PHM Advisory Group Meeting

May 31, 2022

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Jonah Frohlich – 00:00:52	Hello and welcome. My name is Jonah, and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the Q and A. We encourage you to submit written questions at any time using the Q and A, the chat panel will also be available for comments and feedback. During today's event, live closed captioning will be available in English and Spanish. You can find the link in the chat field. With that, I'd like to introduce Dr. Palav Babaria, Chief Quality Officer and Deputy Director of Quality and Population Health Management at DHCS. Dr. Palav, you now have the floor.
Slide 2	Dr. Palav Babaria – 00:01:38	Thank you so much. Hi, everyone. Really great to see you all again, and I'm really excited for what we have on the agenda today for our May population health management advisory group meeting. This is our agenda for today, not going to read all of it out loud, because we definitely want to get to the discussion part with the brain trust that we have on our advisory group. Go to the next slide. So a few things, most of you have probably seen these slides before. But I'm going to be doing our DHCS public service announcement. As everyone is aware, during the public health emergency, all Medicaid programs suspended redeterminations. So we have seen our Medi-Cal program grow during the public health emergency, as we were not doing redeterminations and taking people off the Medi-Cal program, when they no longer met eligibility requirements. We recognize that when the PHE ends, we anticipate millions of Medi-Cal beneficiaries may lose their Medi-Cal coverage.

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Slide 3	Dr. Palav Babaria – 00:02:36	Hopefully they're eligible for other types of coverage, either through their employer, with employer sponsored coverage or through the exchanges via Covered California. We really do need to get the word out broadly because many of our Medi-Cal members have not had redetermination, their addresses have changed. Their phone numbers have been changed. They may not have heard that they need to go through this process again, sometime this year to keep their Medi-Cal eligibility. So we want to get the word out so that anyone and everyone who is coming into contact with our members or in their communities can help spread the message. So if you are interested in becoming a DHCS coverage ambassador or supporting this work for your organization, please check out our webpage and join the mailing list so you can get updates as well as updated toolkits. Once the process is rolling. And go to the next slide.
Slide 4	Dr. Palav Babaria – 00:03:28	So there's really two phases. Phase one, which is what we're in right now is really just doing awareness for our members, that this process is coming up, that they need to keep a lookout, that they need to update their contact information if they haven't and they've moved. And then the second phase, which we will have 60 days of notification prior to the end of the public health emergency from the federal government. And then the redetermination phase will launch in the staggered fashion. And then at that time, all Medi-Cal members will need to watch for their renewal packets in the mail so that they receive these packets, complete these packets and retain critical health coverage. So please help us get the message out. Links are provided. Go to the next slide.
Slide 5	Dr. Palav Babaria – 00:04:12	So now I'm really please in keeping with our goal of really centering all of the work we do with our members at the center of all of our design work and really paying attention to their needs and pain points and making sure that our policy and programs meet those needs. I'm going to turn it over to Anna Sutton from Santa Cruz county to share a member story with us.
Slide 6	Dr. Palav Babaria – 00:04:39	Anna, I will pass it to you.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Anna Sutton – 00:04:42	Thank you so much, Dr. Babaria. So thank you. DHCS and members of population management for this opportunity to share an experience and case that I was able to participate in a few years ago as a public health nurse working in the field. I was a CPSP coordinator at the time, as well as the SIDS nurse. So this case is a case of a mother who with local Medi-Cal managed care had actually been admitted to a hospital for treatment and evaluation because her baby had actually been found, passed away in the sleep and as required by public health legislation and California legislation, when there is a baby who has died in their sleep, any baby that has died actually under the age of 12 months, the public health department is notified, and there is a PHN, generally a SIDS nurse, who goes out, even if it's suspected to actually provide mom, legally a required assessment and services, as well as ancillary supports, including the pediatrician and other providers.
Slide 6	Anna Sutton – 00:05:48	So this was my role in going out and visiting this mom within 72 hours to assess both her medical, psychosocial, and mental health issues and needs. I was connected with mom after discharge from the hospital at a rehab facility, where she was staying, when I was able to actually meet with her and go through confidentiality and explain to her my role in supporting her, her grief, and her support around the loss of her baby. She did share with me because the required SIDS assessment for a PHN is very comprehensive. We are looking at her housing, her meds, her loss, her grief, her social conditions. And it was at that time that I discovered that she had been without medications for almost a couple of weeks, maybe a week and a half. And she was on quite a number of psychotropics.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Anna Sutton – 00:06:42	She had not received any postpartum care at all. The baby was a few months old, but she had not gone back for any postpartum care. She wasn't wearing any clothing that looked like it had fit her, along with her shoes. And she definitely had not received any services related to the sudden loss of her child, had not been connected to primary care in quite a long time. She didn't know who her primary care doctor was and was clearly still in a state of shock from all the events surrounding her child's loss. This is also a mom who had lost a previous child to custody, not to passing away.
Slide 6	Anna Sutton – 00:07:19	Because of my role of being able to be a SIDS nurse and go out to meet the mom in her place of residence, I was able to help navigate helping her refill medications. I was able to find clothing through a local woman's shelter and connect with our local FQHC, who was a CPSP provider, who I had known quite well and were willing to see her and get her restarted in her OB care. And one thing that made a big difference, too, was I was at the time very closely working with our local Medi-Cal managed care plan, and they had a very strong perinatal program and coordinator. And through that individual, she hooked me up with a point person in member services. And that individual was just a huge help in helping me understand how I could continue to advocate for this mom and link her to services because these things were happening very quickly. I knew that she couldn't be off of her psychotropics for very long and really needed to have evaluation after having had a baby, she was very, very high risk for maternal mental health disorder as well. But he was able to educate me on making her special member status, which at the time, I didn't know what that was.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Anna Sutton – 00:08:25	And it basically unlocked her from having to be in the county of residents. And I was able to then have a much broader network of providers to call around and ask for services, as well as pharmacy and specialty care services, because she was going to need the help of a psychiatrist. And through all of this, I was able to then also begin to talk to her once the safety services were put in place to begin to help her understand how grief was going to impact her path, because addressing her grief at this time when basic needs were needed was just not possible. We were able to meet successfully for several weeks by phone in person, but sadly, and this is very common in these cases, the mom, all of a sudden, left the facility, I showed up one day to meet her and she was no longer there.
Slide 6	Anna Sutton – 00:09:12	I called her OB GYN. She had made one visit but had not followed up since then. She had not picked up a couple more of her prescriptions and I wrote letters and called numbers and phone numbers and addresses that we had on file for her. But we never heard back and with SIDS visits and public health nursing visits, these are voluntary. So we do the best we can to try to contact them and ask them to get back in touch with us. But, unfortunately, this is as far as can go often. So that is the experience I had locally. I really appreciate being able to summarize this all for you, and I think I'll turn this back over to Emma.
Slide 6	Dr. Palav Babaria – 00:09:54	Thank you so much. Sorry, go ahead. Go ahead, Amy. Amy.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Dr. Amy Salerno – 00:09:57	I was just going to say, I think I'm going to just take a minute to just thank you so much for the work that you do every single day, not only you, but kind of all of the public health nurses and a lot of the providers that do these services already. And I think we wanted to just take a minute to like to highlight the value and importance of that work. And also note that the connection to the MCP was critical in being able to access services and point out where we really think this story really highlights the amazing, valuable work that is happening every single day across California in these instances. And also highlights a lot of times the gaps that exist, both in the notification before people are discharged from the hospital so that people can get connected to services like in planning for discharge from the hospital.
