CalAIM July PHM Advisory Group Meeting

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Julian – 00:00:31	Hello and welcome. My name is Julian, 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&A. We encourage you to submit written questions at any time using the Q&A. The chat panel will also be available for comments and feedback. During today's event, live close 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. Paula, you now have the floor.
Slide 2	Palav Babaria – 00:01:12	Thank you so much. Welcome everyone to our July meeting for the Population Health Management advisory group. Really excited to dig in today to some critical topics. I think, as you are all aware, the vision for Population Health Management is really to provide whole person care for each and every single one of our members. And while our program is focused on Medi-Cal Managed Care, we know the only way to really comprehensively take care of our members is to break down those silos and integrate care across all of our delivery systems. So we're going to be doing a deep dive into some of these intersections today, and really focus on transitional care services and behavioral health intersections.
Slide 3	Palav Babaria – 00:01:55	Let's go to the next slide for the DHCS notice. So I think you all have seen this before, but if you have not, we are still, yes, under a public health emergency. And, we know that during the PHE we have stopped redeterminations for eligibility in the Medi-Cal health program, which means that many people have stayed on Medi-Cal who now no longer meet criteria for Medi-Cal and/or have other forms of coverage. When the public health emergency ends, redetermination will resume the same way it did for years and years prior to the public health emergency. And, it will be critical that we can reach each and every single Medi-Cal member to make sure that they can re-enroll and stay in the Medi-Cal program if they're eligible, and/or to connect them to coverage if they're no longer eligible.

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Slide 3	Palav Babaria – 00:02:45	We are worried that this will affect millions of Medi-Cal beneficiaries. And so, we encourage each and every one of you to sign up to become a DHCS coverage ambassador, we will send out these materials so you can follow the links on these website, as well as be added to the mailing list, so that when it comes time to redetermine eligibility, we can really leverage each and every one of you and get the message out into the communities, so that members know this is happening and know who they need to contact to keep their Medi-Cal coverage.
Slide 4	Palav Babaria – 00:03:17	And go to the next slide. So there's two phases to our communication strategy. Phase one is what we're in right now, which is, we're just trying to share this information broadly. Phase two is when the public health emergency actually ends. 60 days prior to that end, we will start our re-enrollment process and members will be receiving their renewal packets in the mail. Obviously, if they have moved, if they no longer live at that address, if it's their grandmother's address that they only visit once a year, they're going to need to know, and either update their contact information, or find a way to get those renewal packets so that they can submit all of the information they need to in a timely fashion. So, if you work with anyone on Medi-Cal, please just share the word and make sure that they're looking out for their renewal packets in the mail when the public health emergency ends.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Palav Babaria – 00:04:05	Go to the next slide. So as always, we really are committed to rooting everything we do in the Population Health Management program, into what this means for our members in a practical way on the ground. So, I'm really proud to introduce two people today who are going to walk us through real-life member story. So, it's my pleasure to welcome Cesar Vasquez. Cesar, if you want to wave at everyone. Cesar is a substance-use navigator at the Bridge Clinic at Highland Hospital in Oakland, California. I know many of you are familiar with, but the California Bridge program is one of DHCSs' as many programs and has done incredible job setting up similar programs based out of emergency rooms throughout the state, which have been a critical lifeline for individuals who have substance-use disorders.
Slide 5	Palav Babaria – 00:04:55	So, Highland Hospital over the last six years has created a robust program to support patients who have substance-use disorders in its Bridge Clinic. Cesar and his fellow navigators have done a phenomenal job helping patients to navigate our complex health systems to get the care that they need. Cesar's also going to be presenting this with Dr. David Tian, who is an addiction medicine specialist, who has worked at Highland Hospital, still works at Highland Hospital, and is also the newest member at DHCS of our quality and Population Health Management team. So, Cesar and David, I will turn it over to you.

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Slide 5	Cesar Vasquez – 00:05:29	Thank you, Dr. Babaria. Hi, my name is Cesar. I'm a substance-use navigator at Highland Hospital. I just want to present a case, this patient that we ended up seeing several times in AED for alcohol use. This patient was struggling a lot with his drinking, as well as with homelessness. We had been able to engage with him in the past. It was hard for us, because the patient never had a phone that we could contact him on. So, he was paying several visits to the ED, never being able to link up with our Bridge Clinic. But on one occasion I was able to see him. He was admitted and decided to take the measures into getting him to our Bridge Clinic, that way we could provide services for him. We were able to get him medication. We were also able to help the patient get services, as far as primary care. We got him into a rehab facility. We was even able to provide him employment.
Slide 5	Cesar Vasquez – 00:06:38	This patient went from visiting the ED about 12 times within seven months to no visits regarding his substance-use. I did see him recently in the ED and I was worried thinking that it was probably... Had relapsed or something. But fortunately, it was just for an injury he had because of his job. So, the patient's doing very well. We were, like I mentioned, able to link him with primary care, with a rehab facility for support, able to connect him with Spanish speaking providers as well. So now he's been 18 months clean, which is really good. And, we try to provide this service to all our patients that we see, whether it be opioid use, or alcohol use, or stimulant use, we're there to provide services for them.
Slide 5	David Tian – 00:07:38	Thanks, Caesar. What a great story. And, I know that you physically wheeled this patient down to the Bridge Clinic during this discharge. Now, I was wondering if you could talk a bit about your work as a navigator and just engaging him and actually meeting him where he was when he was in the hospital.

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Slide 5	Cesar Vasquez – 00:07:55	Yes. So I figured that the only way to actually get him in, because he wasn't able to attend his appointments in the past. I was like, "Well, now that he is as an inpatient, let me go have a talk with him and see how we could get him down to Bridge." I just took him down. I wheel-chaired him down to Bridge. He was willing, he was able to get his medication. And from then on, his visits started deescalating and saving a lot of resources. So, he was really grateful for the help and the outreach. If I wouldn't have gone and gotten him as an inpatient, we would've still had that cycle of him just showing up to the ED, getting service, and just frequent ED visits, went, like I mentioned, from 12 in 7 months to basically nothing as far as his alcohol use.
Slide 5	David Tian – 00:09:00	Thanks so much Cesar.
Slide 5	Cesar Vasquez – 00:09:02	You're welcome.
