Population Health Management (PHM) Advisory Group Meeting

July 27, 2022

Key Takeaways

During the discussion on the **Member Story:**

- PHM Advisory Group Members:
  - Applauded the impact the substance use navigator was able to have in supporting the Member in getting follow-up treatments.
  - Requested more information on the CA Bridge program.
- DHCS:
  - Shared more information about the CA Bridge program.
  - Shared that on July 15, 2022, DHCS awarded $9.6M to 81 emergency departments (EDs) across California to continue expanding the CA Bridge program.

During the **discussion on Transitional Care and Behavioral Health Intersections:**

- PHM Advisory Group Members:
  - Highlighted the urgency to address limited data exchange and collaboration during transitions of care between hospitals/facilities and managed care plans (MCP)s, and between MCPs and county mental health plans (MHPs)/Drug Medi-Cal Organized Delivery System (DMC-ODS) especially for those with substance use disorder conditions, given data sharing restrictions described in 42 CFR.
  - Discussed additional challenges for members to receive patient-centered, coordinated care when their care crosses different delivery systems, such as limited understanding of funding, resources, and benefits across delivery systems and sectors; lack of integration of community-based organizations (CBOs) and community promotores, and inability to secure safe and good living environments for members to be discharged to.
  - Encouraged DHCS to consider both the “Big C”, which is coordination on the system-level (e.g., systematic and consistent data sharing, building organizational relationships), and “Small c”, which is coordination locally at the point of contact with the member (e.g., micro/fine tuning critical coordination points).
  - Recommended having coordination and navigation services be physically based in hospitals/facilities to meet the member where they are at the moment they need the coordination.
  - Noted the challenges of managing transitions between correctional facilities to behavioral health systems in the community.
- DHCS:
  - Highlighted current efforts to improve data sharing and bi-directional information exchange, such as the Hospital Quality Improvement Program (HQIP), and California Health and Human Services’ (CalHHS) Data Exchange Framework.

- Acknowledged additional facilitated discussions are needed to operationalize these requirements and improve transitions of care across settings and delivery systems.

During the **bright spot discussion on Transitional Care and Behavioral Health Intersections:**

- PHM Advisory Group Members**:**
  - Shared that behavioral health delivery systems invest significantly in mental health care management/coordination services and that, in the public mental health services sector, about 80% are getting robust case management/care coordination. Additional effort is needed to find better coordination points.

During the **case examples discussion on Transitional Care and Behavioral Health Intersections:**

- PHM Advisory Group Members:
  - Shared that the bifurcation of physical and behavioral health systems makes it hard to know where members are and what they might need. There should be bi-directional information sharing at time of admission/discharge between physical health providers/MCPs and county MHPs (including outpatient mental health providers).
    - Coordination currently works in varied and informal ways with heavy reliance on personal or organizational connections and relationships.
    - There is not always official or systematic information sharing or notification/alerts from physical health providers/MCPs to the behavioral health side for a medical admission, and vice versa from inpatient psychiatric facilities to MCPs for a psychiatric admission. For example, county behavioral health (BH) discharge planning at psychiatric facilities has limited insight into primary care history.
    - Provider to provider communication (e.g., between physical and behavioral health providers) is more common than provider to MCP communication.
    - In addition, acute care hospitals are often on a Health Information Exchange (HIE), but inpatient psychiatric facilities are often not, which makes data exchange more challenging.
    - It can be a challenge to even identify the individuals or entities involved with an individual's care that would need to be involved in care coordination efforts, as individual recall is not always sufficient or reliable.

        - Integrated service delivery (e.g., delivering Medication Assisted Therapy (MAT) in primary care settings) can improve cross-sector coordination.
    - Noted that some efforts are ongoing to improve information sharing with specific bright spots identified:
        - Inland Empire Health Plan (IEHP) shared that given the implementation of enhanced care management (ECM), there are notifications/coordination happening between the MCP and county behavioral health departments' ECM teams. Current work is underway to make notifications happen more regularly.
        - Health Net/California Health and Wellness also shared that they make proactive efforts to know about an admission via ADT feeds/concurrent nurse review and identify a member's needs, before the member is admitted. Then the MCP develops a discharge plan, connects the member to primary care or behavioral health, and provides at home supports.
    - Recommended an "Air Traffic Control" system in each county for managing/coordinating acute psychiatric cases.
    - Shared that for members at Community Health Centers, many have Care Transitions case managers now who work with hospital discharge staff (and have access to Epic Care Everywhere via appropriate Business Associate Agreements) and county MHPs for their patients' admissions and discharges.
    - Shared that there's horizontal integration (connection to MCP primary care or Federally Qualified Health Centers (FQHCs) for MAT) and vertical integration (within residential facilities/continuum of specialty services). The delivery systems need to be able to address both types of integration and allow for automatic communications across delivery systems and provider types (e.g., between MCPs, county MHPs and primary care).
    - Encouraged training across the health system to focus on closing the treatment gaps for MAT for opioid use disorders and ensuring connection to MAT clinics with an appointment and appropriate transportation following hospital discharge.

During the discussion on **Updates to the Final PHM Strategy and Roadmap:**

DHCS:

- Clarified that the PHM Service will integrate and aggregate historical administrative, medical, behavioral, dental, social service and program information from disparate sources to support risk-stratification, segmentation and tiering, assessment and screening processes, and analytics and reporting. It

is not intended to support real-time information exchange, which will be through ADT data exchange or under the CalHHS Data Exchange Framework.