# Health Equity:

## Transition to Adulthood Planning

County of San Diego
Health and Human Services Agency
Public Health Services
California Children's Services

May 2024

Inquiries regarding this document may be directed to:


County of San Diego

Health and Human Services Agency

Public Health Services

California Children's Services

6160 Mission Gorge Road Suite 400

San Diego, CA 92120

619-528-4000




This paper was developed under the *Public Health Services Strategic Plan*, in the County of San Diego Health and Human Services Agency, to advance the vision of *Live Well San Diego*. Public Health Services department has maintained national public health accreditation, since May 17, 2016, and was re-accredited by the Public Health Accreditation Board on August 21, 2023.


# Health Equity: Transition to Adulthood Planning

## TABLE OF CONTENTS


**Executive Summary** ..... **1**

**Introduction** ..... **3**

Background ..... 3

Disability Rates Among Children ..... 4

Transition to Adulthood Planning ..... 4

**Methods** ..... **4**

Data Sources ..... 5

Transition Planning (TP) Assessments ..... 5

Transition Planning (TP) Workshops ..... 7

Quality Improvement ..... 7

**Results** ..... **7**

San Diego County Clients ..... 7

Transition Planning (TP) Assessments ..... 9

Transition Planning (TP) Workshops ..... 9

Quality Improvement Projects ..... 10

**Discussion** ..... **12**

**Call to Action** ..... **13**

**Conclusion** ..... **14**

**References** ..... **15**

*Page intentionally left blank.*

# Health Equity: Transition to Adulthood Planning

## EXECUTIVE SUMMARY


### Introduction

Due to medical advances over the past few decades, children with complex or chronic health conditions, who were previously precluded from long-term survival, are living well into adulthood. This has resulted in the increased need to address the transition of youth with special health care needs from pediatric to adult care providers in order to promote the highest level of health in these children.

The purpose of this white paper, titled *"Health Equity: Transition to Adulthood Planning,"* is to demonstrate what is being done locally to address the gaps that exist in the transition from a pediatric to adult model of health care for the most vulnerable children and children with special health care needs. In addition, this document showcases the evolution of transition-related interventions, performed by the California Children's Services (CCS) Branch, in the Public Health Services department, of the County of San Diego Health and Human Services Agency.

### Methods

To qualify for services from CCS, a child must be under 21 in California and meet specific residential, medical, and financial criteria. Medical criteria generally include serious chronic and disabling medical conditions, such as hearing loss, cancer, congenital anomalies, and cerebral palsy. Following California Department of Health Care Services mandates, transition planning (TP) services are to begin when clients turn 14, so they have plenty of time to prepare for their future after CCS services end at age 21. Interventions such as transition planning assessments, in-person and virtual workshops, and revision of processes through a quality improvement lens are utilized to support this population.

### Results

As of December 2022, there were over 7,000 active clients between the age of 14 and 20 in the CCS program, and just over 50% of these clients had disabling conditions expected to last beyond their 21st birthday. As of December 2022, 89.66% of client charts whose medical record indicated a condition that requires a transition plan had documentation of a transition plan. The proportion of client charts including a transition plan has steadily increased in recent years due to interventions.

### Discussion

These efforts relate to ensuring access to continued care and resources that promote maximum independence and quality of life of CCS clients as they enter adulthood. Finally, the paper summarizes further actions the program is promoting to improve health outcomes across the lifespan, including evaluating which of the various delivery system models most positively impacts access to care, quality of care, and the patient experience.

## Call to Action

Children and youth living with physical disabilities served by the CCS program are a vulnerable population with increased risk for chronic disease outcomes. As children and young adults living with disabilities transition through adulthood, they often develop other comorbidities. The influence of these factors are important considerations that have led the CCS program to commit to promoting the following continued actions:

### California Children's Services Medical Therapy Program

- Equity of Services: The CCS program is looking to improve health outcomes across the lifespan, by evaluating which of the various delivery system models most positively impacts access to care, quality of care, and the patient experience.
- Analyses of administrative data focus group and survey input to help determine an ideal model of care coordination that can be implemented to provide optimal outcomes for the underrepresented populations within CCS.
- Referrals to CCS health services social workers to address potential disparities and assist with transition planning.
- Examination of County of San Diego region-based issues related to access to care.

### Transition Planning

- Continue to provide resources to clients as they transition out of the CCS MTP at age 21, including to adult healthcare providers such as occupational and physical therapists and primary and specialty care physicians.
- Continue to provide case management in collaboration with public health nurses and health services social workers at designated age intervals starting at 14 years old.

### Providers

- Adult healthcare providers will seek education on specialized services required for adults with disabilities to address such issues as decreased physical activity and other comorbidities, promoting equitable access to care.

## Conclusion

The CCS program continues to focus on the California Department of Health Care Services performance measure of ensuring children 14 years and older, who are expected to have chronic health conditions that will extend past the 21st birthday, have documentation of a biannual review for long-term transition planning to adulthood. In San Diego County, the specific target is to ensure 90% of children aged 14 and over, whose medical record indicates a condition that requires a transition plan, will contain a transition planning checklist/case note of transition planning intervention based on a quality assurance review of a sample of cases. Supporting CCS youth in the transition from pediatric to adult medical care supports the improvement in long term health outcomes of this vulnerable population which helps advance health equity in San Diego County.

