

## CCS Primary/Specialist Physician Focus Group Guide

[Introduction including confidentiality]

Expected length of time: 60-90 minutes

The CCS program is administered as a partnership between the California Department of Health Care Services (DHCS) and county health departments. The state sets the special care centers (that include hospitals) standards and the overall administrative policy and direction for CCS and oversees CCS provider paneling. County CCS staff determines eligibility, authorize services, and provide case management. The Site reviews and approves special care centers

NOTE: Adjust the provider focus group guide, as needed, depending upon the audience of the focus group – **CCS primary/specialist care physicians in urban and/or rural environments**.

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1. Please comment on your experience in working with the Medi-Cal Managed Care Plans that also serve your CCS patients.
  - *Probe 1:* What are the benefits and challenges of working with MMC plans?
  - *Probe 2:* What is the impact on CCS clients of shifting them from Medi-Cal fee for service to Medi-Cal Managed Care?
  - *Probe 2:* How is the relationship/communication between CCS and the Medi-Cal Managed Care Plans? How might it be improved? How does it impact beneficiaries getting the care they need?
  - *Probe 4:* What has been your experience with Managed Medi-Cal Plans delaying, modifying or denying your treatment plan for CCS client? How did that impact the CCS client's health?
  
2. What have been your experiences with timely access to Durable Medical Equipment (DME)?
  - *Probe 1:* What have been your experiences with reimbursement for DME?
  - *Probe 2:* What DME seems to be the most difficult to get? And is it harder to access DME based on geography?

### **Definitions of Medical Home**

- A medical home is a model for organizing health care so it is continuous comprehensive, coordinated and **family-centered care** in the child's community...[it is a] collaboration among health care professionals and other agencies and service providers assisting these families. [A medical home] provides the services that constitute comprehensive care – continuous access to medical care; referral to pediatric medical subspecialties and surgical specialists; and interaction with child care, early childhood education programs and schools to ensure that the special needs of the child and family are addressed (Lucile Packard Foundation for Children's Health, <http://lpfch->

[cshcn.org/glossary/medical-home/](http://cshcn.org/glossary/medical-home/) and The American Academy of Pediatrics; MCHB/HRSA, [http://mchb.hrsa.gov/research/strategic\\_definitions.asp](http://mchb.hrsa.gov/research/strategic_definitions.asp), accessed 6/18/14).

- The medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them (*Pediatrics*, “The Medical Home: Medical Home Initiatives for Children with Special Needs Project Advisory Committee”, <http://pediatrics.aappublications.org/content/110/1/184.full>, accessed 11/16/14).
3. From your perspective, do your CCS clients have a medical home?
- *Probe 1:* Who do you think is/should be responsible for providing a medical home for CCS clients?
  - *Probe 2:* What would you like seen done differently, if anything to foster medical homes for CCS clients? Why? How?
4. What would you need (e.g., types of resources) to be able to provide a medical home for CCS clients?
- *Probe 1:* What do you think that other local primary care providers need to provide all the components of a medical home?
  - *Probe 2:* What do you think specialists, who may not be trained or experts in providing a medical home, would need to provide a medical home for CCS clients?
  - *Probe 3:* How would the needs differ for urban and rural providers?
  - *Probe 4:* What role, if any, could technology (e.g., telemedicine) play in developing medical homes in urban and/or rural environments for primary care and/or specialist providers?
  - *Probe 5:* What is your experience regarding Managed Care health plans and providing appropriate care for CCS children/youth? Have you experienced barriers to referring the CCS client to a Specialty Care Center appropriate for the client’s specific health condition?

**Definition of *transitioning adolescents*:** Transition involves the engagement and participation of the medical home team (physicians, nurse practitioners, physicians’ assistants, nurses, and care coordinators), the family and other caregivers, and the individual youth collaborating in a positive and mutually respectful relationship...The medical home team facilitates a process that is planned, smooth, and patient- and family-centered. The parents’/caregivers’ role is to actively engage in the process and move in and out of the decision-making position as appropriate. The youth’s role is to maximize his or her independence and primacy in the decision-making process to foster lifelong functioning and self-determination. The receiving adult providers also need to be identified and engaged and, as needed, to provide developmentally appropriate support for the family and young adult during the transition process. (American Academy of Pediatrics. Clinical Report: Supporting the Health Care Transition from Adolescence to Adulthood I n the Medical Home, 6/27/11. <http://pediatrics.aappublicatioins.org/content/128/1/182.full>, accessed 6/18/14).

5. What are your experiences and/or knowledge about CCS clients transitioning from pediatric to adult care? How might this process be improved?
  - *Probe 1: When and how do you start having conversations with your families about transition? What is the current practice when a child “ages-out” of CCS?*
  - *Probe 2: What, if any, changes to the current practices should occur? Why? How?*
  - *Probe 3: Who is involved during the transition (e.g., family, doctor, faith-based support, social worker, school, etc.)? Who should be involved during the transition? Why?*
  - *Probe 4: What is your experience regarding transitioning CCS children to adult care physicians? What are the barriers to finding an appropriate adult care physician?*
  - *Probe 4: What is the role of physician workforce shortages? How might this be remediated?*
  
6. Please discuss how, when, and why you communicate with other physicians/and providers of services/care for your CCS clients. More specifically, is there someone you need to communicate with more, but have difficulty doing so? What are the obstacles?
 

*Probe 1: Is more communication between providers needed? If so, how should it be increased/improved?*
  
7. How often, if at all, do you communicate with local CCS decision makers and how often would you like to?

*Probe 1: What would you like to communicate to CCS decision makers?*

*Probe 2: How do you communicate with local CCS decision makers? How would you like to?*

*Probe 3: What do you see as the greatest obstacles to good communication? How could it/they be overcome? How could communication be improved?*

**Definition – Shared Plan of Care (SPoC):** This is a new and emergent model that can be a tool used to support care coordination and is developed and implemented with input from members of the team caring for a child, including community partners, educational specialists, primary care providers, dental providers, medical and surgical subspecialists, and the family and patient themselves.

8. How much capacity (time + resources) would you or your practice have to contribute to care coordination in your role as a provider?
  - *Probe 1: Do you feel like a SPoC model would be a useful way to coordinate care for your CCS clients?*
  
9. How often do you engage families (i.e. speak with them procedures and aftercare) in the care that you provide to your patients (both CCS and CYSHCN that are served by other insurers)?
  
10. How often do you speak to families about the mental and behavioral health needs of their child? How often do you need to refer children to these services, and are there any barriers in doing so?
  - *Probe 1: How often do you speak to families about their mental and behavioral health needs? Do you ever refer family members for mental or behavioral health?*

- *Probe 2:* What could be done to improve access to mental and behavioral health services for CSHCN?
- *Probe 2:* How relevant is mental and behavioral health of the child to the work that you do? Does it come up often?

11. How is family capacity (capacity = resources and circumstances) considered when meeting the needs of the CCS or non-CCS CYSHCN client?

12. How often do families utilize you as a provider to navigate CCS?

13. Please share any other feedback/comments that you feel are relevant to our conversation today.

**If time permits, ask the remaining questions below.**

14. In what ways has Whole Child Model (WCM) changed or is expected to change the services you provide to CCS children and their families?

15. What is the biggest strength of the CCS program? What aspects of the program should be preserved/safeguarded as the State looks at options for redesigning the program?

16. What are the biggest problems/drawbacks of the program?

- For CCS Patients
- For Physicians

**THANK YOU!**