Slide 6	David Tian – 00:09:03	Yeah. I think that, I'm so proud to be co-presenting this case with Cesar as a doctor at Highland Hospital, and with Cesar as a colleague. And, I think that I'd like to go to the next slide and reflect a bit on some lessons learned from this case and also to help frame our discussion today. So, I think as Cesar mentioned, this story really highlights the impact that a trusted person can have on a patient's life. And so, Cesar as a trusted individual was able to meet the patient in the ED before and then meet him again while he was admitted, and help him to get the care that he needed when he met so many barriers in having both physical healthcare needs, as well as behavioral healthcare needs.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	David Tian – 00:09:49	I think also, even though, ED services, and inpatient care, and substance-use care may actually be on the same campus, people meet a lot of barriers when they are trying to navigate care, especially because they're often not in the same place and actually are paid for by different entities. And, I think this is an all hands on deck approach here. And so, to highlight here, under Population Health Management, we expect the Managed Medi-Cal Plan to be responsible for coordination of care, even if the service is carved out, because they met through the primary contact for the patient. And we'll get to that in a bit, as we talk about care transitions. And importantly, as this case shows that includes behavioral healthcare and substance-use care. At the same time, Drug Medi-CAL ODS, as well as County Mental Health Plans are also responsible for coordinating physical and other behavioral health services when they are taking care of patients as well. And I think that this is where we can all work together to make sure that patients get as much support as they need and deserve.
Slide 6	David Tian – 00:10:56	And finally, I think that, to highlight, we've gone over one example of Cesar's great work at Highland Hospital in the Bridge Clinic as one care model that is at a delivery system, but the Population Health Management program does allow care management navigation activities to be delegated, to be providers who might, as Cesar, have real-time contact. Be boots on the ground, be there in the ED. Cesar was able to actually see that the patient was in the ED again, proactively, which is pretty awesome, and actually identify him. And so, I think that this is an important planning point for some of the stakeholders in this call. And so with that, the goal for the today's discussion is to reflect together and talk about how CalAIM can support promising and successful on the ground initiatives like the substance-use navigator program in CA Bridge.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Palav Babaria – 00:11:51	Thank you so much, Cesar and David, I do see that we have one question in our Q&A about what rehab facility was used. I was hoping you can just give a one liner about the California Bridge program for those that may not be as familiar.
Slide 8	Cesar Vasquez – 00:12:05	Yeah. Sure, no problem. Yeah. So, patient ends up going to this rehab facility called El Chante in our area. So, I was able to also network with the rehab facilities to facilitate the services to our patients, which is what happened in his case. I was able to reach out to the director, provide fast services because of the fact that the patient also was still struggling with homelessness. We wanted to make contact right away and before we lose him to the population all over again and trying to get ahold of them, but this helped a lot with the process.
Slide 8	David Tian – 00:12:45	Yeah. Thanks Cesar. And to speak to the question in the chat and the CA Bridge program. So the bridge program itself across the entire state provides technical assistance, and support, and funding to hospitals who actually set up inpatient and ED services. And so, you can go to cabridge.org to learn more about the program. And, the question in the chat from Dr. Najor about transitions of care when people might lose or change insurance, that is actually something that happens when people get better, get a job sometimes, they might get private insurance. And so, the bridge program does work with patients on creating a planned transition of care to make sure that they don't fall through their cracks, because especially we know that this is another type of transition, right? A transition of coverage. And so, that's very much one of the topics we're talking about today. So when someone actually goes from one payer to another, how do we keep that thread going, so that the patient continues to get the support that they need?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 9	Palav Babaria – 00:13:53	Great questions. Thank you both so, so much. We are going to go to our next slide and kick off our discussion. We can go one more. So, I'm just going to walk us through at a high level what the vision is from DHCS for transitional care services. And then, we'll be digging into some specific scenarios and questions for our wonderful advisory committee to weigh in on. So I think the goals are obviously to get members to the least restrictive level of care that meets their needs, so that they are not staying in institutions longer than they need to or want to, and really to incorporate the member of voice and preferences in those decisions and transitions.
Slide 9	Palav Babaria – 00:14:33	We also know that transitions can be a very risky time for members from both a social and medical perspective, that getting the right medications they need, understanding how to take those medications, getting all of the follow-up care, whether that is medical appointments, or home health needs, or DME can be really challenging and delays and interruptions in having those needs met are a key driver of readmissions and poor outcomes for our members. And, we want to make sure that the system is doing that heavy lift of figuring out how to make that transition possible and not the member themselves who has to focus on their recovery or their family members who too often bear the burden of these transitions.
Slide	Palav Babaria – 00:15:12	And, we also want to make sure that whichever environment they go to, that that environment is really set up to support the member in having a really successful transition and outcome. And so, the way we define care transition is, when a member is transferring from one setting or level of care to another, including but not limited to, discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities to home or community-based settings. This also includes community supports, post-acute care facilities, and long-term care settings. And, you all have seen this PHM framework before. We, today, are focusing on that blue box all the way on the right that is labeled transitional care services.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Palav Babaria – 00:15:55	We can go to the next slide. We're not going to stay on this slide for too long, but just do want to flag that within the PHM strategy and roadmap, there are a lot of different elements that are outlined for transitional care services. We recognize that some of these elements... All of these elements ultimately are the responsibility of the Managed Care Plan, but some of these elements really do lend themselves more than others to delegation, right? So, if there is already someone who is a discharge coordinator at a provider level entity hospital or otherwise, delegating that discharge risk assessment to that person who's already doing discharge planning may make more sense than a plan having a discharge coordinator that has to keep track of every single facility in every single discharge.
Slide 10-11	Palav Babaria – 00:16:42	So some of our conversation today will also focus on, who is best poised to do this work? What level should it sit at? And then most importantly, how is whatever is being done communicated to all the relevant entities so that the plan, the providers, the primary-care providers, the members, their families are aware of the plan and what the next steps are? We can go to the next slide. So, I'm now going to invite Tyler Sadwith, who, for those of you who have not met Tyler is our deputy director for behavioral healthcare services. And we'll be co-presenting since much of what we are talking about today really involves the County Behavioral Health Plans, as well as the Medi-Cal Managed Care Plans for effectuating these services. Tyler, I will turn it over to you.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Tyler Sadwith – 00:17:31	Thanks, Palav. And, good morning everybody. It's a privilege to join this discussion. I think we wanted to take just a moment to set the table for the rich discussion that will happen by highlighting and outlining the foundational framework that's in place today with respect to County Behavioral Health Plans, obligations related to transitional care management, and then highlight some ongoing and anticipated initiatives that may impact and continue to influence transitional care that the County Behavioral Health Plans administer. So, I think we just wanted to sketch that out as a helpful foundation for the discussion.