# Health Equity: Transition to Adulthood Planning

## INTRODUCTION

### Background

The United States Department of Health and Human Services defines health equity as the attainment of the highest level of health for all people. The Public Health Services (PHS) department, in the County of San Diego (County) Health and Human Services Agency, is committed to advancing health equity and reducing health disparities across all its programs. This is integral to the vision of *Live Well San Diego,* since this vision is relevant to every resident, no matter age; underlying disability; or where a resident lives, works or plays. It provides the opportunity to be healthy, safe, and thriving.

California Children's Services (CCS) is one of the oldest public health programs, established in 1927. CCS is a statewide program that offers critical funding for children who need treatment for specific physical and chronic health conditions or diseases.[1] In addition, the program has the ability to pay for medical services and equipment provided by CCS-approved specialists. The program utilizes funding from Federal, State and County taxes (with some fees required for parents) and operates under the PHS department, in the County Health and Human Services Agency, with direction from the California Department of Health Care Services (DHCS). To qualify for services from CCS, a child must be under 21 in California and meet specific residential, medical, and financial criteria.[1] Medical criteria generally include serious chronic and disabling medical conditions, such as hearing loss, cancer, congenital anomalies and cerebral palsy. For eligible children, CCS is allotted the ability to offer treatment including hospital or surgical care, lab tests including X-rays, and medical equipment. The program also has the capability to offer medical case management for treatment from special doctors when medically necessary.

The Medical Therapy Program (MTP) provides specific services under the CCS umbrella. The MTP offers physical therapy and occupational therapy services at no extra cost to the families. Eligibility is solely decided on the medical condition of the child. Some examples of qualifying medical conditions are cerebral palsy, spina bifida, spinal cord injuries, and Muscular Dystrophy, among others. Physical and occupational therapy services take place at six designated public schools in the county. These services are free for families — under federal disability law, states are required to provide children with special education and related services designed for a student's unique needs.[2] Occupational therapy focuses on improving the child's ability to complete Activities of Daily Living. For example, dexterity is often low functioning for children with cerebral palsy and the therapist might focus sessions on improving the child's ability to use his or her fingers by playing with various instruments or media to increase range of motion and strength. Physical therapy's focus is on the improvement of mobility and level of ambulation (walking) or other means of movement in the home and in the community.

The purpose of this white paper, titled *"Health Equity: Transition to Adulthood Planning,"* is to demonstrate what is being done locally to address the gaps that exist in the transition from a pediatric to adult model of health care for the most vulnerable children and children with special health care needs. This document further showcases the evolution of transition-related interventions, performed by the CCS Branch, under the PHS department.

### Disability Rates Among Children

CCS clients have serious, complex, and/or chronic medical conditions and disabilities. Many of these conditions are expected to progress into adulthood when CCS support is no longer available. In 2021, an estimated 23,827 (3.3%) children under age 18 in San Diego County experienced some form of disability.[3] Across San Diego County, disability rates among children fluctuate for a variety of reasons. When examining available data for San Diego County by the lenses of health equity, there are notable variances in rates:

- **Sex**: Among the population under age 18, 4.3% of males had a disability and 2.4% of females had a disability in 2021.[4]
- **Geography**: Among the regions, East Region had the highest percentage of children under 18 with a disability in 2021, where 3.9% of the population under age 18 had a disability.[3]
- **Race/ethnicity**: In 2021, 3.1% of non-Hispanic White children under 18 years old had a disability and 3.4% of Hispanic or Latino children under 18 years old had a disability.[5,6]
- **Socioeconomic Status**: In 2021, an estimated 17% of children under 18 years old with a disability came from households living below the poverty level. In contrast, 13.1% of children under 18 without a disability came from households living below the poverty level.[7]
- Among the population under age 18 with a disability, 73.1% had a cognitive difficulty in 2021.[3]

### Transition to Adulthood Planning

While many children with serious, complex, and/or chronic medical conditions and disabilities receive various services through the CCS program, including medical case management and occupational and physical therapy, at the age of 21, these children are no longer eligible for these same services. It is because of this that one of the CCS State Performance Metrics and Public Health Services Strategic Plan health equity goals is to "ensure timely transition planning services for CCS clients to promote optimal health and independence once these clients leave the CCS program." There are many facets in the transition that include finding adult providers, addressing legal guardianship issues, and establishing new resources.

## METHODS

The goal of California Children's Services transition to adulthood planning efforts is to assist young adults as they maximize their independence on the transition to the adult medical system. However, youth with chronic medical conditions and disabilities must prepare for changes as they get older, particularly with regards to navigating the adult healthcare system. To support these young adults, CCS conducts transition planning assessments, holds workshops, and performs quality improvement processes.

## Client Data Sources

To determine CCS medical eligibility, CCS public health nurses review medical records from a child's medical home or specialty care physician and use the ICD-10 codes that are given by those physicians who are evaluating and/or treating the child's condition. The ICD-10 codes and additional client information, including demographic information, are stored in California Children's Medical Services (CMS) Net.

CMS Net is connected to Microsoft Business Intelligence (MSBI), which is used to extract data from CMS Net and generate reports. Reports are generated by different staff based on operational needs. Related to transition planning, there is a report that is reviewed monthly so that the CCS social workers can reach out to the clients who are of age and have a diagnosis that will last beyond their 21st birthday to reach out and complete transition planning assessments.

