

Summary of Provider Focus Groups –Title V CCS Needs Assessment 2018-2020

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## Provider Experiences Working With Medi-Cal Managed Care (MCMC) Plans

(Specifically the ones that serve CCS patients)

The **Benefits** of working with MCMC plans are:

- They are **specialists that accept Medi-Cal** and can serve low-income populations
- **Specialized care that is ahead of other states** in many ways.
- Providers **‘have relatively good control of care from the authorization perspective,’** because MCMC has fewer barriers to getting authorizations than other insurers. In my experiences, commercial insurance with CCS-like services has a lot of trouble with this.

The **Challenges** of working with MCMC plans are:

- **Issues with vendors and delays** in getting equipment; sometimes this is also associated with getting authorizations for equipment. †
  - There are also sometimes specific delays when CCS is denied and then the provider has to go to MCMC for authorizations. “Sometimes there are issues down the road when CCS denies and then MCMC doesn’t pay [either].”
  - Vendors sometimes take advantage of the system: “Some vendors seem to be adding lots of things “laundry list” that seem to just be adding a lot to bill more when it isn’t something that a PT needs.”
  - Vendors also sometimes withhold equipment if they aren’t paid: “Example of patient that has aetna and needed a safety bed and the vendor was trying to get three pieces of

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equipment and then held the bed hostage because aetna didn't pay for it. Then the mom went on social media, and then aetna paid for it, and the child got the bed."

- **Not all CCS patients are clearly identified** to providers by MCMC health plans.
- There are sometimes **issues in continuity of care when children age out.**<sup>†</sup>
- There are sometimes **issues in the ability to treat patients that do not live in the same county as the MCMC health plan.**
- In the past, from the perspective of the providers, it was **difficult for individuals to get or qualify for MCMC or Medi-Cal Fee-For-Service** because subspecialists would not take any other, non-Medi-Cal insurance.
- It is **difficult to get labs and bloodwork done** outside of the hospital because the patient has MCMC and they likely are having their labs done by a specific contractor. Additionally, these lab results are also not sent electronically—whoever the contractors are, they will only fax it to us or we have to go to them and get a hard copy of the file (if they will even share results at all).<sup>†</sup>
- **Children in MCMC that do not qualify for CCS seem to be worse off** than children that do (from the perspective of some focus group members).
- There is **not much communication between CCS and MCMC** despite the fact that there is an opportunity for communication.<sup>†</sup>
- **Medi-cal Managed Care plans don't know about the diseases of the patient population they are taking on:**<sup>†</sup>
  - "We've had difficulties with [health plan] because they don't know anything about the disease. **We've had two patients die because they weren't able to get the care that they needed,** [health plan] wouldn't allow it. We made multiple phone calls and [sent] letters, notified the state. In California the lifespan for sickle cell disease is lowering, because there is increased mortality when they age out. GHPP and MCMC, that is what the deaths were associated with, not Whole Child Model specifically. We collaborate across the state on hemophilia and sickle cell grant, the stories we hear from patients and providers are horrifying, especially in LA, there is no access, it is frightening."
  - "We're dealing with people that have no background in the diagnosis and they are the gatekeeper."
- **Uncertainty of what will be authorized under WCM,** for some providers this has not been spelled out.
  - "I'm interested in what would be authorized under Whole Child Model, they were so vague about what they were going to authorize, and they *never* answered the question."
- **New methods are burdensome for providers** (example of entering treatment plans for every tiny procedure).
- **Providers are not always able to deal with denials, which puts children at significant risk.** Example given of missing the stroke test deadline by one day, then being denied the test, then having a stroke during that delay.

