.
- g. An RSAB member asks for clarification from the San Diego team regarding the younger age of the diabetic patients in the demonstration. He stated that some of the clinical outcomes are going to be biased by excluding adolescents with Type I diabetes.
 - i. The San Diego team responded that the program is a pilot, that they could only enroll a limited number of patients, and were hoping that they might be able to help patients on their adolescent trajectory if they reached them early on.
- h. An RSAB member commented on the broad, integrated network at Rady and questions how many of the freestanding children's hospitals and other tertiary pediatric CCS hospitals around the State have that kind of network.
 - i. The San Diego team explained that some other hospitals may already be on the journey towards this network.
- i. Ms. Kuhns notes that a proposal has already been shared with the Administration to try and start a dialogue about establishing more ACO-type networks, and emphasized that for this to move forward they need to be given access to the claims data.
 - i. Lisa Chamberlain from Stanford states that she would like to go on record in saying that they are all for creating public access to the data.
 - ii. DHCS supports sharing the data as well, and are looking into options.
- j. Judith Riegal asks the San Diego team what their plans are to establish a baseline on quality measures.

- i. The San Diego team responded that it depends on the measure. Some measures will have 365 days worth of data and others won't. For the ones that don't have the 365 data an overall assessment of the median will be made as opposed to a mean. They went on to further explain that some places may choose to create a baseline based on their first three months of learning.
- k. Dr. Roby wrapped up the question and answer session by explaining a little bit more about how the technical work groups will work in the future.

13. Public Comment Period for Audience Members

- a. Dr. Roby opened up the session by asking anyone who wishes to make a comment to state their name and affiliation.
- b. Tim Curley, Director of Community and Government relations at Children's Hospital, Central California in Madera, thanked the State for allowing public comment. He asked if the RSAB includes stakeholders from either the Central Valley or Northern California.
 - i. Dr. Roby mentioned that a full list of all members will be posted soon.
- c. Mr. Curley went on to state that he feels as though the RSAB should represent all of California, both geographically and ethnically.
- d. No other member of the audience stepped forward, so Dr. Roby closed the session.

14. Wrap-up, Closing, and Next Steps

- a. Dr. Roby began this session by recapping the main points of the meeting, and noted that UCLA would be sending out an email regarding next steps,

along with a survey to get RSAB members' feedback on what the main goals and outcomes of the CCS Redesign process should be.

- b.** Dr. Roby mentioned that there were no specific answers yet as the redesigning process will continue on for the next six or seven months, but RSAB members along with UCLA, Stanford, etc. should be thinking about what the road map will look like going forward, what issues DHCS needs to address, what measures we want to be able to track going forward, and aligning the Redesign efforts with existing standards.
- c.** Several RSAB members suggested that if there are any restraints or parameters, including the timeline for the Redesign and how it would affect the carve-out, DHCS should make those clear.
 - i.** Ms. Dodson mentioned the Blueprint document and DHCS' presentation during the meeting, and asked for more detail on what additional guidelines were needed.
 - 1.** An RSAB member responded that perhaps additional detail or different language would be needed to clarify certain subjects.
- d.** A couple of RSAB members suggested that documents should be posted online ahead of time and dated.
- e.** Dr. Roby closed by thanking everyone for their time and handed the microphone over to Mr. Rico for final remarks.
- f.** Mr. Rico thanked everyone again and clarified that the process is meant to be transparent and everyone's comments are appreciated.

END