Slide 11	Tyler Sadwith – 00:18:16	So currently, we know there are different requirements for how County Mental Health Plans and how counties that participate in the drug Medi-Cal Organized Delivery System must meet the transitional care needs of their members. So for example, in the County Mental Health Plan contracts, there are several longstanding requirements that describe how the County Mental Health Plan must provide transitional care as beneficiaries transition between settings. These include coordinating the services that the county provide, the specialty mental health services between settings of care, including discharge planning for short-term and long-term hospital and institutional stays.
Slide 11	Tyler Sadwith – 00:18:58	In addition, the Mental Health Plan contracts require the counties to coordinate services that members receive from any other managed care organization, including MCPs, services they may receive through the Medi-Cal fee-for-service delivery system, and services that they may receive from community and other social service providers. There's also a requirement for the MHPs to implement a transition of care policy. In addition, the DMC-ODS counties have similar requirements as well. And so just as context, these contracts are currently being amended and these provisions are slated to remain in the updated contracts that are currently being executed across counties.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Tyler Sadwith – 00:19:44	So, just wanted to, at a super high level, sketch out that context. And now I'd like to highlight several upcoming initiatives and changes that may further touch on the transitional care services component of Population Health Management. For example, DHCS is planning to release, in August, updated requirements for the Memorandum Of Understanding that each Medi-Cal Managed Care Plan and County Mental Health Plan must enter into. These updates to the MOUs are intended to cover and incorporate a number of the CalAIM requirements, including CalAIM behavioral health policy initiatives, like No Wrong Door, as well as other CalAIM initiatives like enhanced care management and community supports. And of course, the CalAIM initiatives in the Population Health Management roadmap that was published in July that pertain to transitional care requirements.
Slide 11	Tyler Sadwith – 00:20:47	So, in addition to these existing and anticipated policies, I do want to lift up the fact that the state is intending to apply for a section 1115 waiver opportunity, pursuant to policy guidance that CMS issued in 2018. The goal of this waiver opportunity is really designed to expand access to and to strengthen the continuum of community based behavioral healthcare, especially for members with serious mental illness and serious emotional disturbance. If you review the guidance that CMS issued in 2018, you'll see there are a number of, what CMS calls, milestones that really pertain to ensuring institutional care is clinically appropriate and medically necessary, and that those services are part of a much broader and comprehensive continuum of care. And so, individuals are going to receive intensive pre-discharge planning and other interventions and clinical and quality standards pertaining to transitions of care, consistent with the federal requirements. So, just wanted to highlight that as well as a future state that helps feed into the transitional care services aspect of Population Health Management. So, with that, I'll pass it back to Palav to set the table for discussion.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Sharon Woda – 00:22:21	And, Tyler before maybe we do that, there was a quick question on the other one that showed up in the chat, which was, "Does the short-term hospital stay include ED visits for your current requirements?" Can you check that?
Slide 11	Tyler Sadwith – 00:22:35	Thanks, Karen. I will have to go back to the contract language. Based on my understanding, I don't think it specifies that level of detail. And so, I think, to the extent that an ED visit is considered a hospital stay, it may, it may not. So I think we can follow-up to provide that clarification.
Slide 11	Palav Babaria – 00:23:02	Thanks, Tyler.
Slide 12	Palav Babaria – 00:23:02	... thanks, Tyler. So we can go onto our next slide. So just to share some context, we recognize that there are definitely challenges in coordinating care across these settings and delivery systems. And through listening to all of you, other key stakeholders, we've identified a number of issues that get in the way of doing this really well. So we are absolutely committed to working through all of these issues with stakeholders. But we know that sort of having timely data and information sharing between all the entities, clear workforce shortages across the healthcare ecosystem, some confusion over roles and responsibilities, especially for what is sort of held on the county plan side versus in Medi-Cal managed care, as well as sort of capacity challenges, financing and aligning all the incentives to achieve these outcomes and goals that we want, as well as coordinating across many different organizations are all getting in the way of successful transitional care.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:24:06	We want to focus on some bright spot solutions and detailed scenarios today, but if there are other barriers that you all are aware of in terms of coordinating transitions of care, especially between physical health settings and behavioral healthcare settings, please drop them in the chat, because we do want to capture them so that we can make sure we are coming up with thoughtful policy and interventions to address all those barriers. Okay. Can go to the next slide. So we are going to focus, as I said, on the bright spots today. So we're going to enter into this discussion. So there'll be lots of questions and prompts and scenarios for our advisory group to react to, but we're really hoping to learn from where is this working well.
Slide 13	Palav Babaria – 00:24:51	We obviously started out with a member story where some of that transitional care work was done exceptionally well. Specifically, we want to focus on members with SMI or SUD who are enrolled in obviously managed care plans and then also receiving services through county mental health plans or DMC-ODS and start to think through where are some of those critical points of coordination and intersection and how this shows up, what's the data sharing and coordination that's required to make, and how are these are done in current state with all of the limitations that we have in current state, what are some best practices that local entities have figured out to make this work, and then, to that earlier slide that I showed, who's in the best position to do this. Where is it that the plan is best poised to do this? Where is it that someone on the delivery system side or the primary care provider or others are best positioned to provide these services?
Slide 13	Palav Babaria – 00:25:46	And then also discuss short-term policy solutions and where DHCS can really do some of the heavy lifting and support to make sure that we can collectively as a state overcome the barriers that we all know exist out there. Tyler, anything that you want to add to this slide before we dig into the specific scenarios?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Tyler Sadwith – 00:26:04	No. No. I think I look forward to hearing from the group. I know a lot of the data sharing and information sharing and care coordination components to achieving successful transitional care services is a strong area of interest from our MCP and county behavioral health plan partners. And I think we look forward to continuing to provide guidance on data sharing and look forward to providing additional sort of technical assistance, especially around some of the behavioral health CalAIM policies going out. So I look forward to learning more. so thank you.
Slide 13	Palav Babaria – 00:26:46	We will be digging into specific scenarios, but I just wanted to pause there to see if anyone on our population health management advisory group would like to share sort of any bright spots or thoughts on some of these overarching questions. Please feel free to take yourself off of mute and share with the group.
Slide 13	Maria Lemos – 00:27:11	Good morning. This is Maria Lemos. Can you hear me?
Slide 13	Palav Babaria – 00:27:17	Go ahead, Maria? Yes, we can hear you.
Slide 13	Maria Lemos – 00:27:19	Thank you. I love to hear that story and I think it's really critical that we get community involved and I just am thinking as we move forward how we can integrate the community model and the CBOs as part of this and always keeping that in mind, not just from the integration perspective. So I just kind of wanted to highlight that.