Slide 6	Dr. Amy Salerno – 00:11:04	And then also the longitudinal support that sometimes is missing in the long term services that these members need and show that while these services that you've provided are really critical, we really do, we're trying to imagine how PHM can help fill some of these gaps. So when the transitional care services, portion of the population health management, we are really expecting MCPs to identify members when they're admitted and connect them to care managers, to help plan for discharges prior to discharge and follow them through their needs, including assessment for ECM, and this member would've qualified for ECM due to her substance use disorder, and therefore could receive these supportive care services prior to discharge from the hospital to the rehab facility all the way throughout long term. And we're hoping that these services and supports can really bolster up the really great work that, Anna, you're doing already. And I'll turn that back over to Palav.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Dr. Palav Babaria – 00:12:15	Thanks, Amy. And yes, Anna, thank you so much for the work you do for lifting up the story and for really showing us areas where things are working and we need to scale them, but also opportunities that we have for doing better. I think we can all recognize obviously losing a child is one of the most traumatic things any individual human being can go through, as are numerous other interactions with our healthcare system and illness and loss. And the more we can make these transitions seamless to really take out navigating the system as an additional barrier and source of trauma for the members that we are serving, the better it will be. And so really look forward to digging into a deeper dive on transitional care with all of you a little bit later today, but in meetings to come to really think through how do we much more effectively support our medical members, Medi-Cal members at periods that are probably among the most vulnerable periods they're going to experience in their lives.
Slide 6	Dr. Palav Babaria – 00:13:19	Thank you, Anna. We can go to the next slide.
Slide 7	Dr. Palav Babaria – 00:13:25	So the rest of our time today, we're really going to dig into the advisory group comments that we received on our draft population health management strategy in roadmap, and then really dig into a few areas where we'd love to hear more from all of you and help us flush out our understanding as we work to finalize this strategy and roadmap. Just a reminder to everyone, our advisory group, please just take yourself off of mute and join in as we're going along. To everyone else who's joined from the public, the chat is open and you can access it, and so as we are reviewing this, if you have thoughts and ideas and suggestions and answers to our questions, please do not be shy. We read each and every single one of them and incorporate them into our thinking.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 8	Dr. Palav Babaria – 00:14:09	So a little bit of background, if you're new to this meeting, last month, we released the draft population, health management strategy and roadmap for public comment. We got 37 letters, and then we also got specific feedback from our advisory group members that we're going to be digging into today. The roadmap really at a high level describes what the concepts are for population health management, the terminology, and what the vision is for 2023 and beyond with specific vignettes and member stories to really illustrate how we envision this working in the future state. And go to the next slide.
Slide 9	Dr. Palav Babaria – 00:14:49	So these are the five sorts of buckets of topics that we're going to be going through. We had substantial comments sort of on screening and assessment around the specific population needs assessment and the population health management strategy that will be required on a periodic basis. Lots of comments about transitional care services, very pertinent to the member story that we heard today. Lots of questions and comments about providing services and supports and who does what and how they're contracted. And then obviously just given the important role that the population health management service will be playing in our program. Lots and lots of questions about the service, risk stratification segmentation, and data sources. We can go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Dr. Palav Babaria – 00:15:33	So we're going to start with the screening and assessment section. So a few questions that we got that we just want to answer and make sure that everyone is clear about. First was what is the timeline for completing the HIF/MET and the IHA and whether or not they can be combined? So the HIF/MET must be completed within 90 days. This is a requirement that we have not set. If the IHA is completed within 90 days, then we are fine with the HIF/MET being delegated to the provider and combined with the individual health appointment. And DHCS will consider both of those screening requirements to be fulfilled by a single activity done at the provider level, given that it meets the requirements. I will flag that the IHA does not need to be done within 90 days, but in order for it to be combined with the HIF/MET process, it does need to be done within 90 days, since that is when the HIF/MET is due.
Slide 10	Dr. Palav Babaria – 00:16:29	In terms of the screening timeline for the IHA, for any member less than 21 years of age, if the member is less than 18 months of age, the contractor is to make sure that the initial health appointment is within 120 calendar days from enrollment or within the regular periodicity table and timelines as set by the American Academy of Pediatrics. For members ages 18 months and older, the contractor must ensure an initial health appointment performed within 120 calendar days of enrollment. And then for adults, it also has to be done within 120 calendar days of enrollment.
Slide 10	Dr. Palav Babaria – 00:17:10	The second question was with the retiring of the HRA, if a member's high risk and or has LTSS needs, what tools should the MCPs use and will the CCM or ECM tools suffice. So on this one, we do still have some requirements to use the standardized LTSS referral questions that can be found in APL 17-013 for only select high risk members. MCPs can sort of more broadly retain their HRA tools if they want, but that will not be a requirement imposed by DHCS. And then MCPs can also use other existing tools to the extent that it makes sense for the patient use, including ECM and CCM tools that may be available. But the only requirement is to use the standardized LTSS referral questions for select high risk members.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Dr. Palav Babaria – 00:18:02	I'm going to pause there if any of our advisory group has questions. Otherwise would love to open up for discussion here. I think a fair number of the comments touched upon DHCS's proposed requirement that HIF/MET results should be shared between managed care provider plans and providers. And so that if the plan conducts the HIF/MET, they figure out a way to transmit that information to the provider or vice versa. If that HIF/MET is delegated to the provider, that the provider is sharing the results of that HIF/MET back up to the plan level, so that there is robust information sharing and coordination around whatever the results of that survey are. We did not specify how this should be done, and we're going to leave it up to the MCPs and providers to figure out what the mechanism is, what specific information would be shared and through what mechanisms. I'd love to open it up to our advisory group now, to hear what concerns are there, if any, with this approach and, or have you solved this problem locally and want to share the amazing ways in which you are transmitting data between plans and providers.
Slide 10	Dr. Palav Babaria – 00:19:12	And Tangerine, I see you've already got your hand up, so we're going to go to you first.
Slide 10	Tangerine Brigham – 00:19:15	Yeah, no solution, more questions than solutions follow if that's okay.
Slide 10	Dr. Palav Babaria – 00:19:23	Only for you. Fine.
Slide 10	Tangerine Brigham – 00:19:25	So, I think we commented on this one and thanks for clarifying the 90 versus 120 days, but when it comes to sharing this information across the health plans and providers, one of the things I'm a little unclear about is, whoever is sharing the information, is it just the ultimate result? Is it all aspects of the actual form? Every question the person answered, is it the results? It's unclear to what level of information you want shared. And then I'd be curious if the state has any perspective of whether they think this should be something that the health plans do and share with providers or vice versa.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Dr. Palav Babaria – 00:20:18	So I would say, I think at a high level, the goal and why this requirement was envisioned in the first place is that, we do not want any assessments that are done and then get shoved in a drawer, electronic or literal, where no one sees them. No one looks at them again, everyone forgets what the responses were, and we don't want a situation where a member spent 20 minutes filling out an assessment for their plan, and they show up to their provider's office only to have each and every single one of those questions asked of them again. So that's the goal. The goal is really, let's not ask the same questions over and over again for our members. Let's value their time, that if they answered a question once, we do the due diligence to share it, and that we are doing something with this information, that we are not just asking questions to ask questions, but that we are taking action on the results that we get. So I would turn it back to this group and say, if that's the vision, what is the information that is helpful here? Is it every single question? Is it just the positive questions? Is it something that you have to get via your EHR to make it actionable? I will. I will ask the group. Bhumil, I see your hands up if you want to go next.
Slide 10	Bhumil Shah – 00:21:32	Yeah. Thanks Palav. I think this may be an area where we may want to be a little bit prescriptive, provide a minimum expectation on how the data would be shared between the plan and the provider, because sometimes we see sharing information is printed out and mail it, or and then it gets scanned and saved in the EHR and nobody ever looks again. So it's the two values, the data being available at the point of care, most providers are on EHRs, capturing social determinants of health. If this information flows back and updates the right field, then it becomes useful at the point of care. So setting some expectations electronically at a minimum, how the data can be submitted. The plans and providers should be allowed to go over and beyond, if they find a more efficient process, but at least a minimum expectation of how this information becomes available electronically at the point of care. I think having the guidance would be helpful.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Dr. Palav Babaria – 00:22:27	Thank you. So hearing that, maybe we don't want to just leave it up to everyone to figure out and having some more standard formats that meet that goal would be great. Rebecca, I see your hand up.
Slide 10	Rebecca Anderson – 00:22:39	Yeah. So it's very similar to what Amelia just said. I think with our providers, we have a wide range of providers that are under a wide range of systems. To make this data as useful as possible, each of those responses would be mapped to a location in their EHR that would give, would be where that provider tends to look, not like not just to be a separate-
Slide 10	Rebecca Anderson – 00:23:03	Provider tends to look not just be a separate document or a secondary place to look. And I think the burden of that mapping and making sure that feeds to a place that's useful to providers is where the challenge lies.
Slide 10	Dr. Palav Babaria – 00:23:22	Thank you. Phoebe I see your hand is up.
Slide 10	Phoebe Bell – 00:23:33	I don't know if this is the place it belongs, but just throwing in the behavioral health piece of things and just kind of underscoring the need to do screenings on the primary care side that then effectively translate into referrals to the behavioral health side, whether it's at the county level or the managed care plan level, but building in that two way connectivity and equally much on our side, making sure that the appropriate health screenings are happening. And yeah, so again, I'm not totally clear this is where that belongs, but just want to throw that back into mix.
Slide 10	Dr. Palav Babaria – 00:24:07	Yeah. Thanks Phoebe. Especially as we start to work on all the screenings and the behavioral health side for the CalAIM projects too, really thinking through that connectivity is critical. I don't see any other hands up. My Manatt team, if I'm missing hands, please let me know. But I think we can maybe go onto the next slide. And if folks have comments on this, you can always drop them in the chat or we can come back to it in a little bit. So.
Slide 10	Sharon Woda – 00:24:40	Took a moment to get off mute. There was a comment in the chat on the IHA and who would complete the IHA. And I think it's probably worth resaving again, that the IHA is the health appointment completed by the position. Just so that folks are clear about that.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Dr. Palav Babaria – 00:25:00	Correct.
Slide 10	Sharon Woda – 00:25:00	I don't know if you have anything else to add.
Slide 10	Dr. Palav Babaria – 00:25:02	Yeah. So even in current state, the IHA, it is essentially sort of your first medical appointment once you've been enrolled into the health plan and is completed by a licensed medical provider, whether physician, nurse practitioner or otherwise. So, that will not be changing. We will be clarifying obviously what the requirements are for the initial health assessment and revising that ATL language to broaden it and be more consistent with the way we track some of those annual visits using HEDIS data. Rebecca, anything else to add or is that your hand up just from before?
Slide 10	Rebecca Anderson – 00:25:42	Oops.
Slide 10	Dr. Palav Babaria – 00:25:44	No problem. Great. You can go to the next slide.
Slide 11	Dr. Palav Babaria – 00:25:49	Okay. So the next bundle of comments was really around the population needs assessment and the population health management strategy. So there's a question about can the strategy be aligned with N C Q A submission to avoid duplication and then also particularly around the sequencing and the cadence, why is the strategy an annual thing? Why is the PNA a three-year cycle and does the PHM strategy need to be revised in its entirety on an annual basis? Or will the framework remain the same with just some of the elements updated? So I think for the first point, we absolutely agree as we've stated before, the goal is not to create undue administrative burden and wherever we can align with N C Q A, we absolutely intend to do this. So starting in 2023, all managed care plans will need to meet the N C Q A population health management standards, which include the requirements for performing a population assessment and developing a population health management strategy.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Dr. Palav Babaria – 00:26:52	So the sort of annual cadence of that is aligned with what N C Q A already requires. And then in terms of the PNA reports, we envision the population needs assessment as we are describing it in the roadmap to be a much broader, more comprehensive, almost community level community health assessment, and to be more expansive and in depth than what N C Q A requires on an annual basis, which is really looking at the data and understanding your assigned population. The goal of doing it on a three-year cycle is we think that lift and level of community engagement, is really-
Slide 11	Dr. Palav Babaria – 00:27:36	Sorry. We at the state turned off our lights to conserve energy. It's really wonderful until you're in the dark. So we really didn't think that it is something that really can be done on an annual basis just given what the lift is of that in depth community engagement. And this also aligns with sort of the frequency with which public health and other entities are doing their local community health assessments. And we are going to be supporting in requiring collaboration with those entities to really have coordinated local plans. So I hope that that answers those questions. And Sharon, did I miss any major content on that one?
Slide 11	Sharon Woda – 00:28:18	Nope. I think you got it all.
Slide 11	Dr. Palav Babaria – 00:28:20	Great. And we won't be [crosstalk 00:28:22] go ahead.
Slide 11	Sharon Woda – 00:28:24	Caroline's point. I didn't know if you want to take a question now.
Slide 11	Caroline Sanders – 00:28:28	Oh, just really quickly. I wanted to say thank you to DHCS for explaining the difference. I think we're excited that there is an N C Q A PHM strategy that's getting rolled out and at the same time, I think California is doing, can and should be doing more and this broader type of strategy is really important. Realizing that there may be similar aims of both, but they are separates strategies and ones that compliment rather than duplicate. So I just wanted to say, thank you for that clarification. It wasn't a question that we had, but I think we're happy and supportive of that approach. Thanks.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Dr. Palav Babaria – 00:29:28	Thank you. And then we will be issuing much more detailed guidance specifically on the PNA and the PHMS in the future. But obviously I think that principle to this last bullet point, we are really going to try to lessen administrative burden and really focus on when we are updating things that it is because we have new data or new information or need to adjust our programs to maximize outcomes, quality, and equity, and focusing on those elements as the highest priority.
Slide 11	Dr. Palav Babaria – 00:29:59	And then for the discussion and Gary, I see your hands up, I'll come to you in one second. I don't know if it's about stuff I said or stuff that we want to talk about, but as we've described, I think the vision, especially for the three year cycle needs assessment, is to foster much more collaboration between managed care plans, providers, counties, public health departments, which are also doing this work and other stakeholders that there is really a coordinated, local effort around population and community health. So I would love to hear any thoughts from this group on what is the best way to do that and ensure that collaboration is robust and meaningful. Gary we'll go to you.
Slide 11	Gary Tsai – 00:30:38	Yeah, thanks. So on the collaboration between the managed care plans and counties, providers, other stakeholders, I know that you just addressed this somewhat, but I think I'd like to see more of a focus in the roadmap and in some of the PHM documents on behavioral health, obviously Cal aim has a big focus on it generally, but I think for PHM specifically, we need to get specific with the managed care plans around how we want to see them focus on whole person care, right? And in terms of how we can achieve effective collaboration. I think making sure that we include certainly counties. And when we talk about counties, physical health, mental health, substance use, making sure that they're all participating in the development of this process, I think will be helpful.
Slide 11	Dr. Palav Babaria – 00:31:35	Great flag on the behavioral health. Thank you. Beth, we'll turn it over to you.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Beth Malinowski – 00:31:40	Great. Thank you. And appreciate just this question being put up here today. Certainly I think it's central for us at SCIU. Thinking about how does and what does collaboration look like? I think, for us, it is both thinking about what is that collaboration as move towards the actual assessment happening at the local level, but also once we've done that assessment, has that translate to some collaboration on decisions on what happens next?
Slide 11	Beth Malinowski – 00:32:07	And while I know I think there should be a balance probably in how prescriptive the state is, I would just recognize and acknowledge that I think collaboration looks very different across managed care plans today, across counties today. And I do think there is going to be a level of direction that's going to be needed from the state to really make sure there's kind of a clear ground game to make sure there's some consistency I would say, and how the needs assessment are both getting designed and developed, but then how that translates to action and change in terms of how we're meeting the needs of the population. That's of course, inclusive of our consumers, the clinical teams that are doing the work, and our county partners.
Slide 11	Dr. Palav Babaria – 00:32:53	Thank you.
Slide 11	Sharon Woda – 00:33:06	Kimberly.
Slide 11	Kim Lewis – 00:33:10	Hi. Thanks Paula and DHCS for this. And for having this with the feedback that people have submitted to you, it's great to see this discussion. I think one of the questions I had around that sort of if we're doing this every three years, the PNA, and you're wanting to try to get input obviously from existing providers and systems that the person's involved with, I wonder how this would work when you have enrollees who may be moving between plans, or you may have enrollees who are adding their need for services or changing providers, and how are you going to sort of have a more fluid PNA that reflects those changes either population wise or even individually, obviously? And I just don't know if you've thought through that and how that would look if that is impacted by it.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Dr. Palav Babaria – 00:34:04	Yeah. I think lots more thinking that needs to be done in this space. I'll caveat with that, but I think that's part of the impetus of really thinking beyond just the managed care assigned population and really doing a broader community assessment is for that very reason. Obviously if someone moves out of the region entirely, that's sort of a separate issue, but we know people switch plans and providers all the time. So much of what influences and individuals health and health outcomes is really not always even held at that individual level that is held at the community level and in the educational district and in their neighborhood. And what's happening with all of the social drivers and other drivers of health. And so I think the goal of the PNA is to really think broader than just here are my assigned lives and here's my network and what do they need, and really get out of healthcare walls to figure out what those upstream needs are in a much more collaborative way. And that may include individuals who are not in the plan, right? It may include other folks. And we have to think more broadly about that.
Slide 11	Sharon Woda – 00:35:15	Also just in response to one of the questions in the chat that, because this version that we're talking about of the PNA is not yet designed, some of these questions around communicable diseases and what will be included, what isn't, how that collaboration happens and how that all comes together is sort of something we'll want to bring back to this group to look at. I mean, what we're trying to specify now is there's a separate vision us and a for year vision, which entails a lot of collaboration engagement in order to have the broader community-based approach is what we're trying to accomplish. So some of the questions, like just to say in the chat and things are very, very good questions. I think we'll take them into account, but they don't have any answers yet today.
Slide 11	Dr. Palav Babaria – 00:36:08	Laura, I see your hand's up.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Laura Miller – 00:36:11	Yes. Thanks. Coming off mute. I think I'm probably just riffing on similar themes, but I totally want to put an emphasis on that. Getting out of our medical walls, COVID taught us that medical partnering with public health system is something that we hadn't done well, and we certainly need to do that. And then just thinking really broadly about what is community health? It has to do with food, housing, all those areas and really taking it outside the walls. Someone had a comment about consumer engagement that the health plans do, but I think those are a very few and far between people who will go to a health plan meeting. So I think it really does entail moving far outside the walls.
Slide 11	Dr. Palav Babaria – 00:37:00	Yeah. And just to lift up a few of those comments, then Maria I see your hand is up and I'll come to you in one second. You know, I think Rebecca asked about thinking about those consumer advisory councils and there's obviously a role to play in the overall quality and equity strategy and the population health management strategy, but the actual needs assessment, we envision being much more community based and involving many more people than what is just on that consumer advisory council. Again, which is why it's going to be every three years and not in annual effort because you could easily spend six months planning that.
Slide 11	Dr. Palav Babaria – 00:37:33	And then also Tangerine to your point. Yes, we are also tracking the sort of hospital community needs assessment in an ideal state. Those would all be sort of aligned and timed. I think when we last looked at this, they are all on different cycles. So that is a larger fish that we need to tackle as time goes on to see what potential there is for aligning the timing of all of these different assessments that occur across different entities. Maria, I think you had your hand up if you're still on.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Maria Lemus – 00:38:05	Thank you. I wanted just to support John's comment about that warm handoff to community, many CBOs, large, medium, small, already providing those informal services, either through education resources or they may have their own programs, exercise, a lot of they have a lot of services. And being a CBO, I know that we respond to what the community needs by developing curriculum training. And I think we do that across the state and forming the relationship with those CBOs, not only by resourcing funding, technical assistance, but also by acknowledging that dotted line to community. So when the patient leaves the clinic or planner, wherever they leave, they walk out the door, there is that resource there that can help them, that can provide even cooking or exercise or understanding what their services are and how they can utilize them. Those are really important things.
Slide 11	Maria Lemus – 00:39:11	So I think that link is really important, but acknowledging that it's a dotted line, that it is acknowledging the importance of community. And then for counties that think they don't have those resources, helping them build up those resources, building really supporting the organizational development of those small agencies. And there's a lot of informal agencies that are doing well, informal groups that are maybe not a CBO, not a 501 C3, but are doing this kind of work. How do we support them in counties where there are significant numbers of underserved in particular Latinos, especially up north, up above Sacramento and San Francisco, we're working up around Humboldt and Modoc and Shasta? My goodness. There's a lot of need there, but not a lot of organizations that provide service to the Spanish speaking organization. So how can we support those groups? How can we resource CBOs to grow in their capacity to really strengthen that partnership?
Slide 11	Dr. Palav Babaria – 00:40:16	Absolutely. Maria, thank you so much for elevating that. Bhumil, I see your hands up.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Bhumil Shah – 00:40:22	Thanks again. So the more I hear this, it looks like this is so similar to what public health departments often do, right? The public, the community health assessment, community needs assessment. Many of them have been doing it for decades. They have partnership with CBOs. They know the stakeholders, they interview, they have visioning sessions. Rather than having the same stakeholders attend multiple needs assessment, I'm wondering there's an opportunity to collaborate, take advantage of the expertise at public health departments and relationship they've already built. And the plans work with them based on their, support them, the resources and other means if possible, and then take advantage of the work and the relationships done public health departments have in place and use that to prioritize contracting and others as appropriate by the plans.
Slide 11	Dr. Palav Babaria – 00:41:10	Thanks for that suggestion, Bhumil. Mike, I see your hand is up.
Slide 11	Mike Odeh – 00:41:23	Thanks Paula. I'm with children now. I guess I was just wondering if THS is planning on issuing some parameters or minimum guidance or checklists. I mean, I'm sort of building on Bhumil said. I think there's a lot of knowledge and wisdom to leverage from public health departments. And obviously it'll look a little different in each locality, but I think first fives can also have a lot of resources to bear. I think ideas like partnering not necessarily a requirement as much as a recommendation, but partnering with grantees in the asthma mitigation project or the diabetes prevention program, right? Like there's already some thinking that's been built. And so that should be leveraged. And then the other thing I wanted to put on the table is making sure that oral health is part of population needs assessment, and that may be a whole kind of different group of stakeholders. So again, kind of some checklists to make sure that we are asking the right questions and meeting with the right folks could be really helpful.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Dr. Palav Babaria – 00:42:39	Thank you, Mike, for elevating those. Okay. I'm not seeing any other new hands up, so thank you all so much for your feedback on the PNA and PHMS. New acronyms that we get to add to our THCS acronym dictionary. And we'll go on to the next topic, which I think is going to need a little bit of time to wade through because we got a lot of comments on this one.
Slide 12	Dr. Palav Babaria – 00:43:05	So in terms of transitional care services, I'm just going to walk through some of the easier questions. Is the requirement to provide transitional care services to all members effective 1/1/23? The answer is yes. Do TCS requirements apply to members transitioning from incarceration? Answer to that one is no. These requirements are focused on transitions from one healthcare setting to another or to home or another community-based setting. There is an entire justice involved initiative, obviously for individuals who are in the incarceration system, transitioning to the community. And we have a specific advisory group that is working on informing what those transitions look like as well as what other additional supports and services those individuals need. So we can drop in the chat the link to our justice involved group and materials. And so anyone's interested in that group, you can find more information there. So we're focusing on sort of the rest of the population and transitions within healthcare settings and or to community settings.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Dr. Palav Babaria – 00:44:15	So in terms of roles and responsibilities, will the hospital staff or discharge planner be responsible for completing the discharge risk assessment prior to discharge? Was a question that I think several people asked and I think at a high level, the hospital staff or discharge planner should absolutely be involved in discharge planning and they likely would be the ones completing the discharge risk assessment. However, we envision that it's the managed care plan's responsibility and the assigned care manager's responsibility for coordinating with hospital staff, obviously contracting with those hospital entities and making sure that all of the requirements are met, even if those requirements are delegated down to the hospital or provider level. And then the next question was sort of what are the managed care plan's responsibilities when a member has other healthcare coverage, for example, Medicare and are MCPs required to provide transitional care to all me health members, discharging from inpatient health facilities, including behavioral health? And so I think for both of these, for duals and other populations that have multiple payers, we will be issuing more detailed guidance. I think you all can appreciate this gets very complicated, very quick, depending on what type of insurance is there, secondary payer and what type of plan they're enrolled in. So we will provide more guidance on that front. And then we are still figuring out sort of all of the roles and responsibilities for who is the primary care manager responsible when members are admitted to inpatient health facilities, including behavioral health. So more to come on that front, as well. Sharon, did I miss anything?
Slide 12	Dr. Palav Babaria – 00:46:00	Did I miss anything?
Slide 12	Sharon Woda – 00:46:04	Nope. You covered it.

PHM Advisory Group Meeting

May 31, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Dr. Palav Babaria – 00:46:06	So the place we did want to dig into with all of you is that obviously I think the population health management service will play a lot of roles. We do not anticipate at least for the near future, that that service is going to be a source of real time data. Because there will be claims lagged, there will be data that is older, so it'll be very useful, but it will not be very useful right away for real time notifications. So a lot of the work, not surprisingly, that needs to happen for transitions of care, you really need to know at that point in time when someone is admitted or in the emergency room or being discharged, getting that result three months later, not so helpful. So it is our expectation that where ADT feeds, i.e. Admission, Discharge, Transfer, data exists that all managed care plans will ingest that data to conduct transitional care management. Where ADT data does not exist, for example we know not all of our skilled nursing facilities generate ADT feeds, we'd like to understand sort of what existing solutions are in practice today for ensuring that plans are notified of transitions in a timely manner. What other solutions could be deployed? And do we want to make sort of any of these solutions statewide best practice? So would love to hear from a data perspective from this group, what is the best way to make sure that plans know in real time when a member is having a transition of care?
Slide 12	Jonah Frohlich – 00:47:48	I think that was a softball, right Palav? We're looking for... How do you get notifications now? How would you want them on a routine basis for every transition that you see? What would you want to see? Laura, I know you want to say something here.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Laura Miller – 00:48:06	Yeah. You can tell when I unmute, turn on my camera. I mean, I think that so admissions are relatively easy because you've got an authorization. If you can tap into the authorization, that's okay. I think one of the really hardest things is skilled nursing facility discharge even as a primary care physician and somebody who sits within the managed care world, I can never quite tell when somebody drifts out of a SNF and certainly on the primary care side, never have I gotten a discharge summary from a SNF or even a med list. Actually I take that back once I did, and we did have a really good SNF group that was taken care of skilled nursing facility patients at the level of detail that a hospitalist was doing it. So I think I'm sort of... There are some data pieces like authorizations, but I think the whole skilled nursing world and those transitions is an area that really needs a lot of focus. So those are... I would edit myself, but I think I got across some points.
Slide 12	Jonah Frohlich – 00:49:31	So would that suggest that from, I mean from a hospital, I mean there are federal requirements now that if somebody's discharged from a hospital, the primary care provider needs to be notified in real time that that happens, but those are at least... it's a rule. What I hear you saying, Laura, I think is we need to have some mechanism to support and ensure that skilled nursing, similarly, notifies at least the primary care provider, if not the provider of record and probably the plans that are responsible for their benefit, is that right?
Slide 12	Laura Miller – 00:50:16	I would say that yes. And, the add-on to that is, sometimes that discharge notification from the hospital, which is semi-functional, can just go into a bucket and a primary care provider may or may not see it. So how meaningful is that discharge notification? And then building a similar, meaningful notification system on the SNF side.
Slide 12	Jonah Frohlich – 00:50:48	Tangerine?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Tangerine Brigham – 00:50:48	You know, I just put it in the chat. So in addition to SNF, but respite, other sort of board and care facilities, I think it's sort of any lower level of care or any care transition where we think as a provider, either a community health worker or a public health nurse, or someone needs to reach out to the individual to help with either the navigation of that transition, I think is important. Trying to have a system that captures all of those movements.
Slide 12	Jonah Frohlich – 00:51:34	So there would need to be for some of those facilities, they don't have the same kind of infrastructure, right? So there would need to be some sort of technical assistance or support for them to know who to notify and have the capabilities to do some sort of notification. Right?
Slide 12	Tangerine Brigham – 00:51:53	Yeah. When we were talking about SNF a moment ago, I was thinking what do we do today? We generally, I think all use Allscripts, right? When we're trying to communicate to all the SNFs in a particular area to see if they have that availability, and they're all on the same system, they all get the information at the same time. We need something that sort of works for the reverse when someone's discharged, that will allow us to have that information.
Slide 12	Laura Miller – 00:52:25	I like that idea Tangerine, and I would say, also, just date of discharge and med list. If you've got the med list, you've got so much and Med Rec is life and life is Med Rec.
Slide 12	Sharon Woda – 00:52:43	Phoebe?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Phoebe Bell – 00:52:46	Again, not positive this is the right place to add this comment, but on the behavioral health side, we work super closely with our inpatient facilities and really coordinate discharge planning, generally speaking, and often do the transport back from inpatient and all those pieces. I think the piece that I'm worried about is having too many quarterbacks in the mix down the road. Like if we have somebody that's a behavioral health client who also is assigned to an ECM team who also gets care coordination or discharge planning through the managed care plan, perhaps separately, and just wondering how we're going to streamline sort of the coordination of all the care coordination at some point in time and making sure that's an effective process, I guess, basically.
Slide 12	Dr. Palav Babaria – 00:53:37	And Phoebe, do you have any recommendations on that front? Would you like to see it by who the primary payer is, or by type of care manager, whether it's ECM or otherwise, or more a case by case scenario?
Slide 12	Phoebe Bell – 00:53:53	Yeah. Or where they have long-standing history, maybe? Which from the client's point of view would make the most sense, and that's not as simple of a solution, but if they've been our client for 15 years and then they just got assigned to an ECM team and then they've been inpatient and there's a discharge planner, it would seem likely that their 15 year-long case manager would be a key player in the mix. But on the flip side, if we haven't really engaged with them yet and they are deeply involved with their ECM team or, I don't know, that's not a clean answer though. Sorry.
Slide 12	Sharon Woda – 00:54:48	Sort of come up with a theory of the case, right around ECM. That ECM care managers would do transitional care services, and same with CCM, but definitely understand that there are a lot of folks in the mix and that when you're crossing different payers, it gets pretty complicated. So appreciate the comments Phoebe. So this area did get a lot of comments, and I expected it will be one of the areas that will sort of continue development even after. We've always talked about things being a start in 2023 and then a journey from there on out. So I expect this will be an area where it's a little bit more part of the journey. Any other questions you want to raise here, Paula?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Dr. Palav Babaria – 00:55:50	Nope. More to come.
Slide 12	Sharon Woda – 00:55:51	Okay.
Slide 12	Dr. Palav Babaria – 00:55:54	I'm going to go to the next slide.
Slide 13	Dr. Palav Babaria – 00:56:04	Okay. So the next section was really on who should be providing services, especially for basic population health management. So on the primary care side we received recommendations that the member engagement for basic population health management shouldn't be limited solely to the assigned primary care providers, but that staff persons on the care team should be involved as well. Definitely agree. And we will make that clarification. I think there's also a lot of questions about is it recommended, or best, if managed care plans versus primary care providers are responsible for providing basic population health management? And I think this really depends on what the financial and contractual arrangement is between the primary care provider and the managed care plan. Obviously primary care providers in current state do a lot, if not most, of the elements of basic population health management and care coordination.
Slide 13	Dr. Palav Babaria – 00:57:01	And yet if the primary care provider is not sort of capitated or receiving assigned lines, many current electronic health records and providers don't know who their other assigned patients are who've never been seen. They really only get into the system once they've shown up, they've established care. And we know that we have really significant disparities in utilization of primary care and services by race, by ethnicity, by geography, by age. And so only focusing on people who show up to the front door is not what the goal of basic population health management is, it's really thinking about the whole population engagement strategies, how to bring members who are assigned, but not using services that they need such as preventive services and engaging them in primary care.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Dr. Palav Babaria – 00:57:46	And so would welcome additional thoughts from the group, but our thinking is there's probably going to have to be some nuance here where members who are engaged and established, it may be more appropriate to delegate to the primary care provider. Ones where there are capitated arrangements and data feeds are being sent that providers know who's out there that they haven't seen and have engagement strategies may be appropriate to delegate. But for others where they simply don't even know who's not coming in, that responsibility likely needs to remain with the managed care plan.
Slide 13	Dr. Palav Babaria – 00:58:17	The second set of comments was really around provider contracting and really encouraging the state to require levels of care management services to be provided by the same provider. And also that MCP should offer contracts to all existing ECM providers for both CCM and BPHM. So I think for both of those elements, yes, where there is a care manager provided to that member, we agree that the care manager should meet all member needs. For example, if someone is enrolled in a health plans complex care management program, that same care manager can, and should, be providing basic population health management or transitional care needs as needed because they are the one that already have continuity in a relationship with that member. In terms of offering contracts to existing ECM providers, we absolutely, where possible services should be delegated. However, we recognize that this may not always make sense in all situations.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Dr. Palav Babaria – 00:59:18	Some of those complex ECM providers are going to be community-based providers working in specialty mental health. They may not be based in primary care where they can provide comprehensive, basic population health management services to an individual who has no specialty mental health needs. So some of that may need to be taken in a case by case basis. And then for the discussion, as we start to think about accountability, especially for basic population health management, which is ensuring that everyone has engagement, access, and utilization, especially of preventive services and chronic disease management, beyond just the MCAS measures that we have, which are largely HEDIS measures, what other accountability measures should DHCS consider for the managed care plans to make sure that we are hitting our equity wellness prevention, care management, and BPHM goals and strategies? Start with Caroline.
Slide 13	Caroline Sanders – 01:00:20	Yeah. A great question, and I'm sure we'll have other thoughts as well, but I did want to just... A flag. I think this is an area where there are CAPS questions that specifically deal with care coordination and also cultural competency and some of these other, I think, pieces that you're, that you're getting at. And I think... I understand the emphasis on HEDIS measures and metrics and when you look at sort of CAPS, for example, care coordination measures as a composite, you can, I think, get a sense of what the consumer experience is in getting that type of coordination. So I just wanted to flag that. I'm sure others will have additional thoughts as well.
Slide 13	Dr. Palav Babaria – 01:01:31	Thanks Caroline. Mike, I see your hand's up.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Mike Odeh – 01:01:34	Thanks. I guess I'm... Specifically as it relates to BPHM and kids, I'm wondering if there's a measure that looks at under-utilization. I mean, I know there's some MCAS measures that are looking at how many kids got their well visits, but is there something to look at timeliness or the percentage of sort of that inverse those kids that aren't hitting all of those well visits? Because I think, not to put too fine a point on it, but prevention is really important for children's development so I think it can't just be... I think there needs to be something a little bit more upstream, and I don't know that I've seen a measure that does that, but maybe this is an opportunity for the state to create one.
Slide 13	Dr. Palav Babaria – 01:02:27	Thanks, Mike, and agree. Other than the inverse of some of those HEDIS utilization measures, I don't know that we have a great one today. Kim, I see your hand's up.
Slide 13	Kim Lewis – 01:02:41	Kind of on the theme of some of the process measures that are, I think, talking about in terms of how the system's performing. I think those are really important. I mean, there are some around, HEDIS measures around follow-up care after a hospitalization discharge or within a certain number of days, but something more, measures more specific to referred follow-up care. So PCPA recommending follow-up care with certain appointment for other, either for carved out services or for specialty services within the plan and whether those services were provided, whether that follow-up happened some more kind of measures around tracking referrals and follow-up for those referrals, I think is really important.
Slide 13	Dr. Palav Babaria – 01:03:30	Thanks, Kim. Catherine?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Catherine Hayes – 01:03:33	I'm not exactly sure where to put this comment, but as I was reading, and I didn't send it in, I'm sorry, that there's a tension among population-level standards and individual circumstances. And given the risk of delayed diagnosis among the medical population, and the fact that certain kinds of conditions affect some of the members earlier than the standards would have screening. My interest is how do we make sure that exceptions can be rapidly processed? If there is an inkling that somebody should be screened for colon cancer at age 35, for example, and how do you hold plans accountable for expedited processing so we don't have delayed diagnosis? I don't know where that goes, but that's what I've been thinking about.
Slide 13	Dr. Palav Babaria – 01:04:41	No, really helpful. Hearing lots of comments about sort of closed loop referrals, timeliness of getting the services that are needed, because that isn't always captured in our current measure for accountability systems
Slide 13	Catherine Hayes – 01:04:56	And some kind of provisions for exceptions because the standards haven't yet caught up.
Slide 13	Dr. Palav Babaria – 01:05:02	Absolutely. Thanks Catherine. Other questions or comments on this topic?
Slide 13	Maria Lemus – 01:05:14	This is Maria. I just want to comment that, on the last comment, that regarding the timeliness telehealth kind of throws a wrench in things. And while some are increasing the amount of appointments by telehealth, to follow up with that and the real time assessment of what the problem is may not be fully actualized. And so it leaves that patient in limbo for a longer amount of time. I'm not sure this is particularly important in rural areas where there's less access to clinics or hospitals or plans. I'm not sure where to put that, but I know that's an issue in our communities.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Dr. Palav Babaria – 01:06:01	Absolutely. You know, I think, I think it's sort of the double edge sort of telehealth is that how rapidly it rolled out really has been amazing, because it's allowed for such transformation in our healthcare delivery system, but also means that there's still a lot that we need to learn about what's working, what's not working and how to really optimize the appropriate use of telehealth while still meeting our members' needs and expanding access. So thank you Maria, for lifting that up. Laura?
Slide 13	Laura Miller – 01:06:28	Yeah. I just wanted to go back to the piece that you were raising around, who is best placed to do the basic population health management. I fully agree that at ECM, CHW can manage the basic healthcare maintenance, the pop health, for their clients. But I think the role for the general population is really different. If you just think about caseloads, right? A CHW may have 40 people, 50 people. And the panel for someone doing basic population health management has to be much bigger, right? If you think about tiering and all of that, and then we need to think, too, about our technology systems. What can we do with text messaging? It's not warm and fuzzy, but it may work and how do we manage digital provide and really have that happen equitably? So more questions and answers, but just wanted to really raise that distinction between what an... The world of an ECM provider is a small number of very intense need folks and a person in charge of basic population health management has to have a much broader panel.
Slide 13	Dr. Palav Babaria – 01:07:45	Thank you. Phoebe, I'll take your last comment and then we're going to move on to our next section.
Slide 13	Phoebe Bell – 01:07:48	Sorry. This is just sort of a blanket comment, it'll be super quick. But I, as a behavioral health person, not a physical health person, I'm definitely struggling with a number of acronyms we're using and just would put out a plea for whenever we can to use whole words, because I'm really trying hard to keep up, but I'm feeling a little lost by some of them.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 13-14	Dr. Palav Babaria – 01:08:08	Very, very fair feedback. Thank you so much, Phoebe. And we'll type out what these ones made in the... You already got a lot of shoutouts in the chat, which shows what pent up demand was for someone to say that out loud, so thank you. Okay. We can go to the next slide. So we obviously also got a lot of comments just around the population health management service, and so wanted to lift up a few things just for the group and for folks who are joining for the first time. So the PHM service, as we all know, is really going to support whole person care, integrating administrative, medical, behavioral, dental, social service, and other program information from a lot of different sources across the state, from plans, from providers, as well as performing basic population health management functions and allowing from multi-party access so that different levels of the-
Slide 14	Dr. Palav Babaria – 01:09:03	And allowing for multiparty access so that different levels of the program were interfacing with Medi-Cal members, at the provider level, the plan level, at the state level, at the care manager level, and the member level, can access and use this service. As I already mentioned earlier, it is not being designed to provide real-time clinical decision support. We really see that staying locally at the point of care or as close to the point of care as possible. Then we also want to highlight that the PHM service itself is not a health information exchange. We anticipate that regional health information exchange organizations, HIOs, are going to be the source of information eventually that the PHM Service can ingest at some point in time, including ADT feeds, lab results, vital signs, et cetera, but it will take a little bit of time to set that up.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Dr. Palav Babaria – 01:09:53	Eventually, we will come up with data and access requirements, for the service, DHCS is going to establish criteria to authorize access to those different types of users and how much data you can see and use obviously will be dependent upon who you're serving and what that population looks like. The service itself is also going to comply with all state and federal data sharing rules and regulations, including HIPAA. So there will be privacy and consent and other requirements that are stored out in a compliant way. Go to the next slide.
Slide 15	Dr. Palav Babaria – 01:10:29	So a number of questions that were raised up around data exchange. Folks asked, "Will the PHM service have functionality to allow bidirectional data exchange, data look-up, or communication between the Service and the Provider's EHRs?". To that extent, we are considering this type of functionality, but it likely won't be the service directly integrating to EHRs and much more through regional HIOs once they're sort of available and set up through our data exchange framework so that we would potentially send information via and HIO, which then if the provider in their EHR is hooked up to that same HIO, there would be bidirectional data exchange. But this will be a later functionality type. We also got questions about "Will beneficiaries be able to update their individual contact information in the PHM Service?" and we are intending for the PHM Service to support this type of functionality where they can update demographic and contact information through a portal or some other similar means where assessing options for beneficiaries to also update clinical and social information as appropriate, including potential assessments and screenings down the road.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Dr. Palav Babaria – 01:11:49	We definitely believe that beneficiaries... They're the owners of their information and they're the best individuals to update various pieces of information such as their contact information and that this will be really critical if we really want to provide the full suite of PHM services, as we're talking about. The other questions were " Will MCPs be able to use their own local data support sources and methodologies to supplement the PHM RSS approach. The short answer is yes, we anticipate that all plans will use the state risk algorithm generated scores and risk tiers as a baseline and starting point and then we'll be able to refine and nuance with additional information that they may have at the local level or from the member themselves.
Slide 15	Dr. Palav Babaria – 01:12:36	Folks also asked, "how the PHM service RSS, which is risk stratification segmentation, methodology and risk tier criteria will be developed?". We will be launching a public facing scientific advisory committee to really come up with the design principles and the methodology for our risk stratification algorithm and do intend for that to be a transparent public process, leveraging a lot of the expertise we already have with folks doing this across the state, but also making sure that we continuously interrogate that algorithm updated as needed and make sure that is free of bias and working for all of the needs that we need it to.
Slide 15	Dr. Palav Babaria – 01:13:16	Then, the last sort of question that came up repeatedly was "Can an MCP change a member's risk tier?". We do not envision that an MCP would go into the system and sort of manually override and change a member's risk tier. There will be local flexibility, so obviously if the risk tiering is used as a starting point, and additional information is obtained where you determine that individual is not actually low risk and is higher risk and should be enrolled in complex care management, plans absolutely will have flexibility to provide services to the member based off of those member's needs and additional information.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Dr. Palav Babaria – 01:13:54	The hope would be that whatever that clinical condition or additional information is that made you think that person is high risk and not low risk, that is appropriately coded and entered into our data system so that eventually the state service would catch up and also recognize that individual as high risk. For discussion, because I know we're running short on time, would love for this group to weigh in what guidance do entities need to address the current challenges associated with the collection of critical demographic data, especially sexual orientation, gender identity, data, race, ethnicity, and social drivers of health data. Because we know that those elements are going to be critical for us to understand and assess health disparities as well as have a much more comprehensive understanding of risk beyond just clinical claims data and there's lots of gaps all over the place. So, I'd love to hear thoughts from this group.
Slide 15	Jonah Frohlich – 01:14:56	Well, Hillary asked if the beneficiary should be able to indicate gender other than male-female, which goes to your question about gender. Maybe they heard some of the master plan meeting last week, or we had a scenario about this, but can you give any guidance about what's expected?
Slide 15	Dr. Palav Babaria – 01:15:14	Yes, 100%. So we absolutely want the full range of gender identities and sexual orientations to be available in the system so that members are not forced into these binary constructs. There are federal interoperability standards around some of these categories as well that we will be trying to align with as much as possible so that we're not creating sort of a silo and not creating data that doesn't transfer across systems. But, yes is the short answer. Peter, I see your hand is up.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Peter Shih – 01:15:48	Yeah, I think the challenges are patients may not want to provide that information. So, even when staff asks, they're not inputting it because they don't want the staff to know or some people just don't want their race identified. This idea of having the member update their individual information could be super helpful, but, of course, it has to be easy to use. Lots of our Medi-Cal members are... English is their second language and so does then information need to be in different languages in the app or in what they access so that they're more likely to fill out the information. I think that's something that's super important to think about the gooey interface, making sure that whatever system we set up for the members to utilize, it's going to be easy to use.
Slide 15	Peter Shih – 01:16:53	I think we just have to be able to accept that some percentage of these fields are not going to be filled out just because people for whatever reason do not want to input that information or let the staff know what they are, who they are, that kind of stuff. I know we all went a hundred percent because it just helps us do our planning better and everything but I think we have to accept a certain level of empty fields, which drives OCD people like me crazy, but it's something that we have to live with.
Slide 15	Dr. Palav Babaria – 01:17:29	Peter, one follow-up question as a fellow "I love a hundred percent in even numbers". Is there value in sort of a blank versus an official like decline to state to understand where it is just a data capture a gap versus an intentional decision by a member?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Peter Shih – 01:17:45	Yeah, that's a great question. I think we should have that field for staff that are trying to gather their information, but if a member wants to update that, they can override that. I think that's some of that flexibility is important and I could see the downside of having members having too much ability to change fields because they could input in wrong information. There's got to be some algorithm that validates what they're putting in. I don't know if that's too complicated, but that's something that we also want to make sure. The flexibility is there, but not so it's so random or not random, but haphazard so that they put in whatever information that may not be correct. I think you're getting people together to understand what fields should be messed with is also important. They can't change their diagnosis or something like that. You know, I think there's got to be parameters, guardrails, around what members can change.
Slide 15	Dr. Palav Babaria – 01:18:55	Thank you. Bhumil, I see your hands up.
Slide 15	Bhumil Shah – 01:18:59	Thanks again. I think this is no brainer, but if you're going to make this bidirectional, the questions need to be identical social determinants of health because even slightly differently phrased questions and how it could mean something very different as we exchange data. We need to make sure it's identical ask in a very similar way collected. So some kind of a training on how the question is framed and how it's asked because the responses could defer based on that. Then, again seems like a no brainer, but we saw with the state immunization registry race and ethnicity became an issue because how it was collected, how multiple races were reported was different depending on each system and now it's going all into the central depository, which is kind of messing up the central data. So again, standardization on how we collect multiple races, multiple ethnicities, the guidance and then some quality checks with systems we trust and not let that pollute the central repository.
Slide 15	Dr. Palav Babaria – 01:20:04	Thank you. Caroline?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Caroline Sanders – 01:20:10	Hi, to piggyback on Bhumil's comments, I think standardized categories for race, ethnicity, social determinants of health, et cetera, are really going to be key and helpful. Fortunately, there are federal standards, including from the Federal Office of National Coordinator for Health IT, the U.S. Coordinator for Interoperability Standards. There are three versions. The first version includes data on race, ethnicity, and language with comprehensive granularity for disaggregated categories. The second version adds sexual orientation and gender identity as well as social determinants of health. The third version, which will be finalized in July, adds tribal affiliation, disability, functional status and mental status data. So, we would really urge that the framework that version three should be immediately adopted and used universally and many hospitals and systems are already using that. But I think really providing that level of "here's what we want, here's guidance and here this exists let's use this", I think would be really, really important. Thanks.
Slide 15	Dr. Palav Babaria – 01:21:30	Thank you, Caroline.
Slide 15	Jonah Frohlich – 01:21:37	[inaudible 01:21:37] links to the U.S. CBI version. Just everyone might want to check them out. Version Two it didn't publish. It's not a bit incorporated into Cares Act like the Cares Act Rule requires version one, which does not have a lot of granularity on race, ethnicity, or SOGI data. Version Two does, but it hasn't yet been incorporated into federal regs. Doesn't mean that those can't be adopted. Those standards can't be adopted in California.
Slide 15	Caroline Sanders – 01:22:08	Version Three, too, has those additional categories so that it would be great to start with that too.
Slide 15	Dr. Palav Babaria – 01:22:11	Dipa do you want to go?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Dipa Patolia – 01:22:22	I think when it comes to collection of SOGI data, we can set up all the processes for the data to flow in but I think what we'll realize is how limited the data is available currently and how there are opportunities to improve that. I think it goes back to understanding at the point of care and practice if there are strategies providers are using that are really working and empanelment strategies really making it clear what we're going to be doing with the data. I think that's going to go a really long way because it may not be as simple as just filling out a survey. I think members will really want to know what that data's being used for that it's going to be safe and secure. That's just one suggestion. Then I wanted to go back to the ADT question if I can, for a sec. So we are using, as much as possible, inpatient concurrent review nurses in some of the larger hospitals where ADT may not be a possibility to really close those gaps. That can help with not only the inpatient stays but also emergency room usage. Thanks.
Slide 15	Sharon Woda – 01:23:34	That's really helpful. I think we're interested in those strategies from places that are closing those gaps and to try to meet the goals. If you have any examples, even offline, you can put it in the chat or just chat it to me and we'll follow up with you offline just to hear some success stories or ways or mechanisms of people that are overcoming some of the data challenges that we know are out there.
Slide 15	Dr. Palav Babaria – 01:24:04	Great. I think we got everyone. Sharon, should we go on?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Sharon Woda – 01:24:08	Yep. I'll take this one. Just to let folks know, we always said that we'd move sort of obsolete a little bit here between meetings. We've been doing monthly thus far, but we're proposing that our next meeting actually be in July to give time to process all the comments and as you'll see on the next slide, sort of full take release the final roadmap and strategy. I might say finalized I really mean final for 2023 because we all know it's going to be evolving. The only other thing I'll say on the date, so maybe to go back just two slides to the date really quick. Thanks Julian. So just to pencil in that our next meeting will be on Wednesday, July 27th, from 10:30 to 12 in the morning. The last thing I will say is we will be soliciting additional comments for more member stories. We really want to hear member stories from our PHM advisory group so stay tuned for some additional feedback there as well. All right, now we can move on Julian. Thank you. Looking ahead, Palav, I think I'm handing it back off to you.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Dr. Palav Babaria – 01:25:34	Absolutely. So just to make sure we are all tracking where we are, we are consolidating all the feedback from our advisory group and other public comment that we've received and then we'll be releasing the final Pop Health strategy and roadmap next month. In August, we are targeting releasing the program guide as well as the Readiness Deliverable template for all plans in anticipation of our January launch and then we'll be expecting that Readiness Deliverable to be returned to the department in October. In November, we'll be releasing supplemental reporting guidance for the pop health program and what reporting we will require. Then, in December, the revised APLs regarding some of those elements that are changing for January, such as the [inaudible 01:26:20], the shah, and the individual health assessment will be released. In January, we will launch the program with our managed care plan partners, and then also start testing the service with multiple partners of different types. In quarter one and two of 2023 additional APLs will be revised. Then we will be launching additional requirements in quarter two of 2023 in preparation for the first round of the future foreign population needs assessment that will occur. In quarter three of 2023, the Pop Health Service will have its statewide launch after about six months of testing with multiple partners.
Slide 20	Dr. Palav Babaria – 01:27:06	Go to the next slide. Then yes, Tangerine, vendor selection will be announced sometime in August for our Population Health Management Service. Now we can definitely open it up for a few minutes of Q and A, if we didn't hit questions along the way.
Slide 20	Bhumil Shah – 01:27:31	Oh, I had a question about the Scientific Advisory Committee. Have the contours of the committee members been decided? Obviously, there's some concerns about increasing disparity by the risk stratification. So just curious about if you could share any update on the work that's going on for the Scientific Advisory Committee?

PHM Advisory Group Meeting

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Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Dr. Palav Babaria – 01:27:52	Yeah. The short answer is no, you haven't missed a major announcement. We have not fleshed out or launched the Scientific Advisory Committee, as of yet. We definitely will be looking to make sure that we bring on expertise, both academic but also lived expertise. Many of the folks on this call, as well as providers and plans, have been working in this space and figured out really robust local solutions that we want to leverage and learn from and not reinvent the wheel as a state. So we'll be looking for a broad array of perspectives that know how to do this work from a practical implementation and technical experience. So more to come, hopefully by our next meeting. Other questions?
Slide 20	Sharon Woda – 01:28:45	All right, well I think I can thank you for attending. We will be, as we put in the chat, we will be posting the slides and the close captioning on the website for everyone to have it and then following up individually with the advisor group, similar to how we did last time. Thank you for your participation, just really appreciate the dialogue and look forward to hearing back. Look forward to hearing from other stories in the field and also talking more in July.
Slide 20	Dr. Palav Babaria – 01:29:19	Dennis, we did capture your comment, so thank you for the feedback. Thank you all so much for joining.
Slide 20	Tangerine Brigham – 01:29:28	Thank you for joining, you may now disconnect.