

California Children's Services (CCS) Redesign

Outcome Measures/Quality Technical Workgroup
(TWG)

Kick-off Webinar

Friday, April 10, 2015

1-3pm

Webinar Agenda

- **Welcoming remarks** – Anastasia Dodson (DHCS)
- **Roll call** – Michaela Ferrari (UCLA)
- **Goals and purpose of CCS Redesign & the TWG** – Michaela Ferrari
- **CCS Data “Refresher Course”** – Michaela Ferrari & Lee Sanders, MD (Stanford CPOP)
- **Data Request Form overview** – Michaela Ferrari
- **Proposed quality indicators for outpatient care from existing CCS data and suggestions for additional indicators from other sources** – Lee Sanders, MD
- **Guided discussion of proposed indicators’ alignment with CCS Redesign Goals and potential future quality, process, and patient satisfaction measures** - Lee Sanders, MD; Joseph Schulman, MD; Linette Scott, MD
- **Overview of Medi-Cal Dashboards** – Linette Scott, MD
- **Next steps and items for follow-up** – Michaela Ferrari
- **Closing remarks** – Anastasia Dodson

Outcome Measures/Quality TWG Kick-off Webinar Welcome

Anastasia Dodson, DHCS

Department of
Health Care Services



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Policy Outcomes & Prevention

UCLA CENTER FOR
HEALTH POLICY RESEARCH



Outcome Measures and Quality TWG Members

Co-chairs: Linette Scott, MD (DHCS); Joseph Schulman, MD (DHCS)

Members: Lisa Chamberlain, MD (Stanford CPOP); Athena Chapman (California Association of Health Plans); John Patrick Cleary, MD (California Association of Neonatologists); Devon Dabbs (Children's Hospice & Palliative Care Coalition of California); Karen Dahl, MD (Valley Children's Hospital); Ann Kuhns (California Children's Hospital Association); Tony Pallitto (Kern County CCS); Richard Rabens, MD (Kaiser Permanente Northern California); Lee Sanders, MD (Stanford CPOP); Laurie Soman (Children's Regional Integrated Service System (CRISS))

Please email recommendations for parent members to: michferrari@ucla.edu

DHCS' 6 CCS Redesign Goals

- 1. Implement Patient- and Family-Centered Approach:** Provide comprehensive treatment, and focus on the whole child rather than only their CCS-eligible conditions.
- 2. Improve Care Coordination through an Organized Delivery System:** Provide enhanced care coordination among primary, specialty, inpatient, outpatient, mental health, and behavioral health services through an organized delivery system that improves the care experience of the patient and family.
- 3. Maintain Quality:** Ensure providers and organized delivery systems meet quality standards and outcome measures specific to the CCS population.
- 4. Streamline Care Delivery:** Improve the efficiency and effectiveness of the CCS health care delivery system.
- 5. Build on Lessons Learned:** Consider lessons learned from current pilots and prior reform efforts, as well as delivery system changes for other Medi-Cal populations.
- 6. Cost-Effective:** Ensure costs are no more than the projected cost that would otherwise occur for CCS children, including all state-funded delivery systems. Consider simplification of the funding structure and value-based payments, to support a coordinated service delivery approach.

Outcome Measures/Quality TWG

Goals and Purpose

A general consensus expressed by the RSAB is the need to establish baseline measures for quality of care and improved outcomes for CCS enrollees.

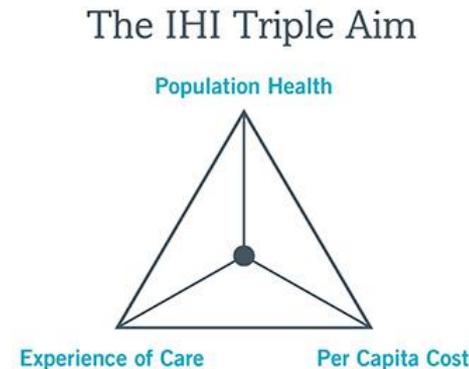
This workgroup will coordinate with the data workgroup to:

- 1) Decide what data are needed to establish this baseline and consistent evaluation of progress.
- 2) Determine if the existing data being collected are sufficient to track and evaluate all quality and outcome measures of interest, or if gaps between the data and desired measures exist.
- 3) If the data are not available, it will be up to this workgroup to make recommendations for establishing the necessary infrastructure to begin data collection in an organized system of care for CYSHCN.

Suggestions for Guiding Today's Discussion

- What shall we use to frame our baseline measures, benchmarks, and targets?

- 6 DHCS CCS Redesign Goals
- The Triple Aim: population health, cost, and quality of care



- What are the main questions we want the data to answer?
- What data are currently available, and what can we do with them?
- What additional data are needed, and how might we collect them in a more organized system of care?

CCS Data – A “Refresher Course”

- State-owned CCS Data includes:
 - **Claims:** Standard 35C paid FFS claims and managed care encounters
 - **Eligibility:** Medi-Cal Eligibility Data System (MEDS), which includes CCS indicator; Children’s Medical Services Network (CMS Net) for all CCS enrollees
 - **Authorization:** CCS Authorization Service Authorization Request (SAR)
 - **Provider:** Provider Master File (PMF) for CCS paneled providers, approved facilities, and Special Care Centers (SCC)

For more information: <http://healthpolicy.ucla.edu/programs/health-economics/projects/ccs/Pages/Data-Workgroup.aspx>

Data Request Form

What data will this TWG need to conduct its work?

Please email completed Data Request Forms to michferrari@ucla.edu, or to request a copy of the Data Request Form if you did not yet receive it.*

*Due to the need to prioritize requests and conduct analyses in a timely manner, submissions will be limited to TWG and RSAB members.

CCS Quality Indicators & Redesign Goals

Lee Sanders, MD, MPH & Lisa Chamberlain, MD, MPH

Stanford Center for Policy, Outcomes, and Prevention (CPOP)

Joseph Schulman, MD & Linette Scott, MD

DHCS

Quality Indicators for Outpatient Care

- Quality indicators for inpatient care have been adapted from adult-care indicators and validated among children. (AHRQ 2015)
- Few quality indicators for child outpatient care.
 - None derivable from administrative data.
 - None specific to children with special needs.

Quality Indicators for Outpatient Care

Objective:

To identify new quality indicators

- derivable from **existing administrative data**
- that may assess the **appropriate delivery of outpatient care for children with special health care needs.**

Quality Indicators for Outpatient Care

Methods:

Systematic literature review

- Identify subset “candidate indicators” that could be derived from administrative data for **all CSHCN**

Modified Delphi process

- Expand list of candidate indicators (8 focus groups)
- Identify the most “appropriate” indicators
 - Iterative surveys of 17 stakeholders (MD + non-MD)
 - Each indicator rated 0 (least) to 9 (most)

Preliminary Results

48 candidate indicators across 5 domains

- Access to Medical Home Services
- Access to Pharmacy Services
- Access to Urgent and Follow up Care
- Potentially Preventable (Ambulatory-Sensitive) Hospitalizations
- Home Health and Outpatient Therapies

19 indicators were deemed most appropriate
(mean score >7)

Most Appropriate Quality Indicators for Outpatient Care

Access to Medical Home Services

1. **Regular Primary Care Visits** (age <24 months: at least 2 visits per year; age >= 24 months: at least 1 visit per year)
2. **Regular Subspecialty Care** (at least 1 visit per year)
3. **Regular Dental Care** (age >= 24 months: at least 1 visit per year)
4. **Usual Source of Care (Physician):** Same Physician seen at least once per year for multiple years in a row
5. **Usual Source of Care (Clinic):** Same Clinic visited at least once per year for multiple years in a row
6. **Care coordination:** At least 1 visit coded for “care coordination” per year.

Access to Pharmacy Services

7. **For children with medication-dependent conditions:** No episode of > 90 days between prescription refills
-

Most Appropriate Quality Indicators for Outpatient Care

Potentially Preventable (“Ambulatory Sensitive”) Hospitalizations

8. No unplanned 30-day re-admission to hospital

9-15. No hospitalization for one of the following primary acute conditions: Dehydration, Urinary Tract Infection, Asthma, Impaction or Constipation, Anemia, Diabetic Ketoacidosis (except at time of initial diagnosis of diabetes), feeding tube or gastrostomy tube complication

Access to Urgent and Follow Up Care

16. For children who are hospitalized: At least 1 outpatient visit of any type (MD, RN, diagnostic, other) during the 30 days prior to hospitalization

17. For children who are hospitalized: At least 1 outpatient visit of any type (MD, RN, diagnostic, other) during the 30 days after hospital discharge

Home Health and Outpatient Therapies

18. For children with DME: At least 1 home health visit per year

19. For children with neurologic impairment: At least 1 PT visit per year

Other Suggested Quality Indicators: from Non-Administrative Sources

Assessable by Parent Survey (examples):

- Unmet child health needs.
- Satisfaction with care
- Reduction or loss of parent income
- Family stress / burden
- School attendance / absence*
- Post-discharge phone calls for follow up*
- Timely communication between referrals and medical home*
- Availability of 24 hour phone triage by staff experienced with CSHCN*
- Regular receipt of multi-disciplinary specialty care services*
- For families with LEP, use of interpreter services*

* Identifies indicators that could be captured from other data sources (including Regional Centers, provider survey, EMRs, patient registry, school district records).

Other Suggested Quality Indicators: from Non-Administrative Sources

Assessable by Provider Survey (examples):

- Coordination with non-medical services, including school and regional centers.
- Satisfaction with communication from medical and non-medical systems of care.

Assessable by EMR or Registry (examples):

- Use of integrated care plan*
- Regular screening for mental health*
- Regular screening for environmental risk (e.g., tobacco smoke, domestic violence)*
- Regular assessment of neurodevelopmental function*
- Referrals completed (%).
- For children with progressive illness, use of pediatric palliative care.*
- For rural families, use of telemedicine and home monitoring.*
- For adolescents, transition care planning.*

Implications: CCS Redesign Goals

- 1. Implement Patient- and Family-Centered Approach:** Provide comprehensive treatment, and focus on the whole child rather than only their CCS-eligible conditions.
Partially assessable with claims data
- 2. Improve Care Coordination through an Organized Delivery System:** Provide enhanced care coordination among primary, specialty, inpatient, outpatient, mental health, and behavioral health services through an organized delivery system that improves the care experience of the patient and family.
Partially assessable with claims data
- 3. Maintain Quality:** Ensure providers and organized delivery systems meet quality standards and outcome measures specific to the CCS population.
Readily assessable with claims data
- 4. Streamline Care Delivery:** Improve the efficiency and effectiveness of the CCS health care delivery system.
Partially assessable with claims data
- 5. Build on Lessons Learned:** Consider lessons learned from current pilots and prior reform efforts, as well as delivery system changes for other Medi-Cal populations.
Readily assessable with claims data
- 6. Cost-Effective:** Ensure costs are no more than the projected cost that would otherwise occur for CCS children, including all state-funded delivery systems. Consider simplification of the funding structure and value-based payments, to support a coordinated service delivery approach.
Costs assessed in prior work (“Value” = “Quality / Cost”)

FROM CLAIMS DATA	Access to Medical Home	Access to Pharmacy	Access to Urgent and Follow Up	Preventable Hospital Admissions	Home Health
Goal 1: Family-Ctrd Care	*				*
Goal 2: Care Coordination	*				
Goal 3: Quality	***	***	***	***	***
Goal 4: Care Delivery	**	**	**	**	**
Goal 5: Lessons Learned	**	**	**	**	**
Goal 6: Cost-Efficiency	n/a (prior CPOP work)	n/a (prior CPOP work)	n/a (prior CPOP work)	n/a (prior CPOP work)	n/a (prior CPOP work)

From OTHER Data Sources	Parent Survey	Provider Survey	EMR or Registry
Goal 1: Family-Ctrd Care	***		**
Goal 2: Care Coordination	**		***
Goal 3: Quality	***	*	**
Goal 4: Care Delivery	**		**
Goal 5: Lessons Learned	**	***	
Goal 6: Cost-Efficiency			

Question & Answer

Lee Sanders, MD, MPH

Stanford Center for Policy, Outcomes, and Prevention
(CPOP)

Please see: <https://cpopstanford.wordpress.com/reports-and-policy-briefs/> for more information

Guided Discussion with TWG Members

Linette Scott, MD

Joseph Schulman, MD

DHCS

Lee Sanders, MD

Stanford CPOP



Medi-Cal Dashboards in DHCS: Considerations for Future CCS Reporting

Linette Scott, MD, DHCS

Department of
Health Care Services



CMS Core Children Measures

- Primary Care Access & Preventative Care
- Perinatal Health
- Management of Acute and Chronic Conditions
- Dental and Oral Health Services



Dashboard Examples

- **Managed Care**
<http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx>
- **Dental Managed Care**
http://www.denti-cal.ca.gov/WSI/ManagedCare.jsp?fname=dental_managed_care_plan_util

Performance Measures & Benchmarks Reporting - 2014¹

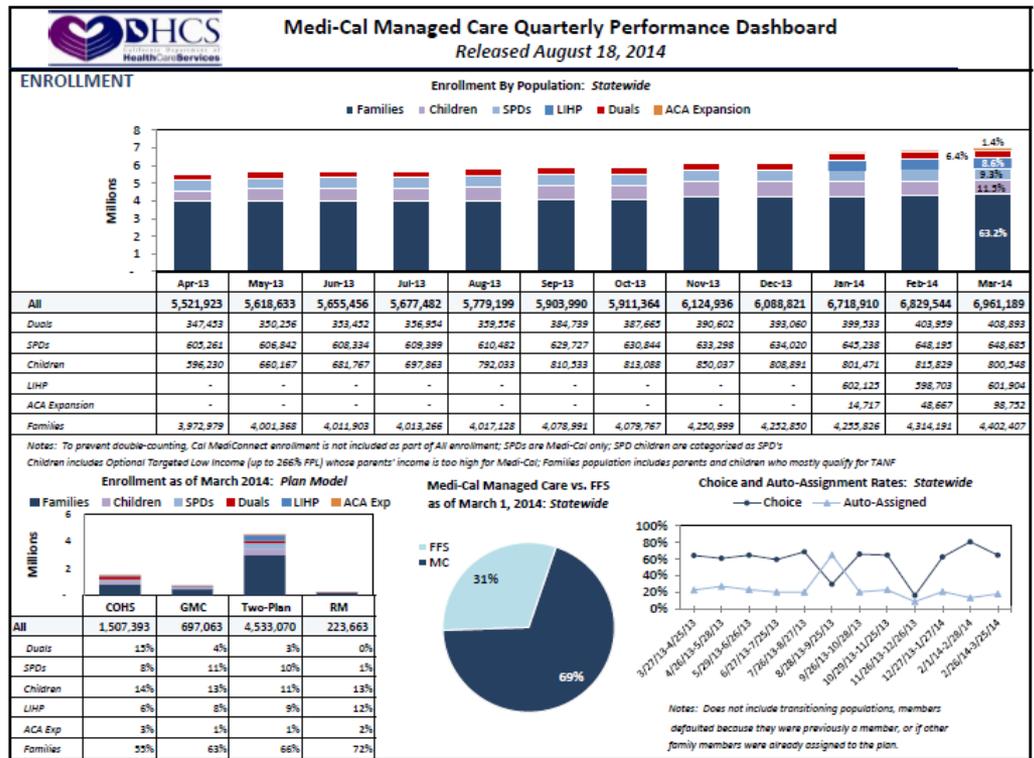
Geographic Managed Care - Sacramento County

Dental Plans Reporting: Access Dental Plan, Health Net Dental Plan, & LIBERTY D GMC Contracts began January 2013 and reporting is on the calendar year. Benchmarks were derived from 2010 statewide Denti-Cal Fee-For-Service data.

Annual Dental Visits		Access													
Percentage of members who had at least one (1) dental visit during the measurement period.		Age Group	0-3	4-5	6-8	9-11	12-14	15-18	19-20	21-18	0-20	0-3	4-5	6-8	9-11
Numerator: Number of members continuously enrolled in the same plan during the measurement period with no more than a one-month gap in eligibility who received any dental procedure (D0300-D9999) during the period.	Benchmark	30.3	66.6	64.1	61.4	54.9	48.6	33.7	56.5	N/A	30.3	66.6	64.1	61.4	
Denominator: Number of members continuously enrolled in the same plan with no more than a one-month gap in eligibility.	Quarter 1	8.6	22.4	20.9	17.7	15.2	13.6	8.9	17.2	15.5	7.9	23.4	24.0	21.5	
	Quarter 2														
	Quarter 3														
	Quarter 4														

Use of Preventive Services		Access													
Percentage of members who received any preventive dental service during the measurement period.		Age Group	0-3	4-5	6-8	9-11	12-14	15-18	19-20	21-18	0-20	0-3	4-5	6-8	9-11
Numerator: Number of members continuously enrolled in the same plan with no more than a one-month gap in eligibility who received any preventive dental service (D1000-D1999) in the measurement period.	Benchmark	22.3	55.4	55.2	52.8	47.0	38.9	24.0	43.3	N/A	22.3	55.4	55.2	52.6	
Denominator: Number of members continuously enrolled in the same plan during the measurement period with no more than a one-month gap in eligibility.	Quarter 1	5.6	15.2	12.8	11.5	9.6	7.0	3.4	9.6	9.3	5.1	17.1	17.3	15.2	
	Quarter 2														
	Quarter 3														
	Quarter 4														

Use of Sealants		Access			
Percentage of members ages 6-9 and 10-14 continuously enrolled in the same plan during the measurement period with no more than a one-month gap in eligibility who received a dental sealant on at least one permanent molar.		Age Group	6-9	10-14	6-9
Numerator: 1.) Number of members ages 6-9 continuously enrolled in the same plan during the measurement period with no more than a one-month gap in eligibility who received a dental sealant (D1351) on a permanent first molar (tooth number = 3, 14, 19, 30). 2.) Number of members ages 10-14 continuously enrolled in the same plan during the measurement period with no more than one-month gap in eligibility who received a dental sealant(D1351) on a permanent second molar(tooth number=2,15,18,31).	Benchmark		19.2	14.2	19.2
Denominator: Number of members ages 6-9 and 10-14, respectively, continuously enrolled in the same plan with no more than a one-month gap in eligibility	Quarter 1	3.0	1.6	4.0	
	Quarter 2				
	Quarter 3				
	Quarter 4				



Note: Data in this dashboard is preliminary and subject to change

¹Data Updated on of July 10, 2014
 Quarterly self-reported data uses the eligibility criteria of continuous enrollment with no gaps. Quarter 1 is cumulative data from January 1, 2014 through March 31, 2014.
 Reporting is based on incomplete run-out. Plans are contractually allowed to report encounters for up to six months following the date of encounter.
 Report is unavailable at this time because the calculations of the performance measure require two years of continuous enrollment in a plan.

Encounter Data Improvement

- Encounter Data Improvement Project (EDIP)
 - Designed a plan to track encounter data submissions, monitor data quality, and report data quality to DHCS data users, managed care plans (MCPs) and other external stakeholders
- Encounter Data Quality Unit (EDQU)
 - Established by EDIP to implement and maintain the tracking, monitoring and reporting plan and processes
- Encounter Data Capture/Transmission Project (PACES Project)
 - Systems development project to modernize DHCS encounter data processing to national standards



De-Identification for Public Reporting

- Health Insurance Portability Accountability Act (HIPAA) De-Identification Standard
- Expert Determination used to support reporting at sub-state geographies (i.e. county) and at monthly or quarterly levels
- Balance between supporting transparency while protecting privacy



Considerations

- Use of Benchmarks, Targets, and Thresholds
- Change Management
 - Develop the Change Management Plan & Live by It
 - Adoption Progress
- Prioritization to Support Focused Improvements
 - Measurement and Reporting
 - Interventions for Improvement





DHCS Dashboard Initiative - Coming Soon

The Department of Health Care Services is developing a comprehensive dashboard initiative to strengthen public reporting practices throughout the department while improving transparency and accountability.

This effort will be carried out in conjunction with the department's ongoing [Stakeholder Engagement Initiative](#), and will follow principles established in the [DHCS Strategic Plan](#) and the [Strategy for Quality Improvement in Health Care](#).

DHCS will regularly consult with stakeholders throughout the development of this initiative. Over the long term this Dashboard Initiative will help the department consistently measure its progress toward goals, and more effectively communicate results and key information to department staff, providers/partners, and stakeholders.

Long-term goals of this comprehensive approach include:

1. Build on lessons learned from the ongoing dashboard efforts targeting [managed care](#) services, dental services, and mental health services.
2. Design an intuitive, overarching technical framework to provide a consistent display format for the array of useful data elements.
3. Develop a department-wide dashboard with information on cross-cutting issues and integrated care.
4. Provide useful links to other DHCS data sources and quality measures, as well as to the open data portal.
5. Work with the Medi-Cal Children's Health Advisory Panel (MCHAP) and stakeholders on a comprehensive children's health dashboard.



Next Steps and Follow-up

- Submit Data Requests
- Proposals for additional indicators
- Consult literature/resources on existing quality, patient satisfaction, or process measures
 - Send resources you would like to share with the TWG to Michaela Ferrari: michferrari@ucla.edu
- Additions?

Thank you!

Anastasia Dodson, DHCS