Slide 13	Palav Babaria – 00:27:42	Really great flag. Thank you.
Slide 13	Rebecca Boyd Anderson: 00:27:48	Good morning. This is Rebecca Boyd Anderson from partnership. And I agree that the story is a really exciting and visionary story. I think one of the things it emphasizes is the importance of somebody knowing the available resources within the network and under the benefit plan. And that I think is also one of the challenges, is if you're not fully versed between physical health and mental health and substance use services, it's hard to know what kind of resources you actually do have access to.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:28:27	Great point. And I see Gary, let's go to you next, and then Phoebe right after that.
Slide 13	Gary Tsai – 00:28:32	Yeah. Hi, everyone. A great presentation. Certainly strongly support the need for care integration at systems, as well as just on the ground clinical levels. And I know that data exchange is one of the goals of the Behavioral Health Quality Improvement Program on the specialty behavioral health side. And Dr. Babaria, I heard you mention that we want to be very practical and operational, which was great to hear. I do think it's important to highlight where we're starting from, because the level of data exchange and communication between the managed care plans and the MHPS and DMC-ODS is quite limited right now.
Slide 13	Gary Tsai – 00:29:18	And so I saw that in Tyler's presentation there's the thought that in the future there'll be MOUs between the MHPS, MCPs and DMC- ODS systems to, I assume, kind of facilitate that information exchange, but it'd be great to hear a little bit more about the timeline in which we're imagining all of this communication happening, because I can just say at the local level, because we've already started that locally, it gets really complex with respect to consent management and forms. And I know that the state's also working with Manatt around that, but just operationalizing that, particularly dealing with 42 CFR Part 2 considerations is going to take some time. And I hope that when we operationalize this, we'll set reasonable timelines that take into account all of the other things that the state and counties are working on together, because I do think that there's a real risk with us taking on a lot of different good ideas but not necessarily having the bandwidth, time, expertise in order to operationalize them in the excellent way I think we all want to.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Tyler Sadwith – 00:30:46	Yeah. Thanks, Gary. I think that's just a really helpful point to lift up. I think we do recognize that the data exchange capabilities between plans and counties today are not as sort of... They're not in a state where I think we'd all like them to be. So I think we do acknowledge the starting point that we're at. As you mentioned, BHQIP does provide incentive funding to counties to sort of demonstrate capacity for bidirectional information exchange. And so I think that's sort of a helpful support and resource to facilitate and accelerate the work that counties can do. I think DHCS through the technical assistance from Manatt continues to provide sort of guidance documents, sort of outlining applicable federal and state policies and rules that impact data exchange and data sharing, including privacy and including of course 42 CFR Part 2 specific to SUD.
Slide 13	Tyler Sadwith – 00:31:48	Those guidance documents we recognize are sort of a helpful foundation but don't solve the problem. The guidance documents might provide clarification. They might help refine and clarify perceptions and understandings of sort of what's allowed, what's not allowed, but we recognize that operationally, we need to roll up our sleeves and just have facilitated discussions to work through some of the naughty issues and operationalizing it. So I think what we're doing, Gary, is reaching out to folks, MCPs, counties, to learn more about what that targeted TA and supports look like, so we can sort of collectively have that dialogue continue and grow stronger so that data exchange becomes a reality, not an aspiration. So thank you. Thanks for lifting that up. I think we know it's a challenging road and we're committed to moving on it.
Slide 13	Palav Babaria – 00:32:43	Phoebe, why don't we go to you next?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Phoebe Bell – 00:32:46	Thanks. And I could say lots on that previous strain, but I'll just add an exclamation point to what Gary shared and what you're saying there, Tyler. There's a long way to go though we share the desire to get there. But focusing on the bright spot side, something that I was thinking about when you were talking through the slide is I think one of the things we don't do perfectly but we do relatively well, which is discharging people from psychiatric inpatient care to community resources. And we look at it, all our levels of care as one system and work really hard to constantly be managing those beds. So if somebody's inpatient right now and we have a respite bed and it's full right now but maybe we can move that person to supportive housing so we can move that person into respite. And so our discharge planning team and our case management team, that's pretty much what they do all day long, is manage that flow of people through our system.
Slide 13	Phoebe Bell – 00:33:41	And I think they can be really skilled at it. And I think we have to acknowledge the reality that at the end of the day, if somebody's not coming from a safe and supportive living environment as they go into an acute level of care, returning them to whatever situation they were in before is not optimal, but having enough beds anywhere in the system to place them in as an alternative to that original situation is what's the challenge. And we see that particularly on our SUD side, somewhere in the neighborhood of 60 to 70% of the people coming into our SUD residential ODS programs are homeless coming in. And so doing 30, 60, 90 days of residential and then returning people to homelessness isn't a great option and we didn't magically create 50 beds of supportive housing while they were in.
Slide 13	Phoebe Bell – 00:34:26	And so just acknowledging that limitation, managing that system of care, I think is a strength. And then the challenge is literally not enough beds. And I know we're investing a lot in trying to create more beds throughout our systems, but, but those choke points are what create a lot of the tensions in the system.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:34:43	Phoebe, can I just ask a follow-up question? So it sounds like I'm hearing there is sort of an existing workforce who has this scale of really thinking about transitions of care already on the behavioral health side. Do you know, at least in the counties that you're aware of, how much they're also collaborating and coordinating with the managed care plans on both physical sort of follow-up needs but also given now that ECM and community supports and sort of other benefits have rolled out through managed care, leveraging some of those resources as well in this transitional care planning?
Slide 13	Phoebe Bell – 00:35:14	So super honestly, that's all entirely within the mental health plan and ODS plan system right now. We don't interface with the managed care plans on that work. And I mean, we drive and pick people up every day from psychiatric inpatient and drive them back to our county, because we don't have any beds in our county and drive them to the next spot they're going to go to and arrange that spot and all those things. In our county, we're the only ECM provider standing up as behavioral health. And then on the community support side, it's existing providers. So I'm not yet seeing a whole bunch of new capacity coming online per se, new resources to support and strengthen those existing capacities and then new partnership with the managed care plans because we'll be coordinating around those clients. So I guess I don't know yet, would be the short answer. Maybe six months from now, that'll start to look different, how we're working together in some of those situations.
