California Children's Services (CCS) Redesign
Redesign Stakeholder Advisory Board (RSAB)
Meeting #2 Summary
Friday, January 23, 2015
Sacramento, California

Members in Attendance:

Families / Advocates: Devon Dabbs, Children's Hospice and Palliative Care Coalition; Juno Duenas, Family Voices of California; **County Representatives:** Chris Dybdahl, Santa Cruz County Administrator for CCS; Judith Regel, County Health Executive Association; Katie Schlageter, CCS Administrator, Alameda County; Tony Pallitto, CCS Administrator, Kern County;

Hospital Representatives: Amy Carta, Santa Clara Valley Health and Hospital System; Arlene Cullum, Sutter Health; Karen Dahl, Vice President for Quality and Patient Safety, Valley Children's Hospital; Domonique Hensler, Rady Children's Hospital; Tom Klitzner, UC Medical Centers (via conference call)Ann Kuhns, California Children's Hospital Association; Richard Rabens, Medical Director, Kaiser Permanente Northern California State Programs; **Provider Representatives:** Nick Anas, Specialty Care Coalition; Kris Calvin, American Academy of Pediatrics, California; Richard Chinnock, Children's Specialty Care Coalition; John Cleary, California Association of Neonatologists; Stuart Cohen, Chair of American Academy of Pediatrics, California; James Gerson, Medical Director, Health Net; **Foundation Representatives:** Ed Schor, Lucile Packard Foundation for Children's Health; **CCS Executive Committee Representatives:**

Dyan Apostolos, Monterey County; Ed Bloch, Medical Director, Children's Medical Services, LA County; David Souleles, Orange County Health Care Agency; **Other Stakeholders:** Laurie Soman, Packard Children's Hospital and the Children's Regional Integrated Service System (CRISS); Amy Westling, Association of Regional Center Agencies;

DHCS Staff **in Attendance:**	Jill Abramson, David Banda, Claudia Crist, James Delgado, Anastasia Dodson, Brian Hansen, Hannah Katch, Brian Kentera, Annette Lee, Louis Rico, Kimberly Steele, Morgan Staines
UCLA/Stanford Staff in Attendance:	Lisa Chamberlain, Michaela Ferrari, Neal Halfon, Nathan Moriyama, Jessica Padilla, Dylan Roby, Lee Sanders, Jess Schumer
Audience Members:	Maricris Acon, Scott Bain, Marie Barnett, Terri Cowager-Hill, Tim Curley, Allison Gray, Kirsten Halsted, David Jacobson, Erik Kelly, Cinde Kunzman, Jacob Lam, Christine Lazott, Pip Marks, Deborah Martinez, Tedrick Miles, Jennifer Ramirez, Anthony Rose, Pamela M Sakamoto, Tim Shannon, Teresa Stark, Paula Villescaz, Tina Vora

Meeting Summary

1. **Welcome and Purpose Statements**
   PowerPoint slides for this portion of the meeting can be found here: (http://healthpolicy.ucla.edu/Documents/Spotlight/CCS%20Redesign%20Meeting%202%20Presentation%20Slides.pdf)

   a. Jessica Padilla, Project Manager for the UCLA Center for Health Policy Research, opened the meeting, asked the RSAB members to introduce themselves, gave a brief overview of the meeting agenda and topics to be covered, and stated that the goal of the meeting is the formation of Technical Workgroups.

   b. Ms. Padilla directed the stakeholders to the DHCS and UCLA websites (http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx and http://healthpolicy.ucla.edu/programs/health-economics/projects/ccs/Pages/default.aspx) for updated information and introduced the new members of the RSAB.

   c. Ms. Padilla pointed out the definitions document and asked the RSAB for feedback on the definitions.

   d. Ms. Padilla announced that the next RSAB meeting was tentatively scheduled to take place on March 20, 2015 in Oakland and would focus on options available for inclusion and innovative models for CCS. (http://healthpolicy.ucla.edu/programs/health-economics/projects/ccs/Pages/next-meeting.aspx)

2. Goals and Considerations for the Redesign Discussions

a. Anastasia Dodson introduced herself and thanked all of the participants for their participation and dialog.

b. Ms. Dodson introduced a document restating the DHCS goals (http://www.dhcs.ca.gov/services/ccs/Documents/RSABRelatedGoals.pdf) , addressed prior questions about defining the problem, spoke about interaction with the waiver and then introduced Ed Schor.

   i. Ms. Dodson noted that DHCS is using the words Organized Delivery System intentionally and emphasized that this does not necessarily mean Managed Care.
   ii. Ms. Dodson also emphasized that DHCS does not have a predetermined outcome of moving CCS kids into Managed Care.
   iii. Summarizing the goals, Ms. Dodson spoke about improving the care experience for child and family through primary and specialty care, mental health, and behavioral health. In maintaining quality, she emphasized that the standards should remain in place. In streamlining care delivery, she mentioned integrating lessons learned from previous presentations. Cost effectiveness, she identified as a part of the Triple Aim and stated that we want to look at ways to consider simplification of the funding structure and value based payments.
   iv. Ms. Dodson emphasized that although July 2015 is a goal, this transition will take time and there is no “cliff” that we will all fall off of come January 1st 2016. Ideally, Implementation will start in July of 2016.
   v. Ms. Dodson also addressed regional models and that they continue to contract and partner with the right types of providers.
   vi. Ms. Dodson concluded with transparency and outcome monitoring and then asked if anyone had questions.

c. Laurie Soman asked Ms. Dodson to elaborate on the July 2016 transition date.

   i. Ms. Dodson replied that July 2016 is a very tentative date and that it represents the fact that the process will happen over time and not all at once.

d. Ms. Dodson continued, addressing previous questions about the interaction between the 1115 waiver, the 1115 waiver renewal, and the CCS Redesign effort.

   i. Ms. Dodson explained that the CCS Redesign process is not part of the 1115 waiver renewal.

e. Kris Calvin asked if there was anything else related to CCS that would need waiver authority.

   i. Ms. Dodson reiterated that the CCS Redesign is not a part of the waiver renewal and that they are separate tracks, separate timelines, and separate processes.

f. Ms. Dodson continued, addressing CCS' interaction with Title V, stating that the title V stakeholder process has yielded a lot of information that can inform the CCS Redesign process. (http://healthpolicy.ucla.edu/programs/health-economics/projects/ccs/Pages/Title-V-Documents.aspx)

g. Richard Rabens asked if the 1115 waiver process includes elements of CCS.
   i. Ms. Dodson answered that the only elements of CCS in the 1115 waiver renewal are the existing pilots in San Mateo and San Diego. The strategies and models for the CCS redesign are independent from the 1115 waiver process.

h. Going back to Title V, Ms. Dodson expressed that the things DHCS wants the CCS program to do better are: having a lead care coordinator for care coordination, data sharing, and dealing with the bifurcation and fragmentation between primary and health services. Another opportunity for improvement is better coordination with behavioral health services, social services, and mental health.

i. Laurie Soman expressed her excitement that there is attention to care coordination. And expressed concern that representatives of the other systems (who will be coordinated) are not present.
   i. Ms. Dodson answered that DHCS would like to hear more about models that are successful in implementing this during the March meeting.
   ii. Louis Rico echoed the same concern and although a lofty goal, thinks that this group (RSAB) will help us to get there.

j. Ms. Dodson then announced that Ed Schor would be presenting the Lucile Packard Foundation for Children's Health issue brief outlining key components of a system for publicly financed care of CSHCN in the state of California. (http://healthpolicy.ucla.edu/Documents/Spotlight/Key%20Components%20of%20a%20System%20for%20Publicly%20Financed%20Care%20of%20%20CSHCN%20in%20California,%20Lucile%20Packard%20Foundation.pdf)

k. Dr. Schor introduced himself and provided some of his background experience.

l. Dr. Schor continued by summarizing the document. The document is a scan of all literature they could find on the topic.
   i. The first topic outlines the principles / goals of a publicly financed system for children with special health care needs (CSHCN) to inform discussion.
   ii. The next section includes structural components that the system must have. These components, Dr. Schor states, are debatable.
   iii. Third are administrative responsibilities.
      a) The document breaks these down into several components including client and provider eligibility.
      b) The next two points are the division of state and county administrative responsibilities.

        c) Financing the system follows. The state's goals are to remain budget neutral. There are options to do so yet revise the current structure. The goal is to get to a whole child focus and unified payments.
        d) Next, the document lays out policy issues within the Medicaid framework that must take place to shape the system as we would like it.
    iv. Provider issues, including those related to regionalization, certification, and expectations are also included in the literature scan.
    v. Benefits are next. Dr. Schor comments that some options offer opportunities to reduce cost while others may increase cost.
    vi. Quality guidelines depend on a definition of quality. Furthermore, there must be a process in place to monitor quality and to make improvements if there are problems with quality.
    vii. The intention of the document was not to provide answers. Disagreement with the document is anticipated and encouraged. It is meant to structure discussion.

m. Ms. Dodson thanked Dr. Schor for his presentation and opened the floor to questions from the RSAB.

n. Arlene Cullum asked if there was a process to provide input to the document indicating that if the document was going to be used as a reference for the CCS Redesign, that it be complete.
    i. Dr. Schor clarified that that this forum did not exist when the document was published.
    ii. Ms. Dodson added that the document should be considered a companion to the RSAB survey results and the DHCS restated goals.
    iii. Ms. Calvin added that the American Academy of Pediatrics (AAP) used this document as a starting point for discussion. They believed it was intended as an outline and guide. It was helpful to them in that fashion.
    iv. Domonique Hensler echoed Ms. Calvin's remarks and praised Dr. Schor and his team for providing the environmental scan.

3. Vision for the CCS Program, Survey Results, and Technical Workgroup Topics

a. Dylan Roby introduced himself, apologized for being late, and thanked everyone for getting started.

b. Dr. Roby highlighted the overlap between the restated DHCS goals and the Lucile Packard Foundation for Children's Health's document and then moved on to show the main goals identified by the RSAB survey.
    i. The goal was to show the alignment of concepts, in terms of the mission behind the CCS Redesign, as reported by RSAB members.
        a) Examples of this are whole child focus, care coordination focus, and family engagement.

        b) In terms of reimbursement, the state perspective is to remain budget neutral. However, the provider perspective is to make reimbursement better or improve reimbursement.
        c) There is alignment in terms of a better financial model and moving to value-based reimbursement.
    ii. The goals reported by the RSAB in the survey align well with DHCS' restated goals as well as Lucile Packard's principles.

c. Dr. Roby then introduced Karen Perkins of Leapfrog Consulting indicating that she would help with graphical recording and brainstorming and road-mapping, what needs to be improved and what is working.
    i. The goal is to develop a vision for CCS that includes consensus around DHCS' restated goals and the goals identified by the RSAB survey.
    ii. Although ideas about which issue is most important will differ, the goal is to reflect on these goals and bridge the gaps.

d. The focus of the three sessions is road-mapping and brainstorming.

e. The next session will be facilitated by Neal Halfon and will explore the CCS components that are working and the successes identified in the RSAB survey.

f. Following that will be a discussion about what needs to be fixed, improvements needed, what needs to be transformed, and what needs to be upgraded.

g. Next, the results from the survey stakeholder response will be reviewed.

h. After that, DHCS will field recommendations from the RSAB around the redesign and extending CCS.

i. Technical workgroups will be formed to divide the workload amongst the RSAB. The goal for today is to identify the 5-6 groups to be formed, identify outside experts that may helpful, and take RSAB volunteers for leadership roles within the workgroups.

j. Dr. Roby, then introduced Mr. Rico and Ms. Dodson to speak about the Data Technical Workgroup.

4. CCS Data Availability

a. Mr. Rico thanked everyone present and on the phone for taking the time to be at the meeting.

b. He then introduced Claudia Crist, Deputy Director of Health Care Delivery Systems at the California Department of Health Care Services.

c. Ms. Crist introduced herself, gave some background about her former experience, and invited the board and audience members to introduce themselves or ask questions.

d. Mr. Rico then returned to the topic of CCS data availability

   i. The former DHCS data set went back to approximately 2010 and was analyzed by Drs. Paul Wise and Lee Sanders of Stanford.
   ii. The new set of data covers up to 2012 and is available here. (http://healthpolicy.ucla.edu/programs/health-economics/projects/ccs/Pages/ccs-data.aspx)
   iii. The intent of the data workgroup will be to support the data needs of the RSAB as a whole and the workgroups individually.
   iv. The members of the data workgroup at this point are: Ann Kuhns, Dr. Lee Sanders, Dr. Anand Chabra, Anthony Rose, Dr. Tom Klitzner, and Brian Kentera.
   v. Next, Mr. Rico introduced Mr. Kentera to walk through some of the new data set.

e. Mr. Kentera thanked Mr. Rico for the introduction and gave some background information on his expertise and experience relating to the CCS data.

   i. He then went over a chart of fee-for-service claims data combined with eligibility data.
   ii. Mr. Kentera explained that the new data set is statewide. However, he is working on narrowing the focus to counties.
   iii. The initial cut will be identifying the Medi-Cal only population for the 2012 data.
   iv. The data being shown is an attempt to provide the entire picture in the comprehensive care of the child, within what is available in the fee-for-service claims data set.

f. Ms. Kuhns asked to clarify if “non-CCS authorized” means “non-CCS Medi-Cal”.

   i. Mr. Kentera answered that the data represents what patients received under the Medi-Cal program, so it would include Medi-Cal benefits that are not under CCS.

g. Ms. Hensler asked for clarification if the data includes capitated claims through fee-for-service.

   i. Mr. Kentera answered that no, the data does not include managed care.

h. Stuart Cohen asked if data on claims submitted from non-CCS facilities could be provided.

   i. Mr. Kentera answered that the data being shown represents paid claims only, so denied or unpaid claims are not in the data set.

i. Devon Dabbs asked if claims for children under 2 months are billed under the mother or Medi-Cal member and if that data is included in the set.
    i. Mr. Kentera answered that Ms. Dabbs comment is a good example of the limitations of the data set. That is something to highlight in order to be forthcoming with and to address the limitations of the data set.

j. Chris Dybdahl commented that the pool of unpaid claims should have been paid and identified that as a feature problem with the existing program for providers.
    i. Mr. Kentera answered that this issue must be discussed and highlighted and that it would require lots of data coming from actual providers and lots of data work on the DHCS side.
    ii. Dr. Roby suggested that if one county partner was willing to provide examples of denied or unpaid claims, DHCS could potentially use that type of information to analyze the "34" file which collects some of that information, which is not included in the "35c" file that only contains paid claims.

k. Mr. Kentera concluded his presentation by going over an excel pivot table on county, category of service, diagnosis, number of clients in subgroups, and reimbursement amounts for their claims.

l. Ms. Dodson thanked Mr. Kentera from his presentation and highlighted how pleased everyone is to have the data component.

m. Nick Anas asked if the reimbursements were for facilities, physicians or both.
    i. Mr. Kentera answered that it is for both and that depending on which table you are looking at the ability to drill down further exists.

n. Ms. Soman suggested that working with Xerox may help to gather information about unpaid claims.
    i. Mr. Kentara commented that he works closely with Xerox and that he can facilitate interfaces with them.

o. Dr. Roby thanked Mr. Kentera for his presentation and solicited volunteers from the RSAB for the data workgroup. He also announced that Dr. Sanders and Mr. Kentera would be the co-chairs of the group, Michaela Ferrari will be the UCLA staff person, and that he will be facilitating.

p. Dr. Roby then announced the next session and that a lunch break would follow. He encouraged the RSAB to review the survey results document and to discuss them amongst themselves during the break.

5. Vision for the CCS Program, Survey results, and Technical Workgroup Topics (Continued)

a. Dr. Roby summarized the remaining sessions for the meeting, announced that Leapfrog will be doing graphic recording in the background, laid out the ground rules for the upcoming discussion, and prescribed roles.

b. As a starting point, Dr. Roby summarized the RSAB survey and its results.

  i. There were 25 respondents that answered most of the questions.
  ii. Under the category of successes, 44% identified specialized care and delivery,
    a) Respondent answers differed in that some identified this quality as a success while others identified the same quality as a challenge.
  iii. Under the category of challenges, the most common response (56%) was that the carve-out prevents whole child care.
  iv. The other qualities identified as challenges included reimbursement, lack of staff, regional inconsistency, quality standards and enforcing quality standards, data issues, cost, and lack of coordination

c. Ms. Dodson commented that she believes regionalization with regards to expertise is appreciated but that inconsistent regionalization is viewed as a challenge.

d. Ed Bloch pointed out that these are perceptions and opinions and that evidence exists that is more objective and would argue against some of this opinion.

e. Dr. Roby then directed the RSAB to the survey results document and pointed out that the open-ended comments are all documented for their review. He encouraged the RSAB to review the document during the break and then announced a lunch break.

6. Lunch Break

7. CCS Program Components that are "Working Well"

a. Ms. Padilla called the meeting back to order and asked if any RSAB members calling in could identify themselves on the line or email Ms. Ferrari. She then handed the floor over to Dr. Halfon.

b. Dr. Halfon began by describing the focus of the session, things that are working well, and announced that Dr. Roby would be facilitating the next session, things that need to be improved.

  i. Dr. Halfon commented that some of what we think is working well also needs to be improved depending on how we define working well.

ii. Dr. Halfon also commented that the CCS population is very heterogeneous. So, what is working well for one may be oversimplification and not necessarily working well for all.
iii. Dr. Halfon made the analogy of the CCS program to a Lego set and that in redesigning the program and identifying what is working well is like picking the Lego pieces of the previous build that will be included in the new build. Furthermore, identifying what pieces would no longer be used, and what pieces need to be new and different.
iv. Dr. Halfon then asked the RSAB for their input on what is working well with respect to specialized care.

c. Ms. Soman commented on studies showing that the standard of care set by CCS are in actuality the standards for the entire pediatric system in California and that they need to be preserved.

i. Dr. Halfon expanded on Ms. Soman’s comment and asked the RSAB how we can make sure that these standards are implemented optimally and how we can update and improve the standards as we move forward.
ii. Ms. Kuhns commented that she felt Ms. Soman meant that the standards have enabled a high-quality regionalized system of care and that the standards specifically exist and act as a greater set of standards for California pediatrics.
iii. Ms. Soman expressed her agreement with Ms. Kuhns and added that the two pieces are linked. The regionalized system of care is documented which then points to the standards that were created and are maintained.
iv. Dr. Halfon discussed that thinking about standards, we are talking about standards for delivery at an individual level, standards for how the system should be organized, and the performance of that system.
v. Dr. Bloch commented that he did not see how regionalization guarantees that the standards are upheld.
vi. Clarification was offered that the standards result in regionalization of care. So, special care centers become regional centers of excellence.
vii. Dr. Halfon then added that enforcing the standards is a whole different issue.
viii. Dyan Apostolos commented that for some, special care centers are located far away and specialists are not available in their areas. Visiting special care centers is imperative despite local providers’ desire to see them to gain experience.
ix. Dr. Klitzner added that the regionalization issue is related to the payment model. Prior to Medicaid managed care, unqualified providers could be reimbursed by “TAR-ring” (TAR: Treatment Authorization Request) and receiving fee-for-service payments from Medi-Cal which were equivalent to CCS payment at the time. When managed care began, it made sure that those cases went to CCS which means that the standards were incentivized by payment. Retaining that incentive towards regionalization is important.

d. John Cleary commented that when answering the survey the context of answering what's working was what respondents were afraid of losing in the event of wholesale change to the program. The labeling of a specific item as what's working does not mean that it need not be improved.
   i. Dr. Halfon expanded on Dr. Cleary's comment and asked the RSAB what the optimization strategy would be for these things that are working well.
   ii. Dr. Bloch commented that there is always room for improvement and that one area that needs improvement with respect to regionalization is the hub and spoke model. The system needs a better way to triage that allows for optimal use and frees space for those who benefit most from regionalized tertiary care.

e. Stuart Cohen commented that communication between primary and specialty care is not as good as it was and that a solution would be to use IT systems to link the two.
   i. Dr. Anas commented that e-referrals exist where communication between primary and specialty care providers amounted to wasted visits. However, he also specifies that in some cases these visits are beneficial.
      a) Dr. Halfon asked for clarification on where this is happening.
      b) Dr. Anas answered, San Francisco General and that an adult gastroenterologist designed the component.
      c) Dr. Halfon mentioned a system at Cincinnati Children's called C3N that is a robust system of coordination that has vastly improved care for children in that network.

f. Dr. Halfon summarized that in exploring care coordination optimization, some of the ideas that came up are better use of technology, risk stratification, and tiered care.

g. Ms. Kuhns stressed that related to Dr. Schor's earlier point, some cases exist where community hospitals hold onto cases as long as they can and then, by the time they get to the specialty care centers, they are extremely sick.
   i. Dr. Halfon commented that there is a Cleveland model that accounts for that through a robust connection between faculty and community hospitals.
   ii. Ms. Kuhns clarified that the main idea is to welcome improvement. But, we must be cautious that we do not create more problems.

h. Dr. Halfon then asked the RSAB how these standards can be optimized.
   i. Katie Schlageter commented on care coordination mentioning that LA is doing a great job and hearing more about that would be beneficial.
   ii. Ms. Apostolos added that Monterey County is also part of a collaborative working on improving care coordination and that a more robust health information exchange would help in care coordination.
   iii. Juno Duenas commented about linking families, assuming that families have the information they need to make choices, to understand the system, and what they can do to make that system accountable.

i. Ms. Soman commented that the special care center and multidisciplinary approach are things we would not want to lose. She also mentioned that the concept of the broadest possible network is another thing worth retaining.

j. Ms. Apostolos commented on quality standards stating that it would be helpful if some of the CCS eligible conditions could be registered with national quality standards and that reporting for those conditions could become institutionalized.

k. Dr. Schor commented that the discussion is leading towards policy making based on opinion and impression rather than solid data.
  i. Dr. Halfon summarized that it would be helpful to have a set of outcomes that we strive for and that creating a kind of driver diagram would aid in the design process and in identifying what we need to measure moving forward.
  ii. Dr. Bloch offered that we can do both of these things and that we are trying to do both of these things.
  iii. Ms. Calvin added that we are a long ways from understanding the impact on children and families if we are to make these large moves without data and a baseline to compare to.

l. Dr. Halfon then outlined the other topics within the working well category as financial models and multidisciplinary support.
  i. Dr. Bloch defined the CCS financial model as a risk-based financial model where an enhanced payment is made for caring for children with complex needs. He went on to say that we need to ensure that special care centers are doing their part of the coordination and if we find that they are not, we need to do it. In terms of financial ideas, he mentioned that there are savings to be had by not double paying for primary care.

m. Ms. Cullum commented that special care standards, although a bit outdated, allow for comprehensive and thorough multi-disciplinary care. That piece is working well in terms of reimbursement for the San Francisco center as well as other centers that have duplicated the model.
  i. Dr. Halfon commented that there needs to be a design element where only the kids that need the multidisciplinary team receive it, and that these resources are not wasted on those without need.
  ii. Ms. Cullum commented that it could be acuity based but also that there must be points of re-assessment.

n. Ms. Dodson interjected that the conversation has migrated into a discussion of models, which is a good thing, and that DHCS is glad to hear all of the input from the experts. She then asked Dr. Roby if we would be moving on to the next session.

8. CCS Components that "Can be Improved"

a. Dr. Roby stated that the most prominent response to this section is the issue of whole child care and that the carve-out prevents this.
   i. Ms. Soman commented that the carve-out does not necessarily cause fragmentation. CCS and non-CCS services could be better coordinated. However, the heart of the discussion needs to be that the child and family are the focus and not the body part or condition. How we manage payment is a separate issue.
   ii. Ms. Duenas added that a child cannot be disconnected from their family and that these children should not be seen as widgets with things being done to them.

b. Ms. Schlageter commented that it is very confusing to figure out what CCS is coordinating and paying for vs. what managed care is coordinating and paying for. She identifies this as inefficiency.

c. Amy Carta commented that when care coordination is broken apart, it becomes an argument about who is responsible, like a hot potato. She also mentioned that sharing a child's entire medical record and being able to have a conversation with all of those involved begins to get into whole child care.
   i. Dr. Roby asked the group to discuss communication versus coordination.
   ii. Maya Altman commented that having a single accountable entity is not necessarily the answer and that communication between the parts is possible and an improvement. Having a single accountable entity is not itself sufficient but a baseline necessity.
   iii. Dr. Bloch added that the whole child concept comes down to shared accountability and shared responsibility. Each component can contribute, like an instrument in an orchestra, but someone must be conducting. As of now, the conductor is the family, and families can use some help. A medical home, someplace where these pieces come together can help to manage that everyone is accountable for what they should be.
   iv. James Gerson commented that regardless of how the model is set up, communication allows for interdisciplinary care and having a team that looks at the home and owns the needs of the member, not just one aspect of that member is important.
   v. Dr. Bloch suggested that instead of there always being one person who is responsible, that there is always a team and that team will be configured to the needs of the child and family. However, he asks how will that team be created when there is no tertiary care infrastructure?
   vi. Ms. Kuhns added the question, how can we help provide support to families to empower them and to instruct them of where and whom to go to when things are not working to make sure the system works for them?
      a) Ms. Duenas answered that there should be a first resort instead of a last resort. As an example she offered the story of her daughter's stolen wheelchair and all of the involved parties disagreeing about who should

pay for the replacement wheelchair with the family and child stuck in the middle without a wheelchair.

vii. Dr. Roby summarized that there is care coordination support out there. However, one person may be very informed about a single aspect of care but not others. Of course, communication between the parts will help. But, perhaps there needs to be some underlying training or baseline so that all members of the team have a basic understanding of how the system works.

viii. Ms. Soman echoed Ms. Altman's comment, saying that there is a natural tension in who is ultimately responsible in a team. What falls through the cracks? Who is responsible for answering that?

d. Mr. Dybdahl commented on Dr. Roby's question to CCS counties about case management. He stated that quality varies by county, the experience of who is doing it, the problems faced by a particular provider / set of providers, and the challenges the family has. That being said, he stated that it can be very effective and that is a goal within his county. The case manager's job is to answer the hard questions like are you doing anything or trying to do something; whether it be the family asking or the primary care physician.

   i. Ms. Hensler commented that they do not question certain things when they have standardized protocols. The goal is to get what the family needs right away.

e. Ms. Apostolos commented that in trying to develop a care collaborative they learned that as many as 6 different organizations are working to resolve issues and link the family to different services and that there is no communication between those organizations. So, a family services center is critical. It is critical to have one responsible person to coordinate the coordinators.

   i. Ms. Schlageter commented that it is very difficult to bring all of the organizations together. In Alameda County, they are working to join the pediatricians at Children's Hospital in Oakland with a nurse case manager to roll out all of the sub-specialties.

f. Ms. Carta expressed her appreciation for Ms. Duenas' comments on the whole child. She explains how a child's care changes and evolves over time. So, in an effort to best benefit the child and their family, the idea is to find the simplest way to share information and establish some accountability. However, at different times, different agencies will need to step up in different ways depending on the needs of the child and their family life.

g. Ms. Soman asked to change gears and to address funding and the fragile provider network in California. She points towards data that suggest the provider network is aging away and not being replaced, particularly in rural areas. This is driven by financing. Thus, despite efforts to improve the system, without providers, there is no care.
   i. A comment was made that financial incentives need to be aligned with the hospitals and clinics. As of now, hospitals are paid under the DRG model and physicians are paid on a fee-for-service model. These are not aligned. There needs to be attention paid to the transition. He comments that he believes all of the RSAB understand what needs to happen. It is the how to get there that is a problem.
   ii. Dr. Cleary commented that the data points to areas where the majority of funds go. He suggests transparency about financial angles, shared saving, and honest oversight.

h. Dr. Roby then introduced the next session and excused everyone for a short break.

9. Break

10. Additional Information Needed to Make Decisions

a. Jess Schumer announced the last session and described it as, what we need to know to create the technical workgroups, what their focus should be, what things we want to maintain, and what information we need about high achieving examples. She opened discussion to the group and asked for feedback on what they want to know to make further decisions, what models and options should be reviewed, and what type of information activity will help drive the technical workgroups, as well as external insight that should be incorporated.

b. Ms. Calvin suggested having a different family for each meeting to identify the problems that they are facing and for the board to solve that problem.
   i. Dr. Halfon suggested creating 4-5 prototypes of children/families with different conditions in different areas in an effort to model these technical problems, without using actual patient data or individual families.
   ii. Ms. Dodson expressed her concerns about confidentiality.
   iii. Mr. Dybdahl suggested that administrators and counties could bring samples of problems that are especially frustrating to get a sense for what counties and families are up against.
   iv. One of the problems is the lack of good data. What we need to know depends on what problems we are trying to solve. The state's goals are to better integrate services and improve the whole child focus.
   v. Ms. Dabbs added that she would like to have actual problems and wonders if there is some way to survey families about what they really want the RSAB to know, what is happening in their lives and what challenges they face.

    vi. Dr. Halfon summarized that his suggestion was to create family situations out of the experiences of real families to aid the design process as a check to make sure that the program handles these types of issues. He mentions that the data does not exist for things like this.
    vii. Ms. Soman suggested a deeper dive into the Title V survey data. She also mentioned that the Family Voices summit and the CRISS conference have panels of families to comment on what works, does not work, and concerns for their children.

c. Dr. Roby addressed the evidence and data issue with the data workgroup's future work, describing it as additional evidence we would need to judge the models, the various problems, and their importance.

d. Dr. Bloch added that he could present the project done in LA County to illuminate case management and care coordination redesigned.

e. Ms. Kuhns suggested an outcomes and baseline measurement workgroup.

f. Ms. Carta requested that the data be compiled of CCS only data not Medi-Cal CCS data.

g. Dr. Bloch suggested that, in terms of provider networks and access, density of pediatricians and where children's hospitals are located is a key issue.
    i. Dr. Roby asked for clarification if this is a separate issue from lack of staff and providers
        a) Comment was made that they are separate because they have separate solutions.

h. Dr. Roby clarified that we should not be restrained to one model that would meet the needs of the overall population. Flexibility and regionalization are important. There is no cure all fix. Instead, it would be components of different models that can be duplicated or pulled from, like a toolkit that everybody should have access to. There can be standards in terms of quality and monitoring or standards in terms of developing better coordination and communication. It is up to the RSAB to decide what the recommendation will be.

i. Ms. Soman reiterated the need for a framework to work within to measure proposals. She also mentioned that, on the one hand, work is done to reduce inappropriate inter-county variation while, on the other hand, it is being said that we can have different models, perhaps geographically. Large scale providers dislike variation and she assumes that families will dislike it as well. This inconsistency should be addressed to inform the RSAB about the framework for how to proceed.

j. Ms. Kuhns suggested that the workgroups will allow for conversations about topics where consensus is difficult to reach for the RSAB as a whole. One such topic is who or what should be the medical home and who or what should be the Affordable Care Organization (ACO). Thus, she suggested a workgroup that addresses framework / medical home.

k. The eligibility issue was suggested as an important topic for a workgroup. We should conserve program resources for children who really need it and expand resources to children who have no access now.
   i. Ms. Apostolos seconded the suggestion.

l. Ms. Duenas commented that there is a need for data about the cost to families. Children are becoming more complicated, expectations rise, and costs escalate. We need to look at what families can actually do and make sure we help them do it.
   i. Dr. Roby clarified that technical workgroup members need not be RSAB members.
   ii. Ms. Duenas clarified that she does not want a family workgroup. Instead, the cost to families concept could be used by workgroups to measure outcomes. An example of this is missed school days and missed work days. If the system is working properly and the children are receiving the services they need, they shouldn’t be missing school and their parents shouldn’t be missing work. So, if you have an outcomes workgroup, families need to be a part of it to ensure that the outcomes being measured are things that have real world societal meaning for the customer.

m. Dr. Halfon asked what the protocol will be for workgroups communicating with one another.
   i. Dr. Roby clarified that the model would be bi-weekly conference calls and webinars when necessary. For instance, a workgroup may task the data workgroup with an analysis. In this case, someone from the specific workgroup may have to work with the data workgroup on that issue. Once the analysis is complete the results would be given to that specific group or the RSAB as a whole. It is flexible. These are like technical assistance teams.
   ii. Dr. Halfon commented on the volume of interdependent data.
   iii. Dr. Roby clarified that the data workgroup will probably get lots of requests. So, they may have to triage analyses to Stanford or UCLA etc. But, they would advise the RSAB, DHCS, and UCLA on what the data looks like and what they can do.

n. Ms. Dodson outlined the workgroups that DHCS envisioned as eligibility/condition, data, fiscal, outcomes / care coordination, access and provider network, outcome measures and quality, and possibly health IT and electronic medical records. Also, transition as a stand-alone group or as a sub-topic within other groups and Medical Therapy Program (MTP) as it relates to how we think about the options and solutions that will help the community. Finally, partners and how they would be integrated. Perhaps that would be the same group as MTP.

   i. Ms. Soman requested further clarification on what each group's scope would be.
   ii. Ms. Dodson clarified the eligibility and condition scope. What are the current definitions, what are the things that we can come to consensus about, what the fractures are, what the regional inconsistencies are, and what the potential solutions are.
   iii. For data, Ms. Dodson stated that the group would serve as a hub for data questions, combining data resources, and modeling.
   iv. Fiscal has an interaction with data. They may be separate or they may be the same group. What makes sense? What are the potential outcomes? Are there incentives that would be built in? Also, how does county funding fit into this? What are the options, pros, and cons?

o. Ms. Soman suggested that the fiscal and data group be separate. Fiscal is two-fold, one incentivizes appropriate care and the other is the state-county fiscal relationship.

   i. Ms. Kuhns added that although they would be separate, it would need to be integrated into the broader discussions and workgroups.
   ii. David Souleles commented that it depends on how you want the new system to work. The existing financing structure may not fit the new model. He also suggested a review of the current financing structure, the state-county match, current barriers, county risk, and state risk.
   iii. Ms. Kuhns agreed that a review of the state-county fiscal relationship and the MTP program would be beneficial.
   iv. Dr. Roby clarified that not all of these topics need be workgroups. Some of this information may come from DHCS or UCLA.
   v. Ms. Kuhns suggested that the financing workgroup focus on fiscal incentives. Once agreement is reached, the next step would be the state-county financial relationship.
   vi. Dr. Roby asked if this should be for the whole group or the fiscal workgroup and Ms. Kuhns suggested that it be global.
   vii. Judith Reigel echoed the need for information on the state-county federal financing model. She also expressed confusion about how financing and model workgroups can be separated.

p. Ms. Kuhns commented on the outcome measures and quality group asking what data is available and what can be made available to the group. Focus could be priorities for measuring a new system or evolved system and distinguishing process measures and outcome measures while incorporating quality throughout.

   i. For access and provider networks, Ms. Kuhns outlined the importance of geography, and interacting with the data group to determine the capacities, supplies, and demands as important.

q. Ms. Kuhns also commented on the health IT and electronic medical records group. Should this be a separate group? What state systems need to be improved?

r. A comment was made that the EMR portion is medical home and care coordination and is also related to data. Clarification on the role of the state is generally desired amongst the RSAB.

s. Dr. Roby summarized that there is now a long list of workgroups and that they may not be finalized today. He suggested considering posting of notes online to define each workgroup and perhaps a survey to determine which are most relevant instead of trying to identify five or six and getting volunteers.
  i. Ms. Dodson stated that DHCS' preference would be to try to identify at least 5 that are the most popular to get those started.

t. Dr. Rabens asked for clarification if the access and provider network group will also address transition to adult networks.
  i. Dr. Roby clarified that DHCS suggested a separate transition group.
  ii. Ms. Soman added that transition would also tie in to medical home and care coordination.
  iii. Dr. Roby added that it would tie in with quality as well.

u. Ms. Kuhns, Ms. Soman, Dr. Bloch, Dr. Halfon, and Dr. Roby conversed about the link between models and fiscal and whether they should be separate groups.
  i. Ms. Kuhns concluded that she feels the fiscal component should be plugged in once goals are established, aligning fiscal incentives with the goal. If it were the other way around the redesign would be fiscally driven instead of care driven.
  ii. Ms. Soman agreed that it makes no sense to discuss fiscal incentives without knowing what to incent for. She went on to state that the model should be built on the positives and that would be a logical place to start.
  iii. A comment was made about not having a fiscal workgroup. Instead, to have the RSAB as a whole look at models, and then once a model is chosen, plugging in the fiscal incentives.
  iv. Ms. Christie asked the RSAB if discussion about the models would include eligibility or if it would be a separate group.
  v. Ms. Apostolos answered that she advocates keeping it separate at this time. She explains that defining the population should preclude model discussions and that eligibility should be a separate group.
  vi. Dr. Roby reminded the RSAB that the fourth meeting will focus on design and will be informed by all of this work. He clarified that the model group would not be making a decision on what model to adopt for the RSAB.

v. Dr. Bloch suggested a group focusing on management structure and responsibilities that includes family participation.

w. Comment was made about evaluating models and suggested that this tool would be valuable in preparation for the next meeting.
  i. Ms. Soman clarified the concept as criteria for evaluating models.
  ii. Ms. Apostolos added that principles should be included with the criteria.

x. Ms. Soman asked if Dr. Roby suggested a framework group.
  i. Dr. Roby clarified that a framework standard criteria discussion could be had and that it may be a part of another group.

y. Dr. Roby also clarified that the workgroups could be where the prototypical families would come into play with the groups reporting back to the whole.
  i. Comment was made that the Title V data should be used and that what the hypothetical family would accomplish is uncertain.
  ii. The hypothetical family was then discussed with Dr. Halfon stating that it would not be representative of the CCS population as a whole.
  iii. Dr. Halfon responded that they would not be representative. They would represent different kinds of issues and problems that families face. They would be built out of data but would be hypothetical and not necessarily representative.
  iv. Ms. Kuhns added that similar hypothetical cases were created for their Packard survey of the AAP membership. They were not intended to be representative. But they came from knowledge, surveys, and data. It is not scientific but it is a frame that helps to evaluate the model.
  v. Dr. Halfon summarized that function drives form, and form drives finance.

z. Ms. Soman suggested going forward with workgroup formation, seeing what happens with models, moving into the “driving simulation” with each model, while involving real life families if possible.

aa. Ms. Cullum suggested that the model and the fiscal incentive is what will drive everything else. So, she suggested that one of the groups be reserved for that.
  i. Ms. Kuhns disagreed with Ms. Cullum and would not like having one group discussing models independent of the rest of the workgroups and their work.
  ii. Ms. Cullum clarified that she does not want the workgroups to be chosen and model fiscal incentives not be one of them.

bb. Dr. Roby then summarized the workgroup topics and their connections and called the RSAB to vote on the most important.
  i. Health home care coordination / transition was the top choice. Eligibility and condition, outcomes measures, and quality and provider access network rounded out the four chosen with data being a given fifth.
    a) Ms. Dodson commented that a workgroup will be established to cover the state-county fiscal relationship.

cc. Dr. Roby then thanked the RSAB for their votes and cooperation, introduced Mr. Rico and Jessica Schumer and outlined the remaining sections of the agenda.

11. Reflections about the Goals identified for the CCS Program & CCS Population

a. Mr. Rico briefly summarized the take away points as: implement patient and family centered care approaches, improve care coordination, maintain quality standards, streamline delivery system, build on lessons learned, and to pursue triple aim cost efficiency wherever possible. He then thanked everyone and concluded his talk.

b. Dr. Schumer summarized things that are working as: the specificity of goals, making sure we know exactly what we're looking for, being data driven, not doing wholesale change, starting with outcomes and working backwards from there, transparency with regard to payment systems and financing, child and family focus accountability.

12. RSAB Members Questions and Comments

a. Dr. Roby opened the floor to questions from the RSAB.

b. Ms. Calvin thanked Dr. Roby for doing an excellent job in facilitating the workgroup selection process.

c. Dr. Rabens asked for clarification on the models workgroup.
  i. Dr. Roby answered that the next meeting will include presentations representing some of the ideas for the different models and asked the RSAB to think about how the models align with their goals.

d. A suggestion was made that Ms. Dabbs present on the pediatric palliative care waiver model.

e. Ms. Padilla corrected Tony Maynard's emailed votes for the workgroups with the change not affecting the outcome.

f. Dr. Roby clarified that UCLA is doing a comprehensive literature review of various models and developing a compendium. However, if there are specific innovations that are happening in other states, please send them to UCLA so that they may be included and send them to DHCS to see if we may identify an expert to speak.
  i. Ms. Dabbs suggested models in Michigan and Ohio, both effective in coordinating care. She mentioned that one of the medical directors for Kaiser in the Bay Area works with the program in Michigan and may be a good speaker.
  ii. Dr. Roby asked for clarification on the Ohio program asking if it is the nationwide children kind of ACO, pediatric ACO, pilot or something else.
  iii. Ms. Dabbs stated that she believes it is a different one.
  iv. Dr. Roby asked Ms. Dabbs to send in any information about it that she had so that UCLA can track it down.

13. Public Comments

a. Dr. Roby opened the floor to public comments.

b. Harriet introduced herself as the chief therapist for the MTP program in Orange County. She directed the RSAB to a position paper drafted by a group of MTP administrators that can be found on the DHCS website under stakeholder input documentation. She expressed her joy in hearing that MTP is a goal for the RSAB and considers the MTP as integral for CCS. She commented that families have been receiving hands-on care, care coordination, and case management from the MTP for decades, and despite restrictions and limitations, the MTP provides a framework and model that can be strengthened and broadened. She expressed that if a whole child model evolves from this process, MTP could be expanded to the role of medical home for those patients with medical Therapy Unit (MTU) eligible conditions or perhaps even extending it into the general program. She urged the RSAB to refrain from ignoring the MTP and continuing to back burner the issue.

   i. Addressing a question clarifying the population within MTP, she answered that 40-50% of patients have cerebral palsy and the remainder have muscular dystrophy, spina bifida, or acquired spinal cord Traumatic Brain Injury (TBI). Some of the other children have lesser known and rarer diseases.
   ii. She mentioned that the eligibility criteria are outdated and need to be revisited.
   iii. She also pointed out that the children who use MTP are some of the most costly and complex children in the CCS program and that many of them are referred straight from Neonatal Intensive Care Units (NICU) and receive care until they are age 21.
   iv. Ms. Dodson asked how MTP plays a role as a partner to the other players in the system and mentioned that discussion of MTP should be included with care coordination and home health support.
   v. Harriet answered that MTP provides pediatric, orthopedic Durable Medical Equipment (DME), occupational therapist, nutritionist, and social work services directly in the MTU. The MTP pediatricians interface with community pediatricians and the program works with families, schools, regional centers, CCS, Child Protective Services, and fosters.

c. Diane Blitzner commented via email that rural communities have their own set of problems. First of all, resources are scarcer so families must travel long distances to receive care. Because of this, travel and care coordination are at odds when appointments cannot be made on the same day or subsequent days.

   i. Dr. Roby expressed that this will be a consideration of many of the workgroups, thinking about the impact on rural areas not only urban.

ii. Ms. Dodson also commented that DHCS has been thinking about this and has emphasized that more than one model may be adopted. She also mentioned that the rural issue as well as care coordination will be addressed by the access and provider network group.

iii. Ms. Apostolos asked about problems in scheduling more than one visit per day.

iv. Dr. Halfon answered that you cannot bill for two visits to the same office in one day without a special modifier.

d. Ms. Schlageter commented that she really appreciates Harriet's comment about MTP. She went on to inform the RSAB that the program is sometimes separated. But, most kids receive care management in MTP through the CCS admin program. She concluded, saying that most of the board will want to discuss MTP down the road.

e. Ms. Calvin asked for it to be noted that the provider network access group look specifically at rural and underserved areas as well as reimbursement, telehealth and telemedicine.

14. Wrap-Up, Closing, and Next Steps

a. Dr. Roby thanked everyone for coming and mentioned that it is really helpful to hear everyone's opinions and perspectives. He then asked the RSAB to consider volunteering for and nominating members for the workgroups. He reminded them that the DHCS and UCLA websites will be updated with new information and specifically pointed out the stakeholder input sections.

b. Dr. Roby announced that the next tentatively scheduled meeting will occur on 3/20/15 in Oakland. The next meeting will focus on various models and their impact.

c. Mr. Rico also thanked everyone for their participation and asked the RSAB to be on the lookout for emails announcing new materials on the websites.

END