## Provider experiences with timely access to Durable Medical Equipment (DME)

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### Provider Experiences with DME Timeliness/Delays:

- Within in-patient settings, **providers have begun establishing workarounds to better accommodate patients—sometimes at their own expense:**
  - “In the inpatient side, we have set up workarounds for when a patient could go home but [they] are just waiting for equipment, we use internal funds to get the patient out of the hospital. This is because we see delays in DME. Medications and SARs can take days to get authorized, delays there as well. Historically we did have patients that had to stay for longer, then we set up this fund to try to help with the issue, but they are never reimbursed for this expedited service.”
- Some providers have **not ever heard of issues with reimbursement rates within their specific practices.**
- As was mentioned in the section prior to this one, there are issues with authorization that lead to delays in DME:
  - **Vendors sometimes take advantage of the system:** “Some vendors seem to be adding lots of things, [a] ‘laundry list’ that seems to just be adding a lot to bill more when it isn’t something that a PT needs.”
  - **Vendors also sometimes withhold equipment if they are not paid:** “[There was a] patient that has [health insurer] and needed a safety bed and the vendor was trying to get three pieces of equipment and then held the bed hostage because [health insurer] didn’t pay for it. Then the mom went on social media, and then [health insurer] paid for it, and the child got the bed.”
- Getting access to **DME can sometimes be a geography issue, children in remote areas have less access:**
  - “We also don’t have a lot, but we do pick up a lot of kids that have chronic infections in remote counties, we don’t send [those] kids home sometimes because they won’t be able to get what they need out there—we can’t find anyone out there that can do the dressing changes or get home care.”

### Provider Experiences with DME that is most difficult to get:

- Lyrica, most commonly used to treat fibromyalgia
- Formula
- G-Tube supplies
  - **Please note that all of the above actually fall under the category of supplies or medications, but these were the answers of focus group participants.**
  - **Also, these individuals mentioned that non-DME supplies were actually most difficult to get for them—they had regular had trouble getting them added to the formulary.**
- Home Health Care, which is also not necessarily DME, but the provider expressed that there are large delays in their area.

## Medical Home

### Provider Perspectives on Medical Home

- **CYSHCN do not consistently have Medical Homes:**
  - **Sometimes reimbursement is part of the problem:** “We’ve identified about 3,000 special needs children in our program and only about 1,000 have an established medical home.

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Reimbursement plays a role in that we don't reimburse for case management. We feel that the PMD should be responsible. It would be helpful if they could be reimbursed to do case management and care coordination." (PMD = Primary Medical Doctor)

- **CYSHCN can sometimes have Medical Homes through their Specialty Care Centers**
  - "Our program director way back when CCS required this, made sure we were set up to be what is now called a Medical Home... In the past you didn't get qualified as a SCC unless you had this in the past."
- If providers take on the Medical Home role, they feel that there are **issues during transition with continuity of care and that it may be unfair to the patient and the provider to set up an expectation that cannot be carried through to adulthood:**
  - "If we do find one [an adult, primary care provider for a CYSHCN], we become a huge resource for that primary care MD because they don't understand the patient as well as we do."
- Even though **PCPs are meant to be Medical Homes, they sometimes fall short** of that because they end up...
  - **Serving as urgent care or being inconsistent in MH duties due to issues that sometimes include funding limitations:**
    - "At least for our patients, the PCP ends up being their urgent care—we have one sided information where we tell them what they need to do, but they don't talk to us. They rarely get them for well-child visits. Sometimes they see them for flu shots..."
    - "They [primary care providers] are coming to us for all of the things that they need because they have a money barrier, they [CYSHCN patients] have to come to us anyway, and when we give them PCP things such as flu shots then they don't have any reason to go to them."
  - **Feeling unsure about how to treat children with complex medical issues:**
    - "Difficulties with Medical Home is that some pediatricians are really afraid of our patients—if our patients are immunosuppressed that scares clinic pediatricians in the area. We don't have a list of the ones that will take them and do well, and we don't know which ones will work with our patients, and we also don't know what insurance the good ones take. Pts in the farther flung communities have a harder time..."
- **Provider needs to provide Medical Home:**
  - "We would need **case managers that are skilled and know how to navigate through all of the systems that serve children with special health care needs.**"
  - "**Clinical nurse case managers** are necessary; we need someone to be very responsive like that."
  - In this case, they need a way to **prevent burnout of nurse case managers:** "Some concern about **burnout of nurse case managers** because they see so many patients and have to be in three places at once. Sometimes their jobs are also thankless and the "glory" goes to MDs for helping children."

## Managed Care Health Plans Providing Care to CCS Children

Provider experiences with Medi-Cal Managed Care plans providing appropriate care to CCS children and Youth:

### Needs & Experiences:

- **Mental Health funding and:**
  - “**Psychiatric care** in Solano county (everyone agreed), you cannot get psyche care in Solano county if you are from Solano, sometimes you can in Solano, but only if you are from Alameda.”
- **Dental care for CYSHCN**, there are no dental providers for this population.

## Transition: Provider experiences and suggestions for improvement

Barriers and challenges experienced by providers:

- There are **not enough adult providers for Special Health Care Needs<sup>++++</sup>**:
  - “There’s a lot of literature and four models for transition, I think they all have major flaws. But first, they **don’t have enough providers with understanding of pediatric and congenital conditions.**”
  - “For pediatric and adult world it is day and night, we noticed **when they transition it is hard to find a provider that understands the complexities of their disease**, we have a lot of kids bouncing back and asking to be seen by us after transition. Need a smoother transition.”
  - At [redacted] we are doing a pilot for transition, trying to find providers that have an interest and the infrastructure to take on these patients. I’ve gotten info from PCPs that try to do warm hand offs with outside PCPs that say “how can you have referred this patient?” and so right now we are trying to work within our own system to see how we can do better—which is “out of network” care coordination, technically. It is a transition pilot, but I don’t think we serve our patients well at all because they don’t know how to interact with primary care. Especially if they have ACEs and need mental health care, even if peds have a lot of time, it isn’t realistic that they can cover all of their needs. We aren’t even able to do appropriate developmental screenings. **The child is going to have to be the ambassador to train the new, adult provider**”
  - “**Children are living for longer with complex diseases, when they show up at adult hospitals; they don’t know how to treat them because these kids have historically been treated only at children’s hospitals.**” Reviewer please note: this comment was said by someone from AAP that happened to be there at the time of this focus group, they would not like to be represented as AAP, remove this portion from this document before dissemination, this is just for our records.
- **Patients are not able to afford to live close enough to children’s hospitals that do good transition work:**
  - “The cost of living in big cities is prohibitive so these complex patients are moving farther and farther from adequate children’s hospitals—so even if we could provide transition help, they aren’t close enough to help them.”
- **Providers are seeing a trend in fatalities related to a lack of transition care<sup>†</sup>:**
  - “We are trying to partner with providers in outlying counties that may only see one HIV transition special health care needs kid, and they may only call them once and if they don’t show up, they say that is ‘too bad’ because they are adults and they can take care of themselves. **We’ve had several patients die in the last ten years because of this, because they have had 10-12 regimens in their lifetime and the MDs don’t have the capacity or the support groups to deal with the ‘born with HIV’ population, they don’t fit into the behavioral health support groups for this.**” Meaning that

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individuals that are born with HIV don't do well in support groups with others that have contracted it later in life.

- Sickle cell research says the same, **deaths after transition age**.
- **Reimbursement and insurance does not always carry over into adulthood/transition age:**
  - “Barriers – reimbursement, we couldn't survive without reimbursement options.”
  - “[We] did a study in 2008 of children in [redacted county name] that aged out, had access to their records. Almost all of them continued in Medi-Cal, but almost half of them lost continuity of their specialists and maintained their CCS eligible conditions.”

#### Suggestions for improvement to transition:

- **Pediatric providers/specialists seeing CYSHCN into adulthood:**
  - “One recommendation is, like us, **children's MDs seeing them as adults**<sup>†</sup>. That is one way. You transition them to yourself. But sometimes the kids go to college and move away. The reality anywhere else is that there is nowhere to transfer them to. In LA, there was one adult provider in sickle cell, but they retired. It is really difficult, and it depends on the disease.”
  - **“Need investment from both orgs to have a warm hand off. Also costly to train adult providers so that there are reasonable ones in communities.”**
  - **“Telehealth may help, but it is a challenge and creative solutions are going to be paramount.”**
  - “It would be helpful if the kids have a few more years to mature into their own care, so **maybe 26 instead of 21** might help with that. The psychology of becoming dependent without a complex disease is already proven difficult. Also the developmental issues and the trauma these kids experience means that they'll have an even harder time getting adult care and knowing how to navigate.”
  - **“CCS interacting with the families more** may be helpful.”
  - “We just had a grand rounds where we heard about a hospital where **they set up the peds and the adult providers right across the hall from each other and had them work with each other**. The impetus is on us to work with adult providers on how to treat special care needs. This is especially tricky with Medi-Cal.”
  - **Providers need to be discussing transition with their patients after age 14: “Start talking about transition with patients**, some MDs said 18, some say 15, 16. Nobody wants to leave.”
  - **Outside funding for specialized transition programs**<sup>†</sup>:
    - “We have sickle cell **[transition] boot camps with donated money**. We start kids at 13. These exist all over the country; I don't know how successful they are.”
    - “We have a model for transition for rheumatoid, there is a clinic run out of [redacted] that is **run by an unusual stream of funding.**”

## Provider Capacity for Care Coordination

What capacity (time + resources) do providers or their practices have in place to contribute to care coordination?

- **Limited/needed resources:**
  - **Time**, “We have no time...”

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- **Coordination of provider efforts:**
  - “Who would be driving it? We are all doing that on an individual basis and there are pieces of this that are happening, but they don’t exist in one document—it is all largely fragmented. And we’re already doing that outside of our clinical time.”
- Care coordination **built into the Electronic Medical Record:**
  - “If it was built into the EMR it would be really helpful.”
- **Dedicated reimbursement and funding** for care coordination:
  - “If it was reimbursed that would be helpful, we could dedicate entire appointments to it.”
- **Capacity to write plans of care, need systems to be able to share information:**
  - “We write our own plan of care, but don’t necessarily share it because the systems are not a fan of sharing across.”
- **Better communication between providers:**
  - “Not much communication between MD and MTUs. Occasional communication with CCS admins/physicians, they seem to be helpful. They constantly reject things that we have requested. If I truly feel that the patient does qualify I’ll communicate with them about it. It is easier for me to get ahold of the MD there than it is to get ahold of the case manager.”
- **Transportation costs covered for families and patients** to maintain continuity of care across the state. You cannot coordinate care without being able to see the patient consistently.
- **Family Engagement, specifically engaging low-income families:**
  - “Every Monday and Wednesday, we meet as a team (MDs, SWs, NPs, etc) to discuss the patients that we’re going to see. So we do come up with a plan at those meetings and it is our job as the scribes to put this into EPIC, but in this room it is shared decision making...This has been our model, **but families aren’t in the room. Who is in the room depends on donated money sometimes.**”

## Mental & Behavioral Health Needs of CYSCHN & Their Families

- Mental and behavioral health needs are a **huge priority for providers**, they speak with them often about it:
  - *When asked how often they speak with families about MH and BH of the child and the family:* “All of the time. Every day. For both of these things and there are **so many barriers. Access is one of the primary issues.** We have a place they can go within our hospital, but there is a wait list and sometimes they have to wait 5-6 months and we don’t have many other places to send them.”
- The **main barriers to access in mental and behavioral health care** are:
  - **CCS does not cover mental health care for adults (but Medi-Cal does):**
    - **Undocumented family members get no access at all**
      - “There are not a lot of people that take Medi-Cal for adults, especially for therapy/behavioral health. A lot of our parents are undocumented and have no access to services.”
  - **Mental Health services: in general, they are inaccessible due to capacity and volume of patients** seeking mental health care at this time.

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- **Providers have to be creative and have workarounds** to get mental and/or behavioral health care for CYSHCN and/or their families:
      - “If we felt there was something glaring, we could refer to the family support program here under the kid’s name, but they would know it was because of the parents. They give the parents a couple of calls, if they don’t call back that is the end, or if they do call back then they get phone numbers to call and that is as far as it would go.”
- **Suggestions to improve access** to mental and behavioral health care for CYSHCN and their families:
  - **CCS to bolster mental and behavioral health services:**
    - “In theory, CCS is supposed to **cover all of the mental and behavioral health issues associated with their CCS condition**. Does this happen? It is unclear.”
  - “This would be a **good area of expansion for CCS, a cadre of CCS psychologists would make a huge difference**. It wouldn’t be helpful to link it to the disease, they would just have to qualify based on being in CCS.”

## Communicating and Addressing Mental & Behavioral Health Needs of CYSHCN to Families

- Some providers have a **lot of communication around these needs:**
  - “A lot. Very strong mental health component to ACT model—so it is part of transition tool readiness.”
  - “**All of the time. Every day.** For both of these things and there are so many barriers...”
  - “It is very relevant and it comes up all of the time.”
- ...Even so, **mental and behavioral health services fall short:**
  - “Every visit [we communicate with them about mental and behavioral needs], but it is incredibly difficult to find anyone that can even handle the issues these kids face. They need to be trauma-informed and understand the fear of abandonment that these kids face.”
- Most providers **experience challenges in capacity in the form of personnel and/or financial resources:**
- Many providers **experience time and privacy constraints:**
  - “Manpower is a challenge; our visits are too short to appropriately touch on these subjects. Sparse social workers, and not enough space to ask sensitive questions.”
- Many providers **don’t have the in-house capacity needed for thorough appointments or adequate follow-up:**
  - “Psychiatry is a bigger problem than psychology, we have in-house psychiatry, but that does not continue outside of the hospital. Sometimes we are able to get into the county mental health system in terms of psychology, but they aren’t used to taking care of really sick kids either.”

- “We very often refer patients for mental and behavioral health services. We have long visits in our clinic, but it isn’t a sustainable model because there isn’t much follow up at all. Regional centers are supposed to help, but they haven’t been able to.”
- “All of the time. Every day. For both of these things and there are so many barriers. Access is one of the primary issues. We have a place they can go within our hospital, but there is a wait list and sometimes they have to wait 5-6 months and we don’t have many other places to send them.”
- Providers **experience barriers in getting mental health care for families of CYSHCN, especially for parents, usually due to insurance limitations:**
  - “There are not a lot of people that take Medi-Cal for adults, especially for therapy/behavioral health. A lot of our parents are undocumented and have no access to services.”
- **Providers experience issues with community partnerships/community capacity:**
  - “It is really challenging when there are inconsistencies in regional center’s making diagnoses for autism and we have to wait until they get to transition to the school and then we have to wait to make the DX w/ our own psyche w/in CHLA and then they become lifelong regional center beneficiaries. It is dependent on the regional center.”
  - “I feel like my patients never end up with a psychiatrist, even when I give them a list of local resources they never have room, there are wait lists.”
- Few providers **do not always feel that Mental and Behavioral health is in their scope of care:**
  - “We don’t directly offer to parents any mental health services, sometimes we refer them to Respite care. Sometimes we screen parents for depression, mostly just new moms.”
- Some providers **work in systems that have in-house programs or some workarounds:**
  - “We have in-house psychology and that has made a huge difference. It is a breath of fresh air to say ‘I have someone you can talk to; you can meet with them right after us’.”
  - “If we felt there was something glaring we could refer to the family support program here under the kid’s name, but they would know it was because of the parents. They give the parents a couple of calls, if they don’t call back, that is the end or if they do call back then they get phone numbers to call and that is as far as it would go.”
- Suggestions for improvement in this area:
  - “This would be a **good area of expansion for CCS; a cadre of CCS psychologists** would make a huge difference. It wouldn’t be helpful to link it to the disease, they would just have to qualify based on being in CCS.”
  - “That would be a great amendment to [program name redacted] to **take care of the parent’s mental health and help with the trauma they experience.**”

## Addressing Family Capacity

When, Family Capacity = resources and circumstances based on the social needs of families.

- **Provider capacity is often effected by a family’s unmet social needs:**

- “[Family capacity is addressed] when you have a family actively involved in child’s care, which is so much easier to help the child. It is so much easier. When you have one that misses every apt and it take 4-5 calls to get them there, your time and effort is expended on that.
- ...However, **Social Workers have an important role/potential for partnership:**
  - “We have a social worker and it is somewhat formally assessed, but with me as an NP that is not fully assessed at every visit. We don’t set aside social worker’s time unless someone is bringing up a need. A full social screening is not always part of an acute visit. But no-shows trigger referrals.”
  - “It depends on how a specific clinic is set up; in HIV we have a social worker that sees the child at every visit. But I know that many other subspecialties don’t have that.”
  - “There is an underrepresentation of what I think social workers should be in pediatric clinics, **limited by the CCS structure and how they can’t bill for social needs. This could and should be a part of the comprehensive visits.** This is not an easy thing to fix because the knowledge base is so low, they need to bring in the counties (Alameda, Contra Costa, and San Francisco) and build knowledge base and capacity for what we can do to improve.”
- **Providers believe that screening for social needs could be helpful:**
  - “Oftentimes that no-show is a ‘solution’ to things that aren’t being managed: income, food, shelter, security, trauma—pediatric handholding, when you don’t have a family that is able to engage we have providers that can address these underlying basic needs. We need to do social screening and we need Ped MDs that can address these social issues.”
- ...However there are **complications with billing for social needs:**
  - “There has been very little institutional education on how to bill for social needs, and then on top of that there is turnover in departments. Also financially, don’t know how we would fund this work.”
- **Providers had varying experiences with how or when or if families and CYSHCN were screened for social needs:**
  - “We used to have a clinic, a “special needs clinic” for parent’s that didn’t have that capacity and were going to need extra support. There are some families where they have the capacity from the get go, there are others where they learn it, and there are some that are never going to have the capacity.”
  - “We figure out where they are at based on if they miss appointments or continuously show up in the emergency department because they haven’t listened to what we’ve told them to do or can’t problem solve if a medication doesn’t show up and they don’t call or ask for help. One example of a mom that needed an advocate who helps and this service doesn’t exist for everyone—usually the advocates come from the regional centers.”
  - “They are sort of self-screened; on the out-patient side I’m not entirely sure. Almost all of our patients are in some sort of crisis. We are dealing with an influx of homeless children as well.”
  - “Our entry assessment tool has a medical complexity and a social complexity component and so we tier the patients based on how socially put together that are. [Name redacted] developed this tool. The social determinants of health is a big thing”

## Providers as Navigators of CCS

When asked the question, ‘How often do families utilize you as a provider to navigate CCS?’ The answer was clear:

- **“All of the time. One hundred percent of the time.** Some specialists have the messaging to go back to primary care provider.”
- **“All of the time.”**
- **“Often.”**

## Biggest Problems/Drawbacks of CCS for Providers

The biggest problems or drawbacks mentioned by providers are...

...That **CCS only serves CYSHCN until they are 21:**

- “Why does it even end at 21? Or figure out how to make transition services smoother. It doesn’t make sense to put 21 years into taking care of these children and then to just have them drop off the cliff at the end.”

**Providers can’t bill outside of the CCS range of treatments:**

- “Pay the provider to do the home visit that may make it easier for the families.”
- “I would like to see CCS acknowledge us, other than the designation as a CCS provider—we are spending a lot of time and energy making sure that they are taken care of for things that are beyond their CCS condition and they make it impossible for us to get authorization to reimburse for treatments and equipment that aren’t in the CCS condition, specifically.”

**...Partnerships are not always functional (but also, strong cautions against families of CYSHCN getting insured through Kaiser):**

- “Fire Kaiser, there is a problem with the Medi-Cal managed care population for Kaiser. The Kaiser system provides substandard care according to patients.”
- “Denial of CCS patients that have Kaiser [NOT Kaiser Medi-Cal, Kaiser Medi-Cal will cover CCS], if you have Kaiser you are not eligible for CCS—but they don’t provide that same kind of care. Kaiser kids can see us, but can’t bill for CCS.”
- “Kaiser seems to maybe make it a requirement for employees to get their insurance, low income families get stuck between CCS and Kaiser—stuck with a huge bill, and scared to pay Kaiser.”
- “Some families end up choosing Kaiser through ACA, but end up accidentally getting a plan that does not have prescriptions.”
- “Educating outside pharmacies on how to bill CCS for medications, they won’t give to the family if they can’t bill or will stick the family with a co-pay. “

**...Whole Child Model and other innovations from DHCS are lacking or problematic:**

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- “Other than not doing WCM, would like to see the letters updated”
- “I’d want there to be a philosophy and actual, tangible experts that want us to succeed as a CCS center and to come out, not as police, but to support the work that we do and help to champion us. If they are really invested, the relationship should be mutual. A supportive champion that can help internally or externally.”
- “If there is a standard that we can reference, rather than a webinar that is lengthy. But if all else fails having a champion that I can ask about things I don’t know.”
- “Reinstate CCS, stop the WCM pilot! It has not been good. There have been delays in medications, in labs; it is a bigger problem over time. Everyone at CCS agrees with me. Even in LA, it isn’t easy down there. I would bet if they crunched the numbers, they aren’t saving money.”

## Suggestions for Improvement in the Next Five Years

Quotes from providers:

- **“Increase numbers of nurse case managers**, this would offload patients. Invest in this population.”
- **“New state, home-based palliative care organization** that used to be managed through CCS and will now be based out of MCMC HMOs.”
- **“Better coordination between CCS and regional centers to reduce gaps in therapy**—ideally there would be shared cost for in-home therapies.”<sup>†</sup>
- **“Audit the quality of your MTUs**—we used to train them, but now due to low funding we can’t and they are less effective. Some of the kids that we see cannot get in to the MTUs.”
- “Overall, we do like CCS and don’t want it to go away.”
- “We generally do feel like we are getting quality people on the staff when we send them to CCS MTUs versus other random places.”
- **“CCS is great in its flexibility with contracting**, this would not have been possible on Medi-Cal Managed Care.”
- **“We would like things [trainings] built into our EPIC workflows**, consistently across subspecialties.”
- “Non-CCS CYSHCN will probably need that same transition and have the same mental health issues, but will likely need more care coordination help.”
- My manager wanted me to bring up:
  - “Wanted to let CCS know that they don’t let NP or PA providers sign PT and OT prescriptions and that slows things down, results in delays bc they need to wait for an MD. (someone responded that they should be able to, but it is b/c of how the provider wants to bill, CCS not to my knowledge has that requirement, but some others have been denied for billing a consult and not a new)”
  - Also, the NPs are often relegated to the RN role to meet the SCC requirement, which is not a productive use of their time (another person said that is an internal workflow choice, not a CCS requirement).

† = Mentioned more than once during *different* provider focus groups, each is a multiple of 2—so ††† = it was mentioned at least 6 times.