Slide 13	Palav Babaria – 00:36:13	Great. Thank you. Let's go to Katherine and then Heyman.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Katherine Haynes – 00:36:17	One of the things I just want to flag is the great opportunity and also the great difficulty of managing the transitions from incarceration into behavioral health treatment. And I know that in CalAIM, there's an effort to get people enrolled before they exit. So I think given the prevalence of behavioral health issues that are instead criminalized and result in incarceration, that that piece of it is also introduces complexity, but also really introduces a big opportunity,
Slide 13	Palav Babaria – 00:36:52	Really critical flag. And I know we will come back with an entire justice involved presentation at some future point to this committee to dig in for precisely those reasons.
Slide 13	Heyman Oo – 00:37:06	Hi. So my name's Heyman, and I'm a pediatrician by background and I work at a community health center. So I wanted to give sort of the clinician perspective on some of the questions that are posed on the slide, what are their critical points of coordination and then who's best positioned. And I would say that in my experience what has always worked the best is being able to coordinate this care, either escalating care or de-escalating care when the patient is there in front of you and ready, when they're willing and you've already talked to them about it. And that ability to do a warm handoff, whether it's with our in-house behavioral health and then our in-house behavioral health with our county mental health, if it's a higher level of care, or the other way around, if they're in crisis, the crisis unit or in the emergency room, and then being able to directly connect them in that moment that we have them, that has worked.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Heyman Oo – 00:37:59	And then it's very disheartening when patients are ready and they're willing and they're curious and they're open and you give them a list and a phone number and then... I mean, even if you happen to make an appointment for them, they sort of fall off, because they're not in that moment, because they didn't get to speak to the person that might be taking care of them and form that connection. So to the presentation of the case, he was the key. He was the one that was able to make that connection to be able to continue the service. And I think that when it works well, it works really well because it's that human connection. And when it doesn't, it's because we just aren't able as a system to have that availability. I know there's a lot of staffing challenges around having warm handoffs, but I think that that is one key piece that it's really valuable if you want follow-up to happen, the patient has to feel like they've made a connection with whatever that follow-up is going to be
Slide 13	Palav Babaria – 00:38:57	Really great points. Let's go to Kim, Amie and then I'm going to keep us moving to our next case example.
Slide 13	Kim Lewis – 00:39:05	Thanks. Kim Lewis from the National Health Program. Thanks, Palav. I think to these questions, these are really important on the slide. It seems to me from sort of a advocacy perspective that the transitions within a single system are sometimes smoother if you've got a provider who's helping transition people either from inpatient to outpatient services in the mental health plan or maybe even between mental health plan and drug ODS plans or because they're both sort of county, either they're one agency or their county, sort of sister agencies. And so those, I think, transitions are easier and they're more likely to have coordination we hope within the system, but it's the sort of the marriages that I think need to be developed are more of the system to system transitions. And some of that is happening through CalAIM and some of these sort of unified screening and transition and of care tools to help people speak the same language, but I think that's where we see a lot of the problems.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Kim Lewis – 00:40:11	And so the marriage is the ECM on the health plan side, for example, or population health management, and then either targeted case management or maybe an intensive care management model on the mental health plan side needing to get together and not necessarily replace either function, but really ensure that you're adding those roles to an existing care team model to ensure that the care is being coordinated effectively. So whether it's health or whether it's transitioning to a mental health on the plan side. And then when you add other agencies, someone just spoke to juvenile justice or incarceration, so you have probation, you have child welfare in some cases with kids or CCS, those systems add even more complexities.
Slide 13	Kim Lewis – 00:41:00	So the more you add, the more really things fall apart and the more that you're going to have two different sort of care models within their own systems trying to talk to each other with different languages. And so that's where I think if we can really fine-tune and build those bridges or those marriages across those systems, not to replace, but to really kind of fine-tune those coordination points, and so that they're both being paid for different things, but they're both working together, that to me seems like the most critical.
Slide 13	Palav Babaria – 00:41:33	Thank you so much.
Slide 13	Amie Miller – 00:41:36	Amie Miller with California Mental Health Services Authority. So I ran a public behavioral health system. I think that some of what's being said here, I think it's not really well publicly known how much behavioral health invests in what we call case management... Sorry. Our billing code, and many, many counties are using Mental Health Services Act dollars to fund this kind of core case management out of a fear of recruitment, because it was not fully meeting the standards previous to CalAIM for Medi-Cal billing.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Amie Miller – 00:42:07	But I just really want to reiterate sort of what Phoebe was saying that in the public mental health system, 70% of our clients are getting really robust case management with the most recent data that I pulled. And this is actually a really huge cost driver for us as county behavioral health, a fully loaded therapist in a car co-located in a juvenile justice system is a huge part of why we are so expensive. But just to note that a lot of that is happening for the people that we serve and we have quite a bit of data behind it. For case management, care management, care coordination. We've got a lot of labels for some of the same things, but this exists in a really robust way.
Slide 13-14	Palav Babaria – 00:42:50	Thank you so much, both of you, for those comments. Okay. We're going to go into the next slide because we want to dig in a little bit to all of these themes that you all have been raising. David, I'm going to turn it over to you to walk us through the case.
Slide 14	David Tian – 00:43:03	Great. And so we're going to explore some of these intersections as Kim mentioned earlier in terms of care settings, as well as payers. So I think that will be able to have other opportunities to discuss some of these potentially synergistic service lines that were mentioned. So the first case is a transition between inpatient medical care with the Managed Care Health Plan as the primary payer. And so this is coordination between the Managed Care Health Plan, as well as the Mental Health Plan. So the case is Paula, an MCP member, has controlled schizophrenia and receives care through her county MHP. She's admitted to the hospital for acute appendicitis, treated and discharged back home. And so, Palav, I'll turn it over to you for the discussion.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Palav Babaria – 00:43:48	Yeah. So I think some of you may argue, "Oh, her schizophrenia is well controlled and she has appendicitis, which is now fixed. So there is no transitional case here." And let's take worst case scenario where the well-intentioned discharging surgical team stops all of her mental health meds because they're worried that they will have an impact on her wound healing, and the trauma of sort of the surgery and everything really for this individual member means that her schizophrenia is no longer well controlled and she also develops unfortunately postoperative complication from her appendicitis.
Slide 14	Palav Babaria – 00:44:22	So taking all of that into consideration in current states, sort of how is this coordination done, I think, is the question? How does the county mental health plan even know that one of their members has been admitted and had this sort of change certainly in her physical health status, but potentially also in her mental health status? How are those two entities talking to each other or coordinating on a discharge follow-up plan? And then as we think through future forward, what does a best practice look like between the managed care plan and the providers who need to be involved in this member's care post-discharge, between the managed care plan and the plans on the county behavioral health side, as well as just sort of the providers with the actual patient in terms of communicating and following up on both the physical and behavioral health needs?
