CCS WCM Health Plans Focus Group Guide

[Introduction including confidentiality]

Expected length of time: 90-120 minutes

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1. If the goals of the WCM are that:
Families can get most of their services and care from one source; there is easier access to care; there will be better health results for CCS children because their health plan will have the same type of doctors and services as their local CCS program; it will be easier for CCS children to move out of CCS when they turn 21 because they are already getting their services from their health plan, which in theory offers continued care into adulthood , and lastly, that children get the best possible care. What are the biggest barriers to achieving this goal?

- *Probe 1*: In your experience, do families experience delays and long wait times for care?
- *Probe 2*: Do delays to care and/or long wait times take place more often with specific conditions?
- *Probe 3*: Are there any barriers to being able to demonstrate progress toward achieving this goal?

2. Please comment on your experience in working with County CCS programs on the transition of CCS Medi-Cal clients to the Medi-Cal Managed Care Plans in Whole Child Model (WCM) counties.

- *Probe 1:* What are the benefits and challenges of working with CCS?
- *Probe 2:* What is the impact on former CCS clients of shifting the care for their CCS eligible condition(s) from CCS 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?

3. In your experience, how well is case management being implemented for CCS clients in your health plan and how could it be improved?

- *Probe 1:* Are CCS clients assigned a specific case manager at your health plan who becomes familiar with the client and their specific needs? Are the CCS families provided a name and contact information for their child's case manager?
- *Probe 2:* Does your health plan consider a family's social complexity when determining the level of case management a CCS child needs?
- *Probe 3:* What do you see as the main barriers to better case management for CCS clients?

- *Probe 4:* Are caseloads for health plan Case Managers working with CCS clients realistic?
- *Probe 5:* What, if any, strategies have you been employing to educate your case managers about the complex conditions and needs of CCS clients?

4. From your perspective, how well do the physicians/and providers of services/care for your CCS clients communicate with each other?
    - *Probe 2:* Is more communication between providers needed? If so, how should it be increased/improved?
    - *Probe 3:* What is the capacity of telehealth (or telemedicine) that is available in your health plan for your former CCS clients?

Key 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.

5. How much capacity would your health plan have to contribute to the development of SPoC's for CCS clients in your health plan?
    - Probe 1: Would you provide financial support to your health care providers to work with families to develop a shared plan of care

Key Definition – Medical Home*:* The AAP defines a Medical Home as an approach to providing comprehensive and high quality primary care that is accessible, family-centered, continuous, coordinated, compassionate and culturally effective. A medical home is not a building or place; it extends beyond the walls of a clinical practice.

6. From your perspective, do the CCS clients have a medical home in their Medi-Cal Managed Care Plan in WCM counties?
    - *Probe 1:* Have any of your providers received certification as a medical home?
    - *Probe 2:* What would you like seen done differently, if anything? Why? How?

7. From your perspective, what is needed (e.g., types of resources) to be able to provide a medical home for CCS clients and what role do WCM Health Plans play in ensuring CCS clients have a medical home?
    - *Probe 1:* What do you think that the local primary care providers would need if they are to provide medical comes for CCS clients and other CYSHCN?
    - *Probe 2:* What do you think specialists, who may not be trained in the medical home concept, 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?

8. What comments do you have regarding medical and/or financial eligibility for CCS?
- *Probe 1:* What other conditions do you think should be covered that are not currently? Why?
- *Probe 2:* What do you think about the current financial eligibility and do you think it should be revisited? Why or why not?

9. What has been your experience in providing Durable Medical Equipment to your CCS patients in your managed care plan? Have you had challenges contracting with DME vendors?
- Probe 1: How do the rates affect the level of services provided by the vendors?
- Probe 2: What has been your experience providing medical supplies to CCS clients?
- Probe 3: Has the WCM had an impact on families being able to access needed DME and medical supplies? What has the impact been?

10. What are your experiences regarding CCS clients transitioning from pediatric to adult care? How might this process be improved? Has this changed with the implementation of the WCM?
- *Probe 1:* 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, church, social worker, school, etc.)? Who should be involved during the transition? Why?
- *Probe 4:* What have been your experiences with locating providers for transitioning CHSCN?
  - *Probe a:* Has this changed with the implementation of the WCM?
  - *Probe b*: what are the most difficult conditions to find providers for, specifically for transitioning CSHCN?

11. From your perspective, how considerate of family capacity is care and case management provided by your health plan in the WCM counties?
- *Probe 1*: Are transportation services provided to families that express transportation as a barrier? Have you heard of challenges with transportation services?
- *Probe 2*: What transportation services do you make available to families? What feedback have you heard from families about these services?
- *Probe 3*: Can families bee reimbursed for travel cost if they use their own vehicle or that of a family member?

- *Probe 4*: If a family has to travel many hours to receive services at a special care center, are travel expenses for the family, including hotels and meals reimbursed?

12. From your perspective, how well does your health plan address mental and behavioral health of the CCS child? Of the family?

13. How is family participation in CCS care obtained in your health plan?

- *Probe 1*: Do you have family advisory committees in your region or county for CCS? If not, why?
- *Probe 2:* Are family members involved in providing regular feedback on their child's care through individual consultations, group discussions, or surveys?
- *Probe 3:* How does your health plan handle the formal grievance process for families that experience difficulties and provide feedback?

14. What is your perception or what has been your experience with the Whole Child Model thus far?

Probe 1: What is the biggest strength of the WCM?
Probe 2: What are the biggest challenges/problems/drawbacks of the WCM?

- For CCS Patients
- For Health Plans participating in the WCM
- For Physicians

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

THANK YOU!