

# California Children's Services Program: Title V Needs Assessment

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## Today's Objectives

**By the End of this meeting Stakeholders will:**

- Be familiar with the methods used to gather information for the needs assessment
- Be updated about what is going regarding services for children with special healthcare needs in CA and nationally
- Be updated on the key findings from the key informant interviews, focus groups, and on-line surveys

2

## Meeting Objectives (cont)

- Finalize the list of potential program priorities
- Using the previously developed criteria, evaluate and rank priorities
- Brainstorm strategies for accomplishing top priorities

3

## CSHCN Six Core Objectives

1. Families of CSHCN are partners in decision making at all levels and are satisfied with the services they receive
2. CSHCN receive coordinated ongoing comprehensive care within a medical home
3. All CSHCN will be adequately insured for the services they need

4

## CSHCN Six Core Objectives (cont.)

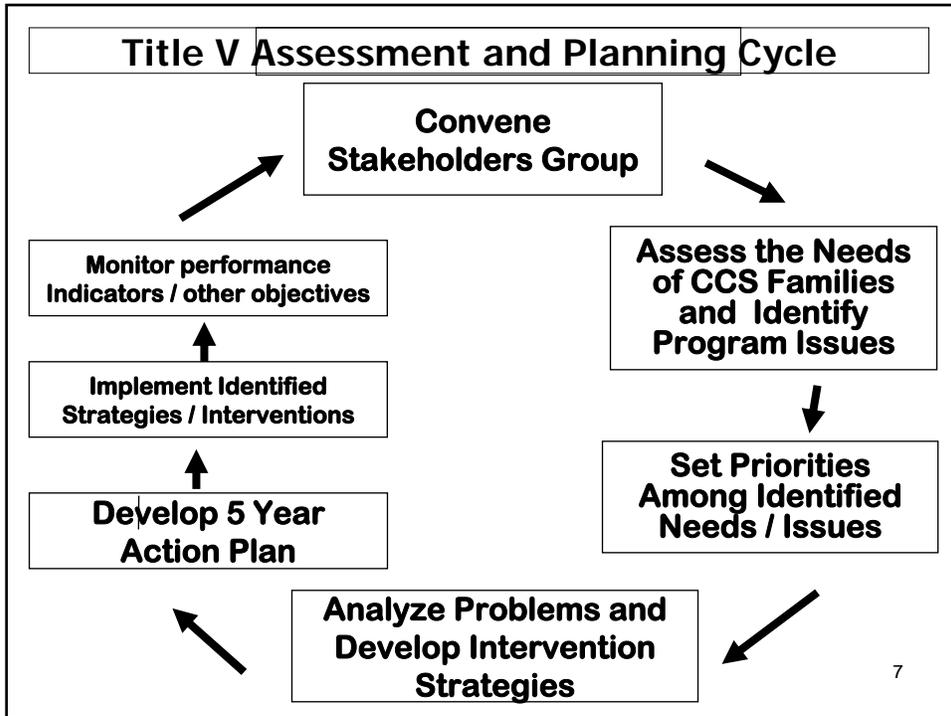
4. Children are screened early and continuously for special health care needs
5. Services for CSHCN will be organized so families can use them easily
6. All youth with special needs will receive services needed to support the transition to adulthood

5

## CCS Needs Assessment and Action Plan Goals

- Within budget and legislative constraints, determine *Action* priorities to be addressed during FY 2010-2014
- Identify the most important and potentially effective changes CCS can make to improve services for CCS-eligible children

6



## Convene Stakeholders Group

- Stakeholders representative of key interest groups: Families, CCS County Programs, Professional and Advocacy Organizations, Managed Care Plans, other State Departments, and Academic Researchers
- Stakeholders to provide input in all aspects of the needs assessment and decide priorities

8

## Convene Stakeholders

- Establish subcommittees for interviews, focus groups, surveys and program/secondary data
- Stakeholder subcommittees provide input on instruments, respondents to recruit, data analyses and interpretation of results

9

## Assess the Needs of CCS Families and Identify Program Issues

- Worked with Stakeholders to identify key issues and existing data sources
- Collected additional data in an iterative process via
  - **Stakeholders**
  - **Key Informant Interviews**
  - **Focus Groups**
  - **On-line Surveys**
- Review all data and findings with Stakeholders via webinars (7) and meetings and conference calls with Subcommittees (12)

10

## Key Informant Interviews

- Working with Key Informant Interview subcommittee:
  - Developed interview questions
  - Identified participants
- 16 Key Informant Interviews completed (+ 2 pilots)
- Participants included MDs, CCS Program staff, reps. from children's hospitals, professional organizations, other DHCS department reps.

11

## Focus Groups

- Focus Group Subcommittee:
  - Using information from interviews and stakeholders, developed discussion guides
  - Identified types of groups/participants
  - Facilitated setting up groups
- 8 Focus Groups conducted by FHOP, plus additional groups done by CRISS and on by Family Voices (10 total)

12

## Focus Groups

- 3 in So. CA: 1 family group, 1 MTP administrators group, 1 specialty care physician group
- 6 in No. CA: 1 hospital/health plans, 1 CCS County Admin and Nurse CM, 2 family groups ( 1 Spanish speaking), 1 MTP group, 1 Transition-age youth, 1 Medical Consultants
- Total # of participants: 98

13

## On-line Surveys

- Survey Subcommittee:
  - Developed 4 surveys using information from stakeholders, key informants, and focus groups
  - Facilitated pilot testing of the surveys
  - Recruited respondents to complete the surveys

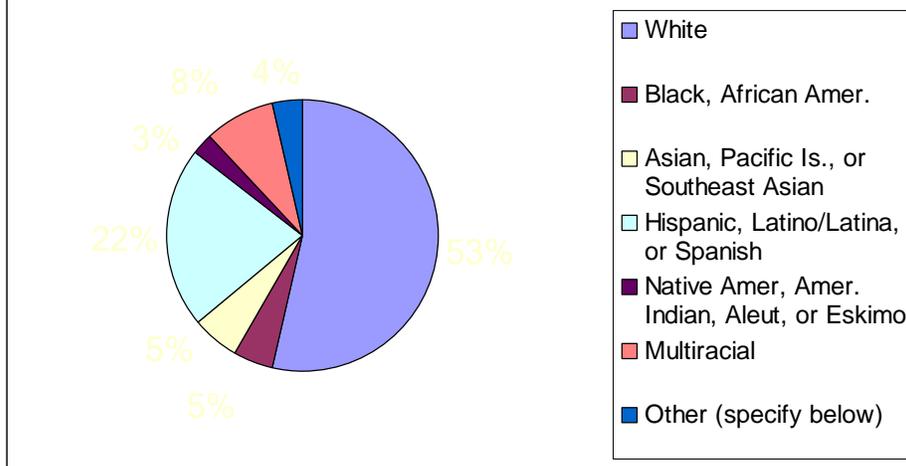
14

## On-line Surveys

- Families – 315 English + 24 Spanish
- Physicians – 142 (130 answered most questions)
- Hospitals, Health Plans, and CCS Administrators - 217
- DME Providers - 12

15

### FHOP Survey of Families 2010 – Race/Ethnicity of Child covered by CCS



16

## FHOP Survey of Hospitals, Health Plans, and CCS Admin/Managers

### What is your current position?

Answer Options	Response Percent	Response Count
County CCS Program administrator/manager or Medical Consultant	40.6%	88
MTP administrator/manager	15.2%	33
Hospital administrator/manager/staff	9.7%	21
Health Plan administrator/manager/staff	7.8%	17
None of the above (specify below)	26.7%	58
Other (please specify)		56
<i>answered question</i>		217

## FHOP Survey of Physicians

Neonatal Perinatal Medicine	19.7%	26
Pediatrician	13.6%	18
Pediatric Hematology Oncologist	10.6%	14
Pediatric Endocrinologist	6.1%	8
Family Medicine Physician	5.3%	7
Other (specify below)	5.3%	7
Pediatric Critical Care	5.3%	7
Pediatric Cardiologist	4.5%	6

18

## Today: Set Priorities Among Identified Needs / Issues

1. Selected criteria for setting priorities
2. Developed criterion weights
3. Use criteria to prioritize issues

19

## Next Step: Develop 5 Year Action Plan

- Solicit stakeholders' recommendations for action plan
- Work with CCS state staff to develop goals and SMART (Specific, Measurable, Achievable, Realistic, and Time-bound) objectives

20

## Criteria Development Process

- Stakeholders selected and defined criteria
- Engaged in a thorough discussion of criteria
- Selected manageable number of criteria
- Voted on weights for the criteria

21

## Prioritization Criteria

- 1. Does addressing the issue positively affect families, providers, and the program?**

**Definition/Concepts:** Addressing the issue would increase satisfaction for one or more of these groups.

Weight: 3

22

### **Criterion 1 Rating Scale:**

- 1 = Addressing issue WOULD NOT positively affect any group (families, providers or the program)
- 2 = Addressing the issue would positively affect ONE of the groups (families OR providers OR the program)
- 3 = Addressing the issue would positively affect providers AND the program
- 4 = Addressing the issue would positively impact families AND one other group (providers OR the program)
- 5 = Addressing the issue would positively affect ALL THREE of the groups (families, providers, and the program)

23

## **Prioritization Criteria**

### **2. Does addressing the issue reduce disparities?**

**Definition/Concepts:** One or more population subgroups as defined by race/ethnicity, income, insurance status, gender, geography, or diagnosis are more impacted than the general group and that addressing the problem would reduce unequal impacts.

**Weight: 2**

24

## Prioritization Criteria

### Criterion 2 Rating Scale:

- 1 = No group is disproportionately affected by the issue
- 2 = It appears that one or more groups is disproportionately affected by the problem, but the differences are not statistically different.
- 3 = Statistically significant differences exist in one group
- 4 = Statistically significant differences exist in more than one group
- 5 = Statistically significant differences exist in one or more groups and impacts a large portion of the affected population

25

## Prioritization Criteria

### **2. Criterion Name: Does addressing the issue enhance the continuity and coordination of care?**

**Definition/Concepts:** Could mean making it easier for CCS children to regularly see the same provider, better coordinating of referrals among needed providers, making it easier for different providers to access and share a child's health record, facilitating authorization and reauthorization of services; providing resources to help coordinate care and referrals

**Weight: 3**

26

## Prioritization Criteria

### Criterion 3 Rating Scale:

- 1 = Addressing the issue does not enhance continuity and the coordination of care
- 2 = Addressing the issue provides some enhancement to continuity and coordination of care
- 3 = Addressing the issue enhances continuity and the coordination of care for a small part of the population
- 4 = Addressing the issue enhances continuity and the coordination of care for a large part of the population
- 5 = Addressing the issues assures continuity and coordination of care

27

## Prioritization Criteria from 2005 Needs Assessment

### 4. Does addressing the issue enhance the systematic efficiency of the program?

**Definition/Concepts:** Could mean many things, including reducing the cost of care, more effectively deploying staff and other resources to save money and/or increase productivity, making it easier for families to navigate the system across counties and payors; and making it easier to administer the program.

Weight: 1

28

## Prioritization Criteria

### Criterion 4 Rating Scale:

- 1 = Addressing the issue does not enhance the systematic efficiency of the program
- 2 = Addressing the issue makes the system more efficient for ONE of the groups (families OR providers OR the program)
- 3 = Addressing the issue makes the system more efficient for providers AND the program
- 4 = Addressing the issue makes the system more efficient for families AND one other group (providers OR the program)
- 5 = Addressing the issue makes the system more efficient for ALL THREE of the groups (families, providers, and the program)

29

## Prioritization Criteria

### 5. **Criterion Name: Does addressing the issue enhance the clients' relationships with providers?**

**Definition/Concepts:** One or more population subgroups as defined by race/ethnicity, income, insurance status, gender, geography, or diagnosis are more impacted than the general group. Addressing the problem or issues would promote equity and reduce disparities.

**Weight: 2**

30

## Prioritization Criteria

### Criterion 5 Rating Scale:

- 1 = Addressing the issue does not enhance clients' relationships with providers
- 2 = Addressing the issue enhances to the clients' relationships with providers in only minor ways
- 3 = Addressing the issue enhances the clients' access to providers
- 4 = Addressing the issue enhances the clients' relationships with providers in at least two areas i.e. access and communications
- 5 = Addressing the issue provides major improvements to the clients' relationships in more than two areas

31

## Prioritization Criteria

- 6. **There is a likelihood of success. Issue is amenable to prevention or intervention, and/or there is political will to address it**

**Definition/Concepts:** There is a good chance that the strategies used to intervene in the identified problem will result in an improvement in outcomes. The intervention strategies are shown in research literature, by experts or by National, State or program experience to be effective or promising. By political will we mean that there is support at the state or federal level for making administrative changes or providing funding.

**Weight: 2**

32

## Prioritization Criteria

### Criterion 6 Rating Scale

1. No proven or promising intervention available
2. Promising or proven intervention with limited impact (not effecting a large promotion of the CSHCN population), little political will
3. Proven intervention with limited impact, moderate political will
4. Promising or proven intervention with broad impact and moderate political will
5. Proven intervention with broad impact and strong political will

33

## Family Involvement and Satisfaction

- **MCHB Outcome: Families of children and youth with special health care needs partner in decision making at all levels and are satisfied with the services they receive**

34

## Family Involvement and Satisfaction

*Priority: Increase family access to educational information and information about accessing CCS services, including availability of and access to services offered by health plans, and family support groups*

*Priority: Increase family partnership in decision making and satisfaction with services*

35

## Family Involvement and Satisfaction: what we heard

- Many parents very grateful for CCS
- Parents confident in CCS providers
- Parents have info and can help each other
- More parent groups are needed
- Some confusion about what services CCS covers

36

## Family Involvement and Satisfaction: the data

- 46.6% of CSCHN in CA had family centered care vs. 57.4% of CSCHN nationally
- 52% of CSHCN in CA with private insurance had family centered care compared to 40.6% of CSHCN with public insurance

37

## Family Involvement and Satisfaction: the data

**All things considered, how satisfied are you overall with the CCS program?**

Very satisfied	83%	{	44%	(126)
Somewhat satisfied			39%	(113)
Somewhat dissatisfied			11%	(31)
Very dissatisfied			5%	(14)
Don't know/Not sure			1%	(4)

FHOP Survey of Families 2010

38

## Family Involvement and Satisfaction: the data

### Satisfaction with services

Dental Care	92%	183
Disposable Medical Supplies	92%	122
Durable medical equipment and medical technology	85%	167
In home support services (IHSS)	93%	102
Respite care	79%	93

FHOP Survey of Families 2010

39

## Family Involvement and Satisfaction: the data

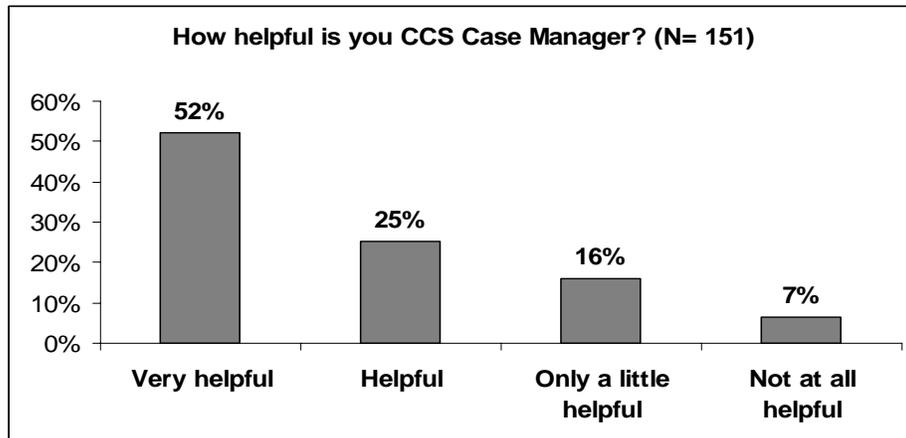
### **All things considered, how satisfied are you overall with the Medical Therapy Unit (MTU)?**

Very satisfied	50%	121
Somewhat satisfied	28%	69
Somewhat dissatisfied	11%	27
Very dissatisfied	6%	14
Don't know/Not sure	5%	13

FHOP Survey of Families 2010

40

## Family Involvement and Satisfaction: the data



FHOP Survey of Families 2010

41

## Family Involvement and Satisfaction: the data

### *Access to Interpretation Services*

- 8.1% (25) families reported needing interpretation services to communicate with their child's medical provider in the *last 12 months*
- Among the 30 families having needed interpretation services, 30% (9) only sometimes got this service and 13% (4) never got this service

FHOP Survey of Families 2010

42

## Medical Home

- Definition - accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective and delivered or directed by a well-trained primary care or specialty physician who helps to manage and facilitate essentially all aspects of care for the child

***Priority: Increase number of family-centered medical homes for CSCHN and the number/% of CCS children who have a designated medical home.***

43

## Medical Home: What we heard

- Some problems accessing primary care
- Delays accessing specialty care
- Use of ER services because of lack of access to timely care
- Delays in getting DME and kids having outgrown DME when it arrives
- Lack of timely DME leading to delayed discharges

44

## Medical Home: What we heard

- Poor communication and coordination between primary and specialty care providers
- Parents playing a big role in coordinating care for their child
- Many barriers to physician participation in CCS – delays in payments, complex paper work, concerns about Medi-Cal
- Reductions of staff at the state level to administer CCS and provide leadership, enforce standards, panel physicians

45

## Medical Home: The data

- 58% of CSHCN lack a medical home (NS-CSHCN CA data)
- African Amer. and Latino CSHCN significantly more likely to lack medical home than white CSHCN
- 87% - CA average for primary care provider listed for CCS clients (CMSNet)
- 95% of families reported that their child has a primary care provider (FHOP Family Survey)

46

## Medical Home : the data

*Family ratings on access to MD most important to child:*

- 8% (26) – poor rating on being easy to contact by phone
- 19% (45) – poor rating on being available to give medical care or advice at night and on weekends
- 15% (37) – poor rating on being easy to reach in an emergency

FHOP Survey of Families 2010

47

## Medical Home: the data

*From the FHOP Survey of CCS Families 2010*

ER Visits

- 13% (40) families report going to the hospital emergency room in the last 12 months for problem/illness that could have been taken care of by their child's health care provider if been able to talk to or see the provider earlier.
- 36 of these families reported a combined total of 82 of these ER visits in the last year, with one family reporting 7 visits.

48

## Medical Home: The data

### ER Visits

- 93% (123) of respondents to the HHPCCS survey agreed that CCS should work with primary care physicians and care coordinators to develop approaches (such as implementing enhanced medical homes) that could decrease ER visits and hospitalizations for CCS children.

FHOP Survey of Families 2010

49

## Medical Home: The data

- Among LA children in Medi-Cal, more children in CCS (85.2%) than in the general population of CSHCN (72.2%) have a personal doctor (LA Survey 2005)
- LA survey found that as children get older, less likely to have personal doctor

50

## Medical Home: The data

### Primary care access problems

- 13% (44) reported some problems getting primary care services and 3% (20) reported a lot of problems
- Frequent Problems include not being able to find a primary care provider with the necessary skills and experience, and coordination between primary and specialty care providers

FHOP Survey of Families 2010

51

## Medical Home: the data

### Specialty Care Provider Access Problems

- 18.2% (62) reported some problems getting specialty care services and 7.6% (26) reported a lot of problems.
- Most frequently reported problem: getting an appointment.
- Other frequent problems: getting a referral, not being able to find specialist with the need skill and experience, and coordination between primary and specialty care providers, and refusal by the health plan to pay for the service

FHOP Survey of Families 2010

52

## Medical Home: The data

### ***Unmet Needs***

*From the FHOP Survey of CCS Families 2010*

- 27% (43) of families reported their child needed physical therapy but did not receive it
- 18% (27) of families reported their child needed occupational therapy but did not receive it
- 34% (32) of families reported their child needed speech therapy but did not receive it

53

## Medical Home: The data

### *Unmet Needs (cont.)*

- 33% (95) families report attending family support groups
- Of the 239 families not currently attending family support groups, 39% (94) would like to attend
- Only 29% (85) of families report that anyone from the CCS program told them that CCS could help them find emotional support, community resources, and family/individual counseling for their child and family
- Only 20% (56) of families report that anyone from the CCS program referred them to any family to family support services

54

## Medical Home: the data

Physicians reporting the following are FREQUENTLY a problem:

Too few DME providers being available due to low reimbursement rates.	71% (44)
DME providers refusing to provide certain kinds of equipment due to low reimbursement rates for that equipment.	69% (41)
Client discharges being delayed because of delays in getting DME (e.g. ventilators, apnea monitors, wheel chairs)	58% (42)

Physician Survey 2009

55

## Medical Home: the data

Administrative Processing Times: The good news

	2 Days or Less	3 days to 1 wk	Within 1 week	Within 2 weeks
<b>Referral Until opened</b>	<b>12% (4297)</b>	<b>27% (9952)</b>	<b>39%</b>	<b>60%</b>
<b>Referral until first SAR auth</b>	<b>7% (3033)</b>	<b>19% (8113)</b>	<b>22%</b>	<b>42%</b>
<b>SAR request to auth.*</b>	<b>25% (14008)</b>	<b>26% (14790)</b>	<b>51%</b>	<b>67%</b>
<b>Hemo. Oncol. SAR to auth.</b>	<b>42% (1675)</b>	<b>18% (713)</b>	<b>60%</b>	<b>70%</b>
<b>HHA SAR to Auth</b>	<b>37% (749)</b>	<b>25% (496)</b>	<b>62%</b>	<b>75%</b>
<b>Wheelchair SAR to auth.</b>	<b>39% (2398)</b>	<b>17% (1040)</b>	<b>46%</b>	<b>58%</b>

56

Source: CMSNet 2009, \* includes LA Data

## Medical Home: the data

Administrative Processing Times: The bad news

	<b>2 Months or more</b>
<b>Referral Until opened</b>	<b>9% (184)</b>
<b>Referral until first SAR auth</b>	<b>15% (6507)</b>
<b>SAR request to auth.*</b>	<b>7% (2679)</b>
<b>Hemo. Oncol. SAR to auth.</b>	<b>8% (4426)</b>
<b>HHA SAR to Auth</b>	<b>11% (727)</b>
<b>Wheelchair SAR to auth.</b>	<b>10% (414)</b>

Source: CMSNet 2009, \* includes LA Data

57

## Medical Home: the data

- CSCC Survey indicated:
  - Roughly 22% of positions for specialty physician unfilled (33% for neurologists)
  - Long wait times for accessing specialists
    - 39 days to see Pediatric Cardiologist for a suspected heart conditions
    - 53 days to see Otolaryngologist for suspected hearing loss

58

## Medical Home: the data

### Barriers to Physician Participation in CCS:

	MDs (HHPCCS)
<b>Time consuming and difficult paper work to complete to get reimbursed</b>	<b>78% (98%)</b>
<b>Delays in payments for the services provided to CCS children</b>	<b>67% (97%)</b>
<b>Low Medi-Cal outpatient reimbursement rates for care of CCS children</b>	<b>60% (97%)</b>
<b>The need to coordinate services for CCS children and the lack of information on how to do it</b>	<b>59% (85%)</b>

Physician Survey 2009 and HHPCCS Survey

59

## Medical Home: the data

### Strategies STRONGLY AGREED to for increasing Physician Participation in CCS:

	MDs (HHPCCS)
<b>Increase the reimbursement rates paid to physicians to care for CCS clients.</b>	<b>88% (80%)</b>
<b>Provide ongoing assistance with authorizations and billing for services once physicians are paneled.</b>	<b>79% (78%)</b>
<b>Better align Codes and reimbursement rates to allow for outpatients tests and procedures where appropriate</b>	<b>78% (68%)</b>

Physician Survey 2009 and HHPCCS Survey

60

## Medical home: the data

### Top barriers to DME Supplier participation in CCS

Low reimbursement rates	53.8% (7)
Delays in payments for the services provided to CCS children	53.8% (7)
Time consuming and difficult paper work to complete to get reimbursed	92.3% (12)

61

## Medical Home: Possible Priorities

***Priority:*** Increase number of family-centered medical homes for CSCHN and the number/% of CCS children who have a designated medical home.

62

## Medical Home: Possible Priorities

*Priority: Increase access of CCS children to 24-7 medical consultation and urgent care services from the child's usual sources of primary and specialty care to decrease unnecessary ER visits and hospitalizations*

*Priority: Increase timely access of CCS children to durable medical equipment*

63

## Medical Home: Possible Priorities

*Priority: Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, primary care physicians, audiologists, occupational and physical therapists, and nutritionists*

*Priority: Increase access of CCS children to preventive health care services (primary care, well child care, immunizations, screening) as recommended by the AAP*

64

## Insurance Coverage

- **MCHB Outcome #3: Families of CSHCN have adequate private and/or public insurance to pay for the services they need.**

65

## Insurance Coverage: What we heard

From Families:

- Having private insurance and CCS makes it harder to get care
- Medi-cal and private insurance don't understand the needs of CSHCN
- Having to pay out of pocket for expenses they can't get covered
- Medi-Cal workers even more overwhelmed than CCS

66

## Insurance Coverage : the data

Experience of families who have a child covered by BOTH private insurance and CCS (n=167)

Having private insurance along with CCS makes it <u>easier</u> to get services	47% (78)
Having private insurance along with CCS makes it <u>harder</u> to get services	22% (36)
Not sure if also having private insurance make it easier or harder	32% (53)

FHOP Survey of Families 2010

67

## Insurance Coverage : the data

Reasons families have trouble getting needed care

<u>Type</u> of insurance that covers their child insurance	37% (105)
<u>Lack</u> of insurance	22% (63)
<u>Changes</u> in insurance	21% (59)

FHOP Survey of Families 2010

68

## Insurance Coverage: the data

- Looking more broadly at CSHCNs in CA, 35.5% report that their current insurance is inadequate to meeting their child's health care needs
- Shift to public coverage:

Private or employer- based insurance only		Public insurance only	
<u>2001</u>	<u>05/06</u>	<u>2001</u>	<u>05/06</u>
72.2*	63.6	16.6*	26.2 <sup>a</sup>

From the National Survey of CSHCN 2005/2006

69

## Insurance Coverage: Possible Priorities

- *Priority: Increase access to CCS services by increasing the financial eligibility limit (\$40,000 limit)*
- *Priority: Implement a system of standards of service delivery for all children with CCS medically eligible conditions regardless of insurance coverage.*

70

## Organization of Services

- **MCHB Outcome #5: Community-based services for children and youth with special health care needs are organized so families can use them easily.**

71

## Organization of Services: What we heard

- Inconsistencies between Counties in services covered and in wait times for authorizations
- CCS deals with conditions, not the whole child
- Challenges in care coordination due to carve out
- Desire for 'whole child' approach

72

## Organization of Services: what we heard

- Variations between counties in size of case load for case management
- CCS should re-examine eligibility, particularly for less complex, short term conditions and NICU care without a CCS Diagnosis

73

## Organization of Services: the data

**Thinking about services your child needs, are those services organized in a way that makes them easy to use?**

Always	65%	{	24%	73
Usually			41%	124
Sometimes			26%	79
Never			6%	18
Don't know/Not sure			4%	11
			<i>answered question</i>	305

FHOP Survey of Families 2010

74

## Organization of Services: the data

Who should be able to provide case management for children in CCS ?	Hospitals/ Health Plans/ CCS Prog. Survey	Physician Survey
RNs, PHNs, Medical Consultants, or Social Workers	<b>93.8%</b>	<b>83.3%</b>
Certified case managers	<b>42.8%</b>	<b>81.7%</b>
Specially trained but unlicensed staff	<b>24.1%</b>	<b>21.7%</b>

FHOP Survey Of Hospitals, HP, and CCS; and Physician Survey

75

## Organization of Services: the data

### One System of Care

- **84.1% (117)** of Hospital/Health Plan/CCS Programs respondents and **75.2% (88)** of Physicians agreed it would be more efficient and effective to have one system of care for children with CCS-eligible conditions.

76

## Organization of Services

Re-examine medical eligibility for CCS to focus on longer term conditions that need intensive case management and care coordination

Agree Strongly	41.5%	49
Agree Somewhat	36.4%	43
Disagree Somewhat	7.6%	9
Disagree Strongly	5.9%	7
Don't know/ Not sure	8.5%	10

FHOP Survey Of Physicians Survey, 2009

77

## Organization of Services

NICU care for infants should only be covered by CCS if the infant has been diagnosed with a CCS-eligible condition, otherwise the cost of the NICU care should be covered by the child's health plan

Agree Strongly	32.1%	25
Agree Somewhat	26.9%	21
Disagree Somewhat	6.4%	5
Disagree Strongly	11.5%	9
Don't know/ Not sure	23.1%	18

FHOP Survey Of Physicians, 2009

78

## Organization of Services: the data

If CCS services were integrated into Medi-Cal managed care plans, the CCS program, CCS standards, and CCS guidelines and special care centers would be compromised.

Hosp./HP/CCS	65% Agree (87)
	20% (27) Disagree
Physicians	58% Agree (68)
	18% Disagree (22)

79

## Organization of Services: the data

Special Care Centers should hire primary care providers (physicians and nurse practitioners) to provide primary care services to CCS clients.

HHPCCS	45% (60) Agree
	35% (47) Disagree
Physicians	58% (69) Agree
	27% (31) Disagree

80

## Organization of Services: the data

- 24% (32) of respondents to the Hosp./Health Plans/CCS Programs survey agreed that Medical eligibility determinations should be made at a regional or statewide level instead of by Counties' CCS Medical Eligibility consultants'
- 67% (78) of Physician Survey respondents agreed

81

## Organization of Services: Potential Priorities

*Priority: Develop and implement strategies to facilitate reimbursing providers in a more timely fashion.*

*Priority: Develop and implement to identify/create IT and other solutions to facilitate more rapid determinations of eligibility and authorizations and communication between CCS and providers*

82

## Organization of Services: Potential Priorities

*Priority: Decrease the time between referral to CCS and authorization of CCS services, particularly in dependent counties.*

83

## Organization of Services: Potential Priorities

*Priority: Increase the capacity of the State CCS program to more quickly panel providers and make eligibility and authorization determinations, to update and enforce CCS standards, and to work with Counties to adopt strategies and best practices to reduce variation between Counties and implement administrative efficiencies.*

84

## Transition to Adulthood

- **MCHB Core Outcome #6: Youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.**

85

## Transition to Adulthood: What we heard

- Very hard to find a provider to see CCS clients as they age out
- Lack of transition planning
- No organized system of care for YSCHN to transition into
- Lack of insurance coverage a major problem

86

## Transition to Adulthood: The data

- NS-CSHCN - 37% of youth in CA achieved this outcome
- FHOP survey of Physicians
- 63% who worked with transition age youth report it is very hard to find a new PCP
- 69% who worked with transition age youth report it is very hard to find a new specialty care provider

87

## Transition to Adulthood: the data

- 35% (99) of respondents have a child 14 or older that is/was covered by CCS
- 21 (21%) have a plan for addressing changing needs developed with child's doctors or other health care providers
  - 27% (27) report that child's doctors or other health care providers discussed having child eventually see doctor who treats adults
  - 19% (19) report child received any vocational or career training to help (him/her) prepare for a job when an adult
  - 26% (26) report child's CCS case manager has talked to them and child about transition to adult providers

88

## Transition to Adulthood: the data

- Suggestions to improve transition from HHPCCS Survey
  - All rated as very helpful (see listing in summary sheet)
  - Suggestion most highly rated on Physician survey: having insurance that covers the cost of care and coordination

89

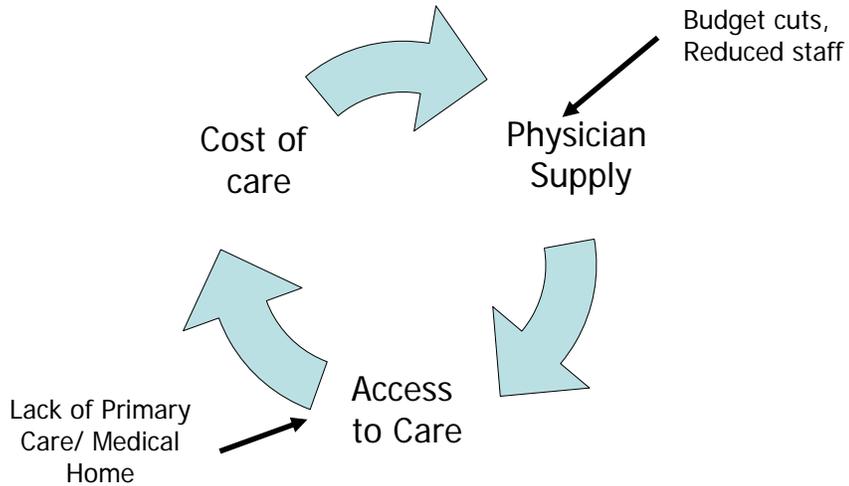
## Transition to Adulthood

*Priority: Increase access to services for CCS youth, 17-21 years of age*

*Priority: Work with medical providers to identify methods, materials and protocols to increase transition planning services provided to CCS youth*

90

## Interrelated components



91

## Instructions for Breakout Groups

## Breakout Group –Assign Tasks Instructions

- Select recorder to enter info into the laptop
- Select recorder for butcher block
- Select presenter to report back for the group

93

## Breakout Groups: Mission

- **Review draft list of priorities and:**
  - Add priorities if needed
  - Delete priorities if not needed
  - Reword listed priorities

**GOAL: Manageable list of priorities  
for Stakeholders to rank**

94