Slide 14	Palav Babaria – 00:45:13	So I'm going to open it up. Would love to hear how this works in current state and if there's really great solutions, people have figured out how we scale them and/or what we should be doing differently in the future. Phoebe.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Phoebe Bell – 00:45:26	And sorry to talk so much. But I guess reiterating what somebody was saying earlier, I think this works incredibly well in a one-off kind of way because of personal connections and relationships. So this kind of thing happens all the time. There's no official way that we get alerted when this occurs. The way we typically know is either this is a client that we see twice a day every day to drop off meds and we show up and they're not there and the housemate or the neighbor or whoever tells us, "Oh, my God. She had appendicitis. They rushed her to the hospital," and then our case manager goes over to the hospital and figures out what's up and starts advocating to get her psych meds going again, et cetera, et cetera. Or we have-
Slide 14	Phoebe Bell – 00:46:00	... going again, et cetera, et cetera. Or we have our crisis team embedded at the hospital and we have close working relationships with them and somebody there lets us know, "Oh, so and so who's your client has just got admitted or whatever." It's that kind of way that we share data. And then once we know there's a whole bunch of things that start happening, but I think to underscore that point, there is, at least in small county land, not a systemic way that information is shared with us. We don't get an email alert in the morning that one of our beneficiaries is inpatient at our local hospital for these reasons and we need to get a care coordination meeting going or anything like that.
Slide 14	Palav Babaria – 00:46:43	Just a follow. If you did get such an alert, do you feel like that sort of infrastructure, it sounds like there are crisis teams and care coordination teams in existence, and it's really the alert that is the missing link?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Phoebe Bell – 00:46:54	A hundred percent. And the receptivity on the other side to coordinate the care. But yes, as Amie was saying earlier, nearly every single one of our clients, especially in the mental health side, has case management support already. And typically somebody that knows where they live and has been to their house and is involved in their daily life needs. And I see as it ends up, many of our clients are turning point clients and they get that times ten. And so, yes, I think if we were alerted and we would have somebody who could do that work, and then again, who on the hospital side would say, "Oh, okay. Yeah, let's coordinate care and let's have you share your records so we know what psych meds work and, "Oh, didn't realize there was a history of substance use disorder, let's not start on those particular pain meds right now, or let's think about that carefully." And all that stuff that should be happening.
Slide 14	Palav Babaria – 00:47:47	Really helpful. Al, let's go to you next and then Amie.
Slide 14	Al Rowlett – 00:47:50	So as Phoebe indicated, we are part of our relationship with the accounting behavior health. We provide those after hour services. And so while there's no blueprint on how that communication works from the hospital to us, when we hear about it, and typically in 90% of the cases, it happens, they contact us and then we contact a clinician and then a clinician will inevitably contract a prescriber who may or may not be able to speak specifically to the case and talk to the ED about exactly what Phoebe talked about.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Al Rowlett – 00:48:29	And then just skipping ahead to discharge because you illustrated that was potentially problematic. We also use navigators and peers to work with the hospital navigators or the county navigators to talk about post-discharge and what works and really helping that person realize a perspective of themselves. Not just as a mental health patient, but as a person that's recovering from an acute episode of appendicitis that resulted in surgery. And that is what works. And, as a person said previously, have that constant contact with the individual makes the difference in them sustaining the aftercare regimen. That's really essential in that person getting better.
Slide 14	Palav Babaria – 00:49:20	Thank you so much, al. Amie?
Slide 14	Amie Miller – 00:49:23	This is really like an emotional and soapbox issue for me. So I have a consumer advocate friend that sort of befriended over the years who recently went to the hospital, and in the community that she lives in, there's no data exchange. Because behavioral health was left to the end of the HIE list because everybody's afraid of 42CFR. So I want to give a nudge of the hard work that Manatt health is doing under Jonah to help get this consent work done and to hopefully demystify everyone's fear of integrating behavioral health data.
Slide 14	Amie Miller – 00:49:54	So in a community where there's no possibility of ADT, admission discharge transfer notifications, because behavioral health was excluded from the HIE. This person went in for an acute physical disorder, was taken off all mental health medications and it totally decompensated from being like a recovery superstar who works harder. I guarantee that any of us work, we work hard people in this zoom room, this person works so hard to maintain their recovery and survive in the world. And taking her off all her meds, took her back down to ground zero. She's lost everything. Almost homeless again.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Amie Miller – 00:50:33	And I think where Phoebe highlighted, when we talk about our goals for population health management, it has to be two way. So we're going to do an ADT, but then we have to create an expectation that physical health is listening to behavioral health because it's a decade worth of work to get this human to this level of recovery that with the nature of the illnesses that we're treating, frankly recovery isn't always guaranteed when you go all the way back to the bottom again. And so anything we can do to elevate that voice, if it's our turning point, like when we've got a behavioral health connection, we're reaching out to you, give us an equal seat that the table to help advocate because there's so much to this behavioral health story. Our humans that we serve living in poverty are so, so fragile. So I just can't elevate enough the importance of this point and the two-way communication.
Slide	Amie Miller – 00:51:22	And then for us all within our systems to be brave about data exchange. Don't exclude behavioral health. Let's keep working on sort of this effort to get this master release and consent work done because it's impacting people lives in a very significant way.
Slide 14-15	Palav Babaria – 00:51:41	Thank you so much, Amie for sharing. Okay, we're going to keep going. Case two. David, you want to walk us through it?
Slide 15	David Tian – 00:51:52	Sure. So this is a different care interface and so this is a case of a psychiatric admission. So we're definitely talking about the other way around now. So looking forward to it. So Joe is a patient who has schizophrenia, diabetes, and hypertension, and is currently admitted to inpatient psychiatric care for an acute psychotic episode, after stopping his medication due to an unfortunate death in his family. So he stabilized on medications during this admission and discharge back to this home. So Palav, turn it over to you.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Palav Babaria – 00:52:24	So I think this is similar, but the inverse of the last case that we talked about, which is really about when someone has an inpatient behavioral health hospitalization, but has clear physical health needs that also need some follow up. How does that transition work? So similar questions as last time, how does this work in current state? How is the county behavioral health side? Passing off some of this information and arranging the physical health follow up. How are our current managed care plans and primary care providers being alerted of this inpatient psychiatric admission? How is that care coordination happening and how do we want this to happen in future state? Thank you, Phoebe, for not leaving us hanging for too much longer.