### Limitations

CMS Net is a State Department of Health Care Services (DHCS) web-based case management application and therefore any enhancements to the system must go through DHCS for approval. DHCS has IT staffing limitations and prioritizes enhancements that will benefit the most counties. Locally, CCS is limited to what data fields exist in CMS Net. CCS may request a special field be created by DHCS, but it may not be approved. This limits the extent of the analysis available at the local level. CCS also does not have access to claims and outcomes data, as there is limited data integration from those systems.

## Transition Planning (TP) Assessments

California DHCS mandates that transition planning services begin when clients turn 14 so they have plenty of time to prepare for their future after CCS services end at age 21. CCS social workers conduct case reviews and make attempts to contact all clients turning 18 and 20 to offer individualized transitional planning resource assessments and ensure clients, if applicable, have signed release of information (ROI) forms or legal conservatorship documents on file.

CCS social worker transition planning assessments are performed to provide CCS youth who will be entering adulthood with additional knowledge on areas they need to act on in order to ensure a successful transition to an adult model of care. The assessments walk the client through a series of questions to assess their awareness and readiness for the transition and formulate a plan to address areas where there are gaps.

### Areas Covered During Transition Planning Assessments

The following areas should be covered during the transition planning assessment. These are as follows:

- Confirm date of birth and inform client that services will end the day before the 21st birthday. Confirm address and contact information.
- Assess ability to provide informed consent.

    - If a client is over 18, check if there is an ROI or Letters of Conservatorship on file with CCS. If not, explain the process.
- Will client's current doctor(s) or specialist(s) continue to treat client as an adult? If not, has the youth identified a new adult doctor(s) and specialist(s)?
    - Confirm immunizations are up to date.
    - Assess challenges with assigned medical specialists.
- Will the client still need the medical services covered under CCS?
    - Assess medical therapy needs.
- How will the client manage any changes to medical coverage? (NOTE: Planning for non-CCS health coverage is VERY important for clients turning 21.)
- What skills and information will the client need to be a healthy adult?
- How will the client's health needs affect their plans for:
    - A future job or career?
    - College or further education?
    - Living independently or in group placement?
- Determine if the client has a California Driver's License or Identification.
- Determine if the client is enrolled with San Diego Regional Center.
- Assess other social needs and referrals made to various community services such as Supplemental Security Income (SSI), Advocacy Awareness, and Recreational Services.

CCS social workers include the client, family, medical providers, health insurance company, and any community partners, such as Regional Center, rehabilitation counselor, school counselor, and In-Home Supportive Services (IHSS) case worker in transition planning (***Figure 1***).

**Figure 1. Care Coordination Model.**


Source: County of San Diego California Children's Services Program, 2016.

For clients with cases open to the MTP, the occupational and physical therapists are required to address and document on transition preparedness during therapy evaluations. It is a mandatory element in the MTP documentation system to identify areas of transition preparedness completed and any recommendations made for all children at ages 14, 17, and 20 years of age—which may include therapy-specific areas and/or those addressed by the social worker.

### Transition Planning (TP) Workshops

In addition to individual transition planning assessments, provided by a CCS nurse or social worker, the CCS program coordinates regular transition planning workshops for CCS youth who are 16 years of age or older and identified with a medical condition that will not be resolved prior to their 21st birthday. The workshops aim to link clients who will soon age out of the program with valuable community resources. To increase accessibility of information and resources related to transition planning, the CCS program transitioned from one annual in-person workshop at a centralized location in 2016, to regional workshops in 2019 and 2020, to a virtual workshop in 2022. In fiscal year (FY) 2023-2024, plans are underway to hold both regional and virtual workshops.

### Quality Improvement

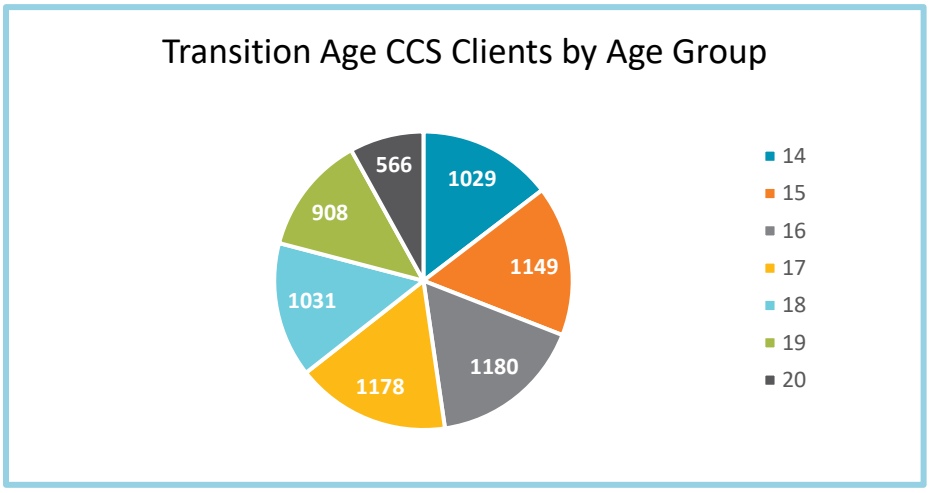
The CCS program utilizes Quality Improvement (QI) methodologies to improve program performance in key areas including transition planning. Efforts involved updating CCS transition planning standards and policies based on sub-committee input in order to improve quality assurance outcomes.

## RESULTS

### San Diego County Clients

In December 2022, there were 7,041 active clients in the CCS Program in San Diego County between ages 14 and 20 (***Figure 2***). Within the CCS Program in San Diego County, 50.4% of CCS clients over the age of 18 (1,263 out of 2,505 CCS clients aged 18-20) have disabling conditions that are expected to last beyond their 21st birthday.

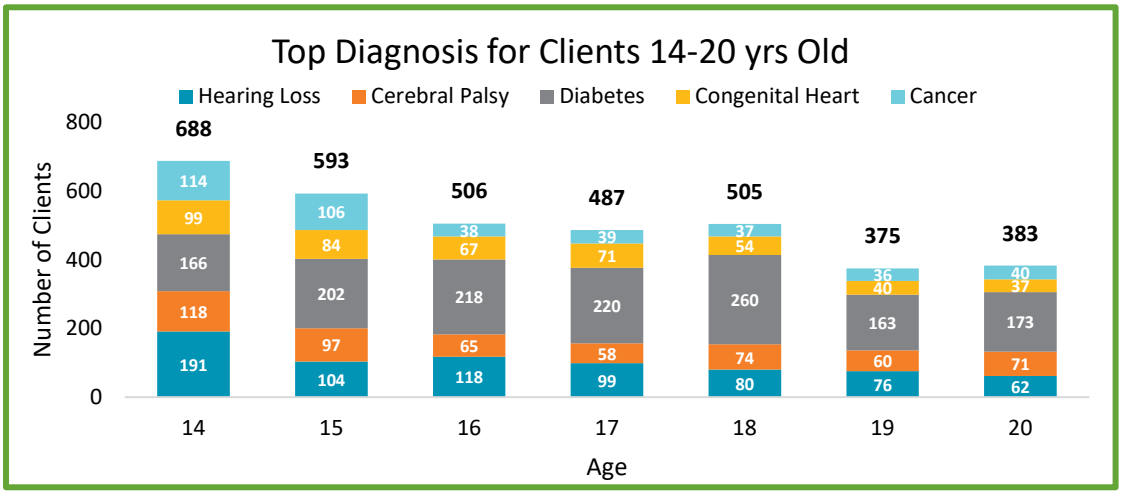
**Figure 2. Transition Age CCS Clients.**




Source: California Children's Medical Services (CMS) Net, December 2022.

Among clients who are at the age where transition to adulthood planning should begin, defined as 14 years old and older, the five most common primary diagnoses were diabetes, hearing loss, cerebral palsy (CP), congenital anomalies of the circulatory system (congenital heart defects), and cancer. ***Figure 3*** shows CCS clients aged 14-20 with the five most common diagnoses, by both age group and diagnosis. The 14-year-old age group had the highest number of clients (688), and the number of clients generally decreased with age.

**Figure 3. Top Diagnosis for Clients 14-20 Years Old by Age.**



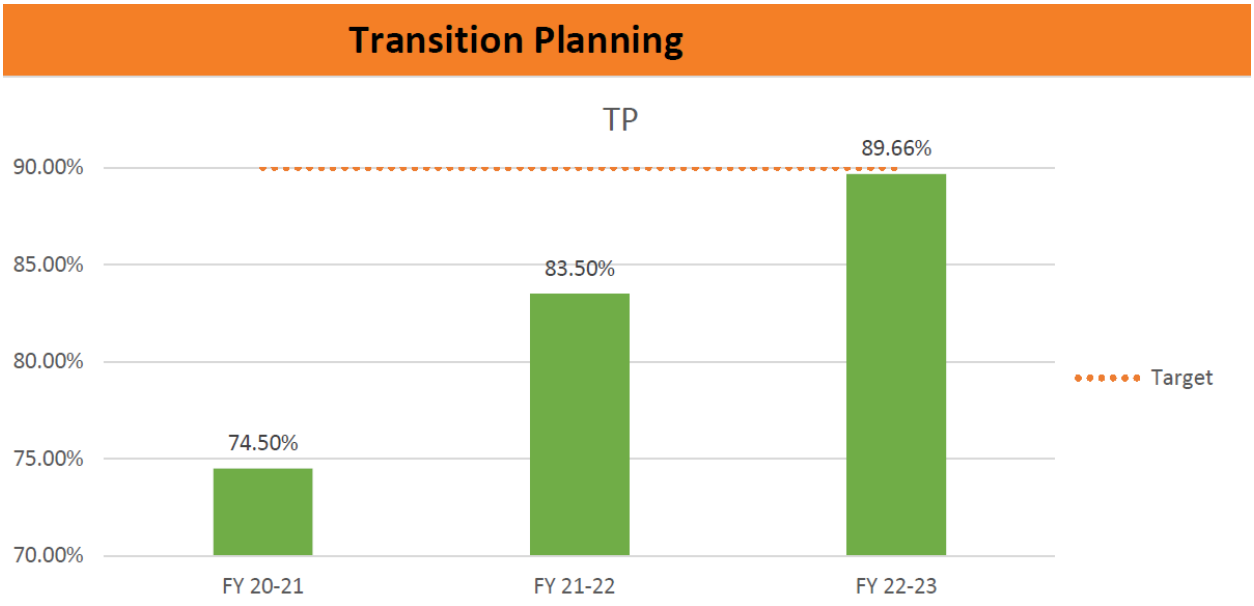

Source: California Children's Medical Services (CMS) Net, December 2022.

## Transition Planning (TP) Assessments

To ensure timely transition planning services for CCS clients, the CCS program has a strategic objective to ensure all children 14 years and older, who are expected to have chronic health conditions past their 21st birthday, have documentation of a biannual review for long term transition planning. The target is for 90% of children aged 14 and over, whose medical record indicates a condition that requires a transition plan, will contain a *Transition Planning Checklist/Case Note of Transition Planning intervention* based on a quality assurance review of a sample of cases.

As of the end of quarter two (December 2022), 89.66% of client charts whose medical record indicated a condition that requires a transition plan had documentation of a transition plan in fiscal year 2022-2023 (***Figure 4***). This percentage has steadily increased over the last few years and is likely to be met by the end of this fiscal year (FY 23-24).

**Figure 4. Percentage of Clients with Transition Planning Documentation by Fiscal Year.**




Percentage of CCS Case Management and Medical Therapy Program charts reviewed of clients age 14-20 years old whose medical record indicated a condition that requires a transition plan and had documentation of a transition plan present. Target Goal 90%

Source: County of San Diego California Children's Services, 2023

## Transition Planning (TP) Workshops

Another method utilized by the CCS program to support CCS clients that are transitioning to adulthood is the coordination of transition planning events. These events link clients who will soon age out of the program with valuable community resources, as well as form connections with other families or clients who have already aged out of the program that they can learn valuable advice from. The first event, the CCS Transition Planning Symposium, was held October 1, 2016, and was themed "Stepping into The

Future." At this event, there was a Wellness Fair with various community resources, as well as several workshops. Workshop topics included self-care, legal services, adaptive driving, educational and vocational opportunities, and support services. From this event, CCS identified there was low attendance due to being in one centralized location. Beginning in 2019, to increase accessibility of information and resources, the CCS program transitioned from one annual in-person symposium, at a centralized location, to regional workshops.

Regional TP Workshops were held throughout 2019 and into the beginning of 2020. The decision was to host the workshops at locations where CCS clients are familiar and may already receive some of their care. Therefore, the workshops were scheduled at four different locations on the site of CCS Medical Therapy Units where some of the clients receive their outpatient rehabilitation therapy services. The regional approach provided better access for North, Central, East, and South County regions for clients to attend the workshops. The agenda focus for the regional workshops included a panel of Medi-Cal Managed Care Providers and a Parent/Client Panel. There were also local Community Resource Exhibitors invited to attend. Additionally, CCS staff conducted a pre and post questionnaire to gather feedback. From the feedback a future improvement was identified as clients expressed wanting to hear more about community resources.

The regional workshops completed included:

- Vista, CA - February 27, 2019, and March 4, 2020
- El Cajon, CA - May 22, 2019
- San Diego, CA (South Region) - August 6, 2019
- Chula Vista, CA - November 6, 2019

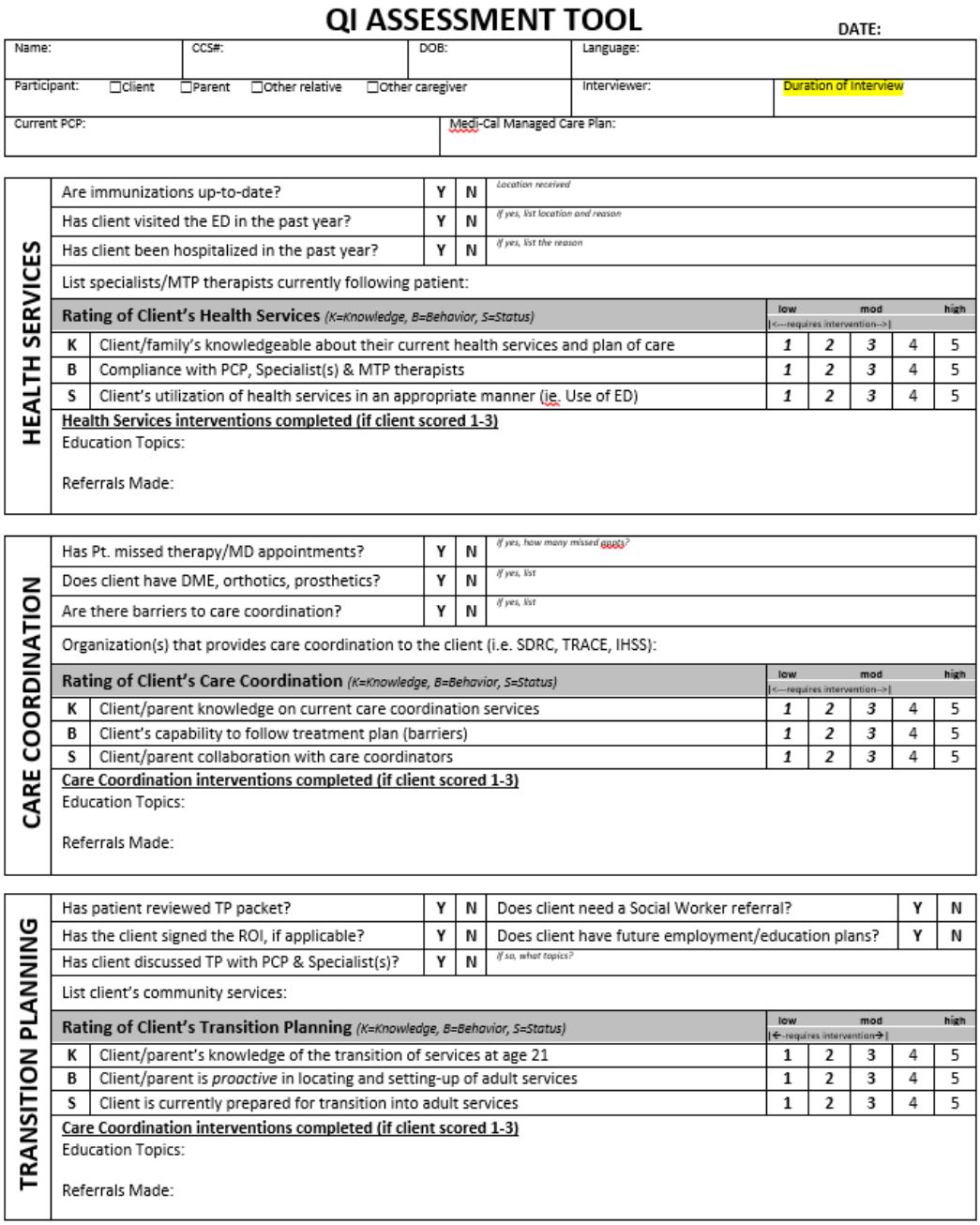
A workshop was scheduled, for June 17, 2020, but cancelled due to the emergency of the COVID-19 pandemic. Due to the ensuing years of the pandemic, the CCS program coordinated a virtual Transition Planning Workshop on June 2, 2022. This workshop followed the in-person model with two panels: Medi-Cal Managed Care Providers and Parents/Clients. New to the virtual format was the creation of a "CCS Transition Planning YouTube Channel," which contained a recorded version of the workshop and short recordings from various community resources that CCS clients can benefit from as they age into adulthood. In FY 2023-2024, plans are underway to hold both another virtual workshop utilizing feedback from the first virtual workshop to improve the client experience, as well as begin offering in-person regional workshops.

## Quality Improvement Projects

The target of early QI efforts was to improve baseline of 65% of Case Management program cases and 71% for MTP cases 14 years and older would have evidence/documentation of a biannual review for long term transition planning to ensure ongoing access to healthcare and other services when a chronic condition exists that will extend past the client's 21st birthday.

Following that project, in 2017-2018, the CCS program embarked on another project called "Transition Well." In this project, through the use of an assessment tool, CCS staff identified as a major problem area that clients expressed need for improved knowledge and skill level to be prepared to transition out to the community from the CCS program. Baseline data (November-December 2015) using a TP Readiness Tool **(*Figure 5*)** produced scores between 3 and 4 on a scale of 5.

**Figure 5. Quality Improvement Assessment Tool.**



**QI ASSESSMENT TOOL**

DATE:

| Name: | CCS#: | DOB: | Language: | |
|---|---|---|---|---|
| Participant: ☐Client ☐Parent ☐Other relative ☐Other caregiver | | | Interviewer: | Duration of Interview |
| Current PCP: | | Medi-Cal Managed Care Plan: | | |

**HEALTH SERVICES**

| | | | |
|---|---|---|---|
| Are immunizations up-to-date? | Y | N | *Location received* |
| Has client visited the ED in the past year? | Y | N | *If yes, list location and reason* |
| Has client been hospitalized in the past year? | Y | N | *If yes, list the reason* |

List specialists/MTP therapists currently following patient:

| | **Rating of Client's Health Services** *(K=Knowledge, B=Behavior, S=Status)* | low <---requires intervention---> | | mod | | high |
|---|---|---|---|---|---|---|
| K | Client/family's knowledgeable about their current health services and plan of care | 1 | 2 | 3 | 4 | 5 |
| B | Compliance with PCP, Specialist(s) & MTP therapists | 1 | 2 | 3 | 4 | 5 |
| S | Client's utilization of health services in an appropriate manner (ie. Use of ED) | 1 | 2 | 3 | 4 | 5 |

**Health Services interventions completed (if client scored 1-3)**
Education Topics:

Referrals Made:

**CARE COORDINATION**

| | | | |
|---|---|---|---|
| Has Pt. missed therapy/MD appointments? | Y | N | *If yes, how many missed appts?* |
| Does client have DME, orthotics, prosthetics? | Y | N | *If yes, list* |
| Are there barriers to care coordination? | Y | N | *If yes, list* |

Organization(s) that provides care coordination to the client (i.e. SDRC, TRACE, IHSS):

| | **Rating of Client's Care Coordination** *(K=Knowledge, B=Behavior, S=Status)* | low <---requires intervention---> | | mod | | high |
|---|---|---|---|---|---|---|
| K | Client/parent knowledge on current care coordination services | 1 | 2 | 3 | 4 | 5 |
| B | Client's capability to follow treatment plan (barriers) | 1 | 2 | 3 | 4 | 5 |
| S | Client/parent collaboration with care coordinators | 1 | 2 | 3 | 4 | 5 |

**Care Coordination interventions completed (if client scored 1-3)**
Education Topics:

Referrals Made:

**TRANSITION PLANNING**

| | | | | | |
|---|---|---|---|---|---|
| Has patient reviewed TP packet? | Y | N | Does client need a Social Worker referral? | Y | N |
| Has the client signed the ROI, if applicable? | Y | N | Does client have future employment/education plans? | Y | N |
| Has client discussed TP with PCP & Specialist(s)? | Y | N | *If so, what topics?* | | |

List client's community services:

| | **Rating of Client's Transition Planning** *(K=Knowledge, B=Behavior, S=Status)* | low <---requires intervention---> | | mod | | high |
|---|---|---|---|---|---|---|
| K | Client/parent's knowledge of the transition of services at age 21 | 1 | 2 | 3 | 4 | 5 |
| B | Client/parent is *proactive* in locating and setting-up of adult services | 1 | 2 | 3 | 4 | 5 |
| S | Client is currently prepared for transition into adult services | 1 | 2 | 3 | 4 | 5 |

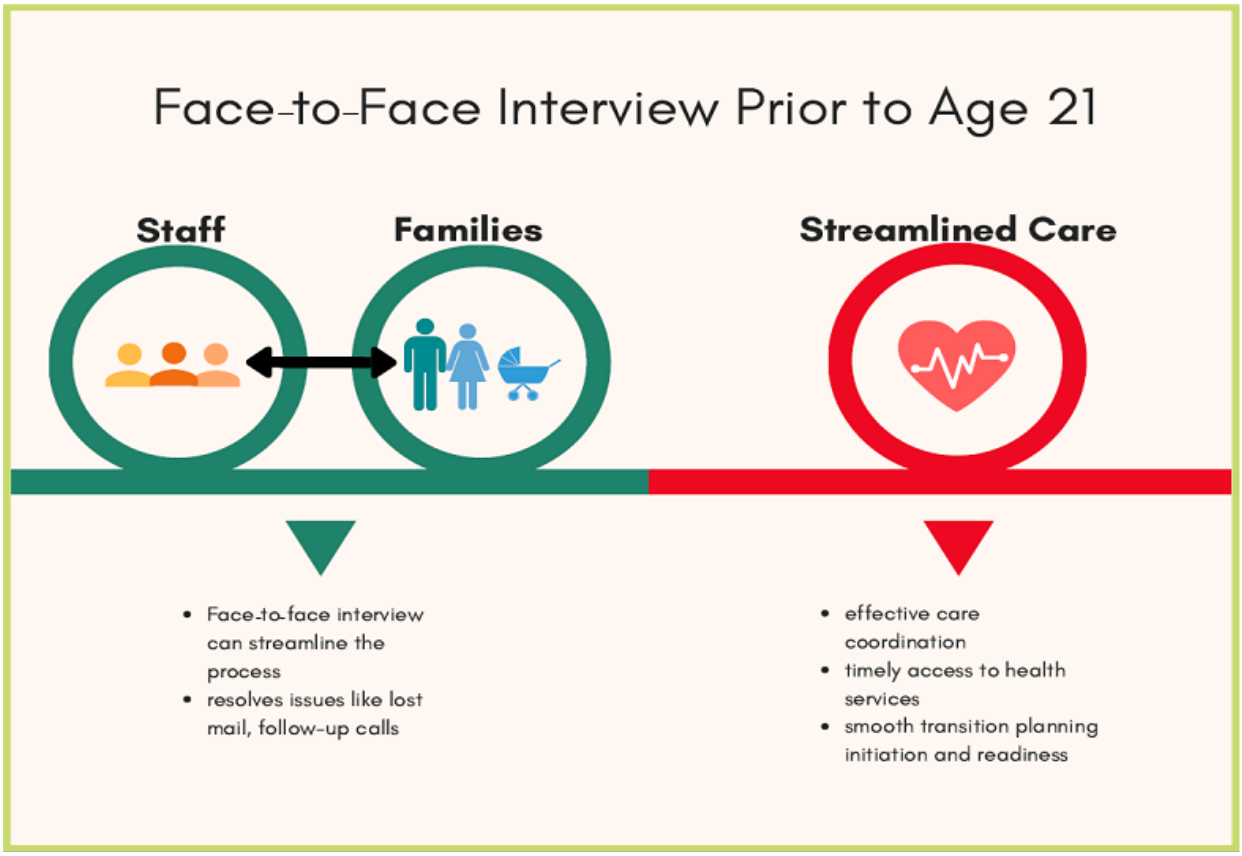
**Care Coordination interventions completed (if client scored 1-3)**
Education Topics:

Referrals Made:

Source: County of San Diego California Children's Services, 2016

An intervention was then implemented: Face-to-face exit interviews to identify barriers to Transition Planning Readiness **(*Figure 6*)**; referrals and education provided, and 3-month follow up.

**Figure 6. Interview Model.**




Source: County of San Diego California Children's Services, 2016

The final results demonstrated improved timely access to health care, effective care coordination, and smooth transition planning. Additionally, there was in increase from 70% to 90% in knowledge, behavior, and skills from 2016 to 2018.

## DISCUSSION

Youth with chronic medical conditions must prepare for changes as they get older, particularly with regards to navigating the adult healthcare system. They are a vulnerable population with increased risk for chronic disease outcomes and development of other comorbidities: premature aging, increased visceral adipose tissue, decreased bone density, increased incidence of mental health disorders, diabetes, emphysema, joint pain/arthritis, and decreased physical activity. The influence of these factors are important considerations in ensuring clients have a comprehensive transition plan (the process of preparing youth and families to move from pediatric to an adult model of health care) prior to their 21st

birthday when they can no longer access CCS services. The CCS program aims to achieve the desired result of having 90% of children aged 14 and over, whose medical record indicates a condition that requires a transition plan, to have documentation of a transition planning assessment and plan.

Looking ahead, the County CCS program continues to focus on meeting the needs of clients with serious, complex, and/or chronic medical conditions and disabilities who have ongoing needs and will be transitioning out of the CCS program. These needs will continue to be addressed through both in-person and virtual TP Workshops, updates to transition planning policies/procedures to align with a health equity focus, increased resources via social media outlets for accessibility, linkages to community resources, and a CCS ambassador program where former CCS clients are set up as mentors for young adult clients.

In 2023, with the COVID-19 Public Health Emergency ending, CCS began implementing a combination of virtual and regional in-person transition to adulthood planning workshops to further promote CCS services as well as *Live Well San Diego* Initiatives— including Supporting Positive Choices, promoting Health Thriving Communities, and Building a Better Service Delivery System. These events will support the CCS Strategic Plan objective regarding providing appropriate and timely transitional planning services.

Additionally, the CCS programs plans to invite community partners to the live workshops to provide community programs information and health insurance coverage information. Community Resource Fair Exhibitors who will be invited include: Medi-Cal Managed Care Plans/Health Care Options, San Ysidro Health, Home & Community-Based Alternatives Waiver, Access to Independence, California State University San Marcos- Disability Support Services, CA Department of Rehabilitation, Exceptional Family Resource Center, Legal Aid Society of San Diego, Maxim Healthcare Services, North County Transit District, Palomar College Disability Resource Center, San Diego Regional Center, Southern Caregiver Resource Center, and Together We Grow.

The County also added two new health services social worker positions to the CCS Program, in 2019, to help address gaps that existed in the transition of children with special health care needs from a pediatric to adult model of health care. Again, in 2022, one new social worker position was added due to an increasing caseload of clients eligible for the program. The CCS Program will continue to evaluate staffing needs as there is more research and direction of best practice interventions related to transition planning for youth with complex medical conditions, to ensure that the County is providing all necessary and evidenced-based support for the most vulnerable.

## CALL TO ACTION

Children and youth living with physical disabilities served by the CCS program are a vulnerable population with increased risk for chronic disease outcomes. As children and young adults living with disabilities transition through adulthood, they often develop other comorbidities. The influence of these factors are important considerations that have led the CCS program to commit to promoting the following continued actions:

### California Children's Services Medical Therapy Program

- Equity of Services: The CCS program is looking to improve health outcomes across the lifespan, by evaluating which of the various delivery system models most positively impacts access to care, quality of care, and the patient experience.
- Analyses of administrative data focus group and survey input to help determine an ideal model of care coordination that can be implemented to provide optimal outcomes for the underrepresented populations within CCS.
- Referrals to CCS health services social workers to address potential disparities and assist with transition planning.
- Examination of County of San Diego region-based issues related to access to care.

### Transition Planning

- Continue to provide resources to clients as they transition out of the CCS MTP at age 21, including to adult healthcare providers such as occupational and physical therapists and primary and specialty care physicians.
- Continue to provide case management in collaboration with public health nurses and health services social workers at designated age intervals starting at 14 years old.

### Providers

- Adult healthcare providers will seek education on specialized services required for adults with disabilities to address such issues as decreased physical activity and other comorbidities, promoting equitable access to care.

## CONCLUSION

The CCS program continues to focus on the California Department of Health Care Services performance measure of ensuring children 14 years and older, who are expected to have chronic health conditions that will extend past the 21st birthday, have documentation of a biannual review for long-term transition planning to adulthood. In San Diego County, the specific target is to ensure 90% of children aged 14 and over, whose medical record indicates a condition that requires a transition plan, will contain a transition planning checklist/case note of transition planning intervention based on a quality assurance review of a sample of cases. As of December 2022, 89.66% of applicable client charts were meeting this target. Attendance at a transition planning workshop that is documented satisfies the requirement of a transition planning intervention for a client. Supporting CCS youth in the transition from pediatric to adult medical care supports the improvement in long term health outcomes of this vulnerable population which helps advance health equity in San Diego County.

## REFERENCES


1. Department of Health Care Services. (2023). California Children's Services. https://www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx

2. U.S. Department of Education. (2010). Free Appropriate Public Education for Students With Disabilities: Requirements Under Section 504 of The Rehabilitation Act of 1973. https://www2.ed.gov/about/offices/list/ocr/docs/edlite-FAPE504.html

3. U.S. Census Bureau. 2017-2021 American Community Survey 5-year Estimates, Table S1810.

4. U.S. Census Bureau. 2017-2021 American Community Survey 5-year Estimates, Table S18101.

5. U.S. Census Bureau. 2017-2021 American Community Survey 5-year Estimates, Table B1810H.

6. U.S. Census Bureau. 2017-2021 American Community Survey 5-year Estimates, Table B1810I.

7. U.S. Census Bureau. 2017-2021 American Community Survey 5-year Estimates, Table C18130.