AGENDA
WHOLE CHILD MODEL CLINICAL ADVISORY COMMITTEE

DATE: Thursday, March 21, 2019

TIME: Noon – 12:10 p.m.: Call to Order and Catered Lunch  
12:10 – 1:00 p.m.: Meeting of the Committee

PLACE:  
In Santa Cruz County:  
Central California Alliance for Health Board Room  
1600 Green Hills Road, Suite 101, Scotts Valley, CA  
In Monterey County:  
Central California Alliance for Health, Soledad Conference Room  
950 East Blanco Road, Suite 101, Salinas, CA  
In Merced County:  
Central California Alliance for Health Board Room  
530 West 16th Street, Suite B, Merced, CA

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1. Call to Order by Chairperson Bishop. 12:00 p.m.  
A. Roll call.  
B. Supplements and deletions to the agenda.  
C. Catered lunch for Committee and Staff.

2. Oral Communications. 12:10 p.m.  
A. Members of the public may address the WCMCA Committee on items not listed on today’s Agenda, which are within the jurisdiction of the WCMCA Committee. Presentations must not exceed five minutes in length and individuals may speak only once during Oral Communications.  
B. If any member of the public wishes to address the WCMCA Committee on any item that is listed on today's agenda, they may do so when that item is called.

Consent Agenda Items: 12:15 p.m.
3. Approve WCMCA meeting minutes of January 10, 2019.  
A. Reference materials: Minutes as above.

Regular Agenda Items: 12:20 p.m.
4. Old Business – Updates  
A. Utilization Management  
D. Bishop, MD / DeAnna Leamon  
B. Case Management  
D. Bishop, MD / T. Erickson
5. **New Business**
   A. Quality Reports
      H. Gillette-Walch, RN, MPH

6. **Open Discussion: 12:45**
   A. Group may discuss any urgent items.

7. **Adjourn: 12:50 pm**

The next Whole Child Model Clinical Advisory Committee meeting is on Thursday, June 20, 2019, 12:00 – 1:00 p.m. Locations: Videoconference from Alliance Offices in Scotts Valley, Salinas, and Merced. Members of the public interested in attending should call the Alliance at (831) 430-2621 to verify meeting dates and locations prior to the meetings.
Whole Child Model
Clinical Advisory Committee

Meeting Minutes
Thursday, January 10, 2019
12:00 – 1:00 p.m.

In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California

In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California

In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California

Committee Members Present:
Constance Caldwell, MD Provider Representative
Gary Gray, DO Board Representative
Jennie Jet, MD Provider Representative
Karen Dahl, MD Provider Representative
Liz Falade, MD Provider Representative
Patrick Clyne, MD Provider Representative
Robert Dimand, MD Provider Representative
Salem Magarian, MD Provider Representative

Committee Members Absent:
Amanda Jackson, MD Provider Representative
John Mark, MD Provider Representative

Staff Present:
Dr. Dale Bishop Chief Medical Officer
Suzanne Skerness, RN Chief Health Services Officer
Deanna Leamon UM Manager - Operations
Jane Daughenbaugh, RN Behavioral Health Director
Jennifer Mockus Regional Operations Director Merced
Jordan Turetsky Provider Services Director
Lilia Chagolla Regional Operations Director Salinas
Mary Brusuelas, RN Utilization Management Director
Melanie Rager Care Management Director
Michael Blatt, Pharm D Pharmacy Director
Michelle Stott, RN Quality Improvement Director
Tonya Erickson Pediatric Care Management Manager
Ms. Jacqueline Van Voerkens Clerk of the Advisory Committee
1. **Call to Order by Chairperson Bishop.**

Chairperson Dr. Dale Bishop called the meeting to order at 12:01 p.m.
Roll call was taken.

No changes to the agenda were made.

2. **Oral Communications.**

Chairperson Bishop opened the floor for any members of the public to address the Committee on items not listed on the agenda.

No members of the public addressed the Committee at this time.

3. **Approval of WCMCAC Meeting Minutes**

Minutes from the September 13, 2018 meeting were reviewed. Two corrections were requested.

M/S/A
Minutes approved with edits.

4. **Old Business**

   A. **Utilization Management**

      Concurrent Review (CR) Nurses will have access to a new form for California Children’s Services (CCS) Neonatal Intensive Care Unit (NICU) cases. Once NICU intervention criteria determination is made a CR Nurse will have access to a form to edit and resend letters to the facility that will indicate “NICU intervention hold” on the top of the letter.

      All authorized referrals will be directed to the Case Management team. When CCS questions arise, the Alliance has CCS representatives to connect, but the CM team will also reach out to the counties as well as a CCS resource. Committee discussed pediatric specialist referrals.

      The Transportation Grievance update was presented to the Committee. Very few CCS grievances have been received (approximately 4-5 per month). Non-Medical Transportation has successfully moved to the Member Services department. An approximate 80% success rate in scheduling CCS transportation was noted since the transition.

   B. **Case Management**

      The Alliance is utilizing the Pediatric Health Risk Assessment developed by Health Plan of San Mateo. Case Management staff will oversee the authorizations of all referrals to specialty care. In the future, Case Management staff will also oversee authorizations for DME and PT/ST/OT, to ensure that the appropriate equipment and referrals are in place, and to coordinate care.
4. **New Business**

   A. **Genetics Testing**
   
   Genetic testing authorization requests have greatly increased in the past year. A policy has been developed (404-1715 Genetic Testing) to specify guidelines according to CCS numbered letter 03-0518 authorization of Genetic Testing. Committee discussed the different kinds of testing and panels of which would likely to have significant impact on diagnosis and/or treatment.

   B. **Early and Periodic Screening, Diagnosis, & Treatment (EPSDT) and Private Duty Nursing (PDN)**
   
   Committee reviewed a presentation on the new EPSDT benefit. A policy has been developed (404-1720 Private Duty Nursing EPSDT Benefit) which describes the approval process for PDN under EPSDT Supplemental Services Title 22 Benefit provisions by Medi-Cal Home Health Agencies (HHA) and nurse providers.

   Committee discussed tracking the availability of home health (HH) nursing. Committee member indicated that San Mateo County tracked the availability of HH nurses which is data that eventually benefited their program (ex: how long from referral to resources, hours, how long it takes to provide the HH nursing.)

   C. **High Risk Infant Follow-Up (HRIF)**
   
   California Department of Health Care Services (DHCS) clarified that eligibility for HRIF would be determined by each County, when reviewing NICU stays. These referrals will be submitted to the County by the Alliance going forward. This will ensure no impact to providers. This will ensure the children are captured in the CCS census.

   Committee discussed referrals to regional centers. The Alliance has a group of nurses in the pediatric case management team that connect children with developmental disabilities with “Early Start”, the regional centers, and the school districts to ensure they have an Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP). The county funds home visiting nursing, for high-risk children; some hospitals provide nurses through Coastal Kids.

   D. **Pediatric Palliative Care**
   
   The Palliative Care waver ended on December 31, 2018, and Pediatric Palliative Care is now the responsibility of the Health Plans. Presently nine children in Santa Cruz county have transitioned from the waver into the Alliance’s Pediatric Palliative Care program. The Alliance is working diligently to ensure this program is provided in all three counties. The diagnoses and components of the program were discussed. Members will be identified for these services by primary and specialty care providers and referred via a prior authorization process. Committee discussed the assurance of continuity of care for these members.

5. **Open Discussion**
Chairperson Bishop opened the floor for the Committee to have open discussion.

Committee discussed CCS eligibility for non-citizen children.

The meeting adjourned at 1:00 p.m.
Respectfully submitted,

Ms. Jacqueline Van Voerkens
Clerk of the Advisory Committee

The Whole Child Clinical Advisory Committee is a public meeting.
**Topic:** Transition of Pediatric Authorizations from UM to Pediatric Case Management team to support WCM

- **Q4 2018:** Transition of CCS Liaison Functions; Transfer of auths to Peds CM team: Authorized Referrals
- **Q1 2019:** Transfer of auths to Peds CM team: Rehab Therapies (PT/ST/OT), DME
Whole Child Model Grievances:

- November 2018: 5 cases were received from WCM CCS members. 3 cases involved transportation: 2 late pick-ups and 1 regarding appointment scheduling, and 2 cases involved DME issues: 1 regarding wheelchair parts and 1 regarding feeding supplies.

- December 2018: 4 cases were received from WCM members. 3 cases involved Alliance denial of services: 2 glucose monitoring and 1 genetic testing. 1 case involved access to a PCP office.

- January 2019: 3 cases were received from WCM members involving Alliance denial of services: genetic testing, organ transplant and brain imaging.
Pediatric Health Risk Assessment

- We continue to find the majority of families assessed benefit from Care Coordination, but do not require ongoing Complex Case Management services.

Identification and Referral of CCS-eligible Members

- The CM Intake Coordinator (IC) Team now supports CCS Coordination functions related to identification, referral, and CM assignment of CCS-eligible members. The IC Team also supports County CCS Programs when records are needed to complete the CCS annual medical review.
- Integrated CM-UM Functions
  - CM staff continue to oversee all referrals to specialty care for the pediatric population. CM staff will also be authorizing PT/OT/ST and rehab-related DME by the end of Q1.
  - This integration of UM and CM functions enables the Case Manager to monitor access to specialty care, ensure appropriate referrals and equipment are in place, and support care coordination with MTP, schools, and other entities.
DISCUSSION/ROUND TABLE
WHOLE CHILD MODEL: PROPOSED DHCS PERFORMANCE MEASURES

Hilary Gillette-Walch, RN, MPH, CPH
Clinical Decision Quality Manager

Whole Child Model Clinical Advisory Committee
March 21, 2019
- Interdisciplinary group selected by DHCS
- Met monthly Jan – July 2018
- Drafted measures:
  - Access to Care (3)
  - Care Coordination (4)
  - Family Participation (1)
  - Quality of Care (2)
  - Transition Services (1)
- DHCS still working to determine:
  - If they will use a continuous enrollment requirement to include a member in a measure
  - If there is a continuous enrollment requirement, whether an enrollment gap will be allowed

= NCQA measure, therefore we have baseline and ongoing data.
Performance Measure 1 (Revised)

Percentage of CYSHCN 1 –19 years of age who had a visit with a primary care provider during the reporting period

- **Numerator**: Number of unique children, within the defined age range, *enrolled in CCS*, who had a visit with a PCP during the reporting period
- **Denominator**: All unique children, within the defined age range, *enrolled in CCS* during the reporting period

**Note**: stratified differently than the NCQA measure, no national benchmark
Performance Measure 2 (Revised)
Percentage of CYSHCN 12 –20 years of age screened for clinical depression, and if positive, has a follow-up plan documented on the date of the positive screen

- **Numerator**: Number of unique CCS enrolled children within a calendar year screened for clinical depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen

- **Denominator**: Number of unique children 12 –20 years of age CCS enrolled within a calendar year

**Data Source**: FFS claims/authorization data and MCP/ACO eligibility, authorization, and encounter data

**Note**: Stratified differently from NCQA, there will be no national benchmark
Performance Measure 3 (Revised)

Utilization of out-patient (OP) visits for CYSHCN [Ambulatory Care (AMB)]
- **Numerator:** Number of OP visits
- **Denominator:** 1,000 member months

Utilization of prescriptions for CYSHCN [Needs development]
- **Numerator:** Number of Prescriptions
- **Denominator:** 1,000 member months

Utilization of mental health services for CYSHCN [Mental Health Utilization (MPT)]
- **Numerator:** Number of Mild to moderate mental health visits
- **Denominator:** 1,000 member months

Further definitions required from DHCS to finalize
**Performance Measure 1 (Revised)**

- Percentage of CYSHCN with select conditions (*cystic fibrosis, hemophilia, sickle cell, leukemia, diabetes*) who have a documented visit *with a specialist, subspecialist or SCC* within 90-days of referral
  
  - **Numerator**: Number of unique *CCS enrolled* select conditions who have an initial visit with a specialist, subspecialist or SCC within 90 days of an authorization, prior authorization or SAR
  
  - **Denominator**: Number of unique *CCS enrolled* children with an initial authorization, prior authorization or SAR

- **Data Source**: Fee-for-service claims and encounter data

- **Alliance status**: Need to modify existing referral report or create a new report or purchase from vendor. Need to explore if/how we receive claims from our specialty care centers.

- **Next Steps**: Build with Analytics once technical specifications are finalized

*Diabetes type 1 and 2 planned*
Performance Measure 2 (Revised)

The number of acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days, and had a predicted probability of an acute readmission for CCS enrolled children <21 years of age

- **Numerator**: Number of unique CCS enrolled children with at least one acute readmission for any diagnosis within 30 days of the index discharge date
- **Denominator**: All acute inpatient discharges for unique CCS enrolled children <21 years of age, as of the index discharge date, who had one or more discharges on or between January 1 – December 1 of the measurement year

**Alliance Status**: data available, note no national benchmark available
**Performance Measure 3 (Revised)**

**Utilization of emergency room (ER) visits for CYSHCN [AMB]**
- **Numerator**: Number of ER visits
- **Denominator**: 1,000 member months

**Utilization of ER visits with an IP admission for CYSHCN [Needs to be developed]**
- **Numerator**: Number of ER visits with an IP admission
- **Denominator**: 1,000 member months

**Utilization of IP admissions for CYSHCN [Inpatient Utilization (IPU)]**
- **Numerator**: Number of IP admissions
- **Denominator**: 1,000 member months

**Alliance status**: 2 of 3 indicators available in current software, one will need to be developed or purchase from vendor.

**Next Steps**: Build with Analytics once technical specifications are finalized
Performance Measure 4 (Revised)

- Percentage of CYSHCN discharged from a hospital who had at least 1 follow-up contact or visit *(face-to-face or telemedicine)* within 28 days post-discharge

- **Numerator**: Number of unique *CCS enrolled children* with at least 1 follow-up visit within 28 days post-discharge

- **Denominator**: Total number of unique *CCS enrolled children* discharged from a hospital

- **Source**: Fee-for-service claims and encounter data

- **Alliance status**: Need to create a new report.

- **Next Steps**: Build with Analytics once technical specifications are finalized
Performance Measure 1 (Revised)

- Measure 1-A: Family satisfaction by annual survey
- Measure 1-B: Family participation by annual survey

Alliance status: have copy of survey, DHCS still determining next steps
**Performance Measure 1 (Revised)**

Percentage of CYSHCN at 2 years of age who had appropriate childhood immunizations

- **Numerator**: Number of unique *CCS enrolled children* who had certain immunizations by their 2\(^{nd}\) birthday
- **Denominator**: Number of unique *CCS enrolled children* at 2 years of age

**Alliance status**: have software now with baseline data
Performance Measure 2 (Revised)

Percentage of CYSHCN with type 1 or type 2 diabetes mellitus who had a most recent hemoglobin A1c (HbA1c) <8 %

- **Numerator:** Number of unique CCS enrolled children from the denominator whose most recent hemoglobin A1c level during the measurement year is <8 %
- **Denominator:** Number of unique CCS enrolled children <21 years with a diagnosis of type 1 or type 2 diabetes mellitus during the measurement year

**Note:** stratified differently than the NCQA measure, no national benchmark
Performance Measure 1 (Revised)

- CYSHCN 14+ years of age who are expected to have chronic health conditions that will extend past their 21st birthday will have biannual review for long-term transition planning to adulthood

- **Numerator**: Number of 14+ years unique CCS enrolled children charts containing a Transition Planning Checklist within the past 12 months

- **Denominator**: Number of 14+ years unique CCS enrolled children charts with at least one condition that requires a transition plan

- **Data Source**: Chart Audit, Completion of Transition Planning Checklist

- **Alliance status**: Will to create a new report or purchase from vendor. DHCS unsure if it will continue with chart review or examine other means of data collection
NEXT STEPS

- Integrate any changes from DHCS
- Finalize metrics
- Establish tableau based dashboard
- Examine which additional reports would be useful to add to the Provider Portal
- Additional measures
QUESTIONS?

Hilary Gillette-Walch, RN, MPH, CPH
Clinical Decision Quality Manager
P: 831-430-2511
E: hwalch@ccah-alliance.org
Whole Child Model Dashboard

**Access to Care Measures**

**Child and Adolescent Access to Primary Care Services 0-19 years of Age (No Benchmark)**

- Santa Cruz: 97.81% (Baseline), 98.39% (Q3 2018)
- Monterey: 97.93% (Baseline), 97.63% (Q3 2018)
- Merced: 96.12% (Baseline), 96.06% (Q3 2018)

Hold for transition Services: CYSHCN 14+ with biannual review of transition plan to adulthood

**AMB Outpatient Care (PKPY)**

- Santa Cruz: 379.19 (Baseline), 420.30 (Q3 2018)
- Monterey: 396.87 (Baseline), 442.48 (Q3 2018)
- Merced: 343.31 (Baseline), 371.86 (Q3 2018)

**Percentage of CYSHCN with select conditions (cystic fibrosis, hemophilia, sickle cell, leukemia, diabetes*) who have a documented visit with a specialist, subspecialist or SCC within 90-days of referral - Build**

**Promotion of Value**

**AMB Emergency Department Visits (PKPY)**

- Santa Cruz: 55.02 (Baseline), 53.91 (Q3 2018)
- Monterey: 59.68 (Baseline), 58.19 (Q3 2018)
- Merced: 73.40 (Baseline), 70.93 (Q3 2018)

**Total Inpatient Admissions (Number of Discharges per 1,000 Member Months)**

- Santa Cruz: 2.90 (Baseline), 5.49 (Q3 2018)
- Monterey: 4.63 (Baseline), 9.13 (Q3 2018)
- Merced: 4.03 (Baseline), 8.07 (Q3 2018)

Holding for:
- Care Coordination
- RX utilization (Number of Rx per 1000 MM)
- 30 day readmissions
- *Utilization of ER visits with an IP admission for CYSHCN*

Last updated 2.27.19 hgw
Whole Child Model Dashboard

Member Wellness Measures

**Depression Screening and Follow up (12-18 Years)**

- Santa Cruz: Baseline (Q2 2018) 50.00%
- Monterey: Baseline (Q2 2018) 0.00%
- Merced: Baseline (Q2 2018) 0.00%

**Childhood Immunizations - Combination 3**

- Santa Cruz: Baseline (Q2 2018) 55.07%, 2019 MPL 64.20%, 2019 HPL 36.54%
- Monterey: Baseline (Q2 2018) 76.68%, 2019 MPL 78.00%, 2019 HPL 33.99%
- Merced: Baseline (Q2 2018) 33.99%, 2019 MPL 36.54%

**Diabetes in Good Control (HbA1c <8)**

- Baseline (Q2 2018) 12.77%, Monterey 9.43%, Merced 9.17%
- Q3 2018 10.48%, Monterey 6.59%, Merced 8.55%

**Holding for:**
- MH Utilization
- Post discharge visits within 28 days (need specs)
- Family participation survey

Last updated 2.27.19 hgw
WHOLE CHILD CLINICAL ADVISORY COMMITTEE
MEETING CALENDAR FOR 2019

Thursday, March 21, 2019       12:00 PM to 1:00 PM
Thursday, June 20, 2019        12:00 PM to 1:00 PM
Thursday, September 19, 2019   12:00 PM to 1:00 PM
Thursday, December 19, 2019    12:00 PM to 1:00 PM

All Meetings will be held via Video Conference
at Alliance offices listed below:

Alliance Main Office: 1600 Green Hills Road, Suite #101, Scotts Valley, CA 95066
Alliance Salinas Office: 950 East Blanco Road, Suite #101, Salinas, CA 93901
Alliance Merced Office: 530 West 16th Street, Suite B, Merced, CA 95340