Slide 15	Phoebe Bell – 00:53:27	Sorry. I feel like I'm talking a lot, but these are such specific to county behavioral health questions. I mean, I think this side is honestly from my perspective and I hope Amie or Gary others chime in, but I think this is a weaker area. So how this would currently happen is we wouldn't probably have any interface with a managed care plan. Ideally our discharge planning team is connecting with the psych hospital, understanding what the next plan is, going and picking the person up, paying attention to, "Hey, wait, where are your diabetes meds or whatever." Why did those get stopped? We need to get you back to a primary care appointment, helping set up that primary care appointment, driving them to the primary care appointment. But it's less foolproof because it's really be... I mean, my perspective is the burden is on us to be tracking on their physical health needs and case managing and supporting that person to get those needs addressed and met. But our case managers act just like any of us would trying to navigate the system. They don't have any special insider or connection to the primary care world. And so they're calling up alongside the person and making the appointment and going to the appointment, et cetera, is how we would go at it basically.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Sharon Woda – 00:54:48	Yeah. And see, can I just ask a follow on to that? Would you be able to sort of speak to how that works in sharing and coordinating with the MCOs in any of that cases? I know that you guys have the case managers and we've heard a lot about what behavioral health case managers can do, but are there any ways that sort of is interacting for patients like Joe with overlapping physical and mental health needs at this time, even on ad hoc basis. I don't mean to put you on the spot, but I'll ask Phoebe, but I will also welcome others to answer that.
Slide 15	Phoebe Bell – 00:55:24	I mean, really it's more provider to provider than us to the managed care organization to the provider. So if Joe, for example, is a patient at one of our FQs where we have pretty reasonably close working relationships, we probably could inside connection that a little bit better than if Joe was not. So it's back to there's not system relationships that enable this. There's individual personal developed relationships with provider to provider connections.
Slide 15	Palav Babaria – 00:56:00	Thanks, Phoebe. Let's go to Amie, and then Gary.
Slide 15	Amie Miller – 00:56:02	I was just going to say I was on site in a rural county's inpatient facility a couple weeks ago, Humboldt county, shout out to the miracles they're pulling off in their facility, built in the 1850s. But I saw evidence of a great work that they were doing to coordinate on admission, they're doing physical health reviews and that's part of the overall discharge planning paperwork for... I just want to make sure that's known to everybody, those are medical standards of care that occur. And then as part of the work that counties do, coordinating discharge, it is that linkage back to the PCP to the best of our ability. But I saw it play out in action. I saw the medical room and people that were getting that care as part of that. So when we think of these psychiatric facilities, part of the admission is that review.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Gary Tsai – 00:56:50	And I just wanted... I mean, I agree with everything that Phoebe said and I want to acknowledge, I think that in every area of healthcare, so on the mental health side and SUD side, as a psychiatrist and addiction medicine physician, I think that we need to be paying more attention to all components and drivers of health. So physical health, social drivers of health, and there are a lot of opportunities I think for us to do better in that space. I think there's also a lot of opportunities on the health side to be paying attention to behavioral health and then the social drivers as well. And it would be helpful I think to hear from the managed care plans. I don't know that if we have anyone on the advisory group that could represent because I love that we're asking questions to the counties around specialty mental health and substance use. I'd like to also understand what the perspective of the managed care plans are. So that we're balancing the information.
Slide 15	Palav Babaria – 00:58:07	Katherine, why don't we go to you next? And then I will say our plans and providers are on this call. We want to hear what your experience of this transition is as well.
Slide 15	Katherine Haynes – 00:58:17	I just want to highlight that there is coordination with a big C that we're talking about data exchange and relationships among organizations, but I know of a case in which somebody was transferred, this will be dealt with, I know in the justice involved system, transferred through behavioral health court to a transitional facility, arrived without medications after the psychiatrist had left for the day. So as we think about the big coordination, we actually also need to really think about the micro coordination because the result of that was death ultimately. So let's keep a big C and the small C in our mind at the same time.
Slide 15	Palav Babaria – 00:59:14	Rebecca Boyd Anderson, Dipa Patolia - would love to hear your perspectives on how this works in current state and your plans.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Rebecca Boyd Anderson – 00:59:21	Hi, it's Rebecca Boyd Anderson. And I'm actually trying to reach out to my care coordination friends, colleagues, who are also on the phone for some of their comments, but I can say from my experience in care coordination, is that the bifurcation of the systems does make it really hard to know when our members are needing a psychiatric stabilization. We are a ODS plan and unfortunately we became an ODS plan after I transitioned out of the care coordination department, and so my experience with the ODS system is less. So I think the issue really is knowing our member was admitted, and how do we provide to you the best information to be able to provide, have medical care insight into the behavioral care concerns, I believe that some of our members... If you're relying on the member to provide a good medical history, I don't think that's the best source of information to get clear data, especially in the middle of a psychiatric episode. And so yeah, those medic psychiatric providers are set up for failure, not having clear insight into what the medical history is.
Slide 15	Palav Babaria – 01:00:59	We'll just go-
Slide 15	Dipa Patolia – 01:01:00	Yeah, this is Dipa Patolia. Sorry, are you going to call on somebody? Sorry, go ahead.
Slide 15	Palav Babaria – 01:01:04	No, no, go ahead, Dipa. Thank you.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Dipa Patolia – 01:01:07	Okay. Thank you, doctor Babaria. So for us, we actually had a case very similar to this. So speaking from real life example, it was an effort on our part to really know about an addition happening. So by way of ADT data, inpatient concurrent review, nurses with boots on the ground support, we were able to identify a member with a similar issue. Before their admission they were not monitoring their SMDGs, had stopped taking their medications. All because of a death in the family. So through the process of knowing about this member, we were able to start developing a plan for this discharge, reconnection into primary care, home support, in home support to make sure that they're supportive and taken care of in terms of their activities of daily living, getting connected into behavioral health, physical health. And so all of that starts with identification. So the proactive measures that we took, we're able to help us support this member throughout the transition and back into their home setting. So I think that's just one example where the coordination among provider home visitation, inpatient nurses can really help us with the seamless closed loop process. That helps.
Slide 15	Palav Babaria – 01:02:38	Thank you so much. Takashi, let's go to you and then we will move on to our next case.
Slide 15	Takashi Wada – 01:02:43	Sure. Hi, Takashi Wada from IEHP. So, yeah, this is a little more challenging for us. I put in the chat that our acute care hospitals are on an HIE. So we get information that way, but our inpatient psychiatric hospitals facilities generally are not. So it's a little more challenging. I think it's getting better. Both of our county behavioral health departments have multiple ECM teams and so I think that has really helped by our members being on ECM teams. And so that coordination, since they're responsible for both the behavioral health side and the physical health side, has definitely improved. But we are trying to figure out with our behavioral health departments for transitions of care upcoming, how does that notification happen more automatically and regularly?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 15-16	Palav Babaria – 01:03:34	Thank you so much. Okay. We're going to move on to our final case. And then we have a few other agenda topics today. So David I'll turn it over to you to walk us through the case.
Slide 16	David Tian – 01:03:45	Yeah. So here's another care interface, and this is transitional care services and behavioral health with a case about an inpatient medical admission and transfer to a residential rehabilitation or a substance use treatment organization. And so this is Katie who has an opioid use disorder and is brought to the emergency room with an opioid overdose. Fortunately, she responds well to Naloxone and requires an admission to the intensive care unit for intravenous Naloxone drip, but has no other medical problems. She is stabilized off of Naloxone and discharge her residential drug rehabilitation treatment facility to continue with treatment, including medications for opioid use disorder. So she completes her residential treatment and is discharged back home. Palav, back to you.
Slide 16	Palav Babaria – 01:04:30	Great. So obviously this one has multiple transitions. From one acute facility to residential rehab and then back into the community. But I think similar questions to what we've touched upon in current state, how are the managed care plans who were responsible for her initial ED visit and admission, and then the DMC-ODS plan that ostensibly provided her residential treatment and coverage for that coordinating today. And what does that data exchange look like? And then when Katie is discharged to home, what does that sort of discharge from the residential rehab look like both in terms of the necessary outpatient DMC-ODS follow up that she may need, as well as the physical health follow up that she may need. And yes, we recognize 42CFR part two is a barrier here, so please feel free to flag how on the ground folks are working around that as well. Thank you, Gary. Go ahead.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Gary Tsai – 01:05:45	Yeah. I mean, I think the responses to these scenarios are somewhat similar in that we're reiterating the opportunities for us to better coordinate. I mean, I would highlight that, number one, there's horizontal integration and there's vertical integration. Vertical integration, I think of as basically integration within the USD system. So I would hope that this person's not simply ending residential treatment, but actually continuing with intensive outpatient or other areas of the continuum of subs, specialty substance use services. Around medications, I think there's opportunities for horizontal integration. For example, if this person has any other co-occurring medical conditions and is treated at an FQHC, or at another managed care plan, primary care provider who offers med, and if she wants to continue with that, there's an opportunity there to connect.
Slide 16	Gary Tsai – 01:06:43	In terms of what exists today, similar to the responses, because of the way in which the systems in California have been structured, there is not this automatic communication with the managed care plans. I think that's something I assume that's why we're embarking on the ECM benefit, which should greatly help with that. And why there are various other efforts that DHCS has been leading, including the BH quality improvement program that help facilitate better data exchange. So I don't know if that addresses the question, but I think it's a different case, but a similar situation.
Slide 16	Palav Babaria – 01:07:42	Thanks, Gary. Rebecca Boyd Anderson.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Rebecca Boyd Anderson – 01:07:44	Hi. Thank you. I think one of the things that comes up with this particular case is that as an ED admission... Well, she went in through the ED, she went to the ICU, didn't go directly home. First of all, there is a gap in communication with the plans under the current system, not the ODS system, so granted. But I think this also highlights that this member often is the kind of member that is very hard to get ahold of post discharge and to collaborate with in her discharge behavior. I mean, she may have been rehabbed, but does she want to stay rehab? Does she want to stay in connection with the system? And I would say this is somebody who is routinely lost a follow up for standard case management care coordination from a telephonic perspective and would be a fantastic candidate for ECM, if we were able to get a hold of that person and engage them with an ECM provider.
Slide 16	Amie Miller – 01:09:00	There's a question in the chat where she coordinated with her PCP, not unless the patient signed consent because this is really truly under 42 CFR. So if we worked on the universal consent and this person signed, we'd be able to notify the PCP of the discharge. I want to highlight that one of the big changes we've made in California with DMC-ODS as the additional case management post-discharge reduced not to be a covered benefit.
Slide 16	Amie Miller – 01:09:29	And so I think that's been really a great enhancement where people are able to stay and get sort of aftercare case management treatment with a community that they've connected to, which might make sense because in a lot of ways for a person where addiction is their primary need, the facility, say they went to like a Tarzana, that almost becomes like their medical home. Right. That's their highest need. And so, for them to continue getting some recovery-based groups on an ongoing basis to stabilize makes a tremendous amount of sense.
Slide 16	Palav Babaria – 01:10:03	Thank you so much, Amie. Phebe.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Phoebe Bell – 01:10:08	Yeah. Underscoring what Gary and Amie have said. But I think the thing I would add that has been interesting and a little bit helpful on the SUD side is because a lot of people receive MAT services through their physical healthcare benefit. We coordinate well and better in some ways because we're sharing care more often. So at least in Nevada County, a lot of people are getting MAT services from our FQs and then participating in ODS-funded outpatient services or residential periodically like this situation.
Slide 16	Phoebe Bell – 01:10:47	So I think that shows us that when we have a shared care goal like that, we can do better coordinating care a little bit. But even though we contract out for all the treatment in our ODS system, we ended up hiring a number of care coordinators as county staff because we recognize that we were losing people between levels of care and between providers. And so, following somebody through those different ins and outs of different systems has proven to be critical.
Slide 16	Tyler Sadwith – 01:11:21	Phebe, I'm curious. For your SUD members who are receiving MAT through the FQHC, is the coordination and information sharing like it is, I think for mental health that you described, at a provider to provider level, or maybe Nevada County Behavioral Health to FQHC level, or is the MCP included in that at all?
Slide 16	Phoebe Bell – 01:11:42	No, they're not at all. And it's been a real challenge for us. We're held accountable for how many people get MAT services, and we know tons of people are getting MAT services, but we have to... we can't get that information. We go to each of our FQs and say, "Can you tell me how many people you have on MAT services right now," for example, let alone on an individual client basis? So it's like I was saying earlier.
Slide 16	Tyler Sadwith – 01:12:01	And when you ask the MCP for some of that information related to Population Health Management in the services you're sharing, what's the experience?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Phoebe Bell – 01:12:14	I mean, we just haven't had a mechanism, and that's obviously changing, right, Tyler. It's going to take a while to change, but we haven't had a mechanism for sharing that. So early on, when I started as behavioral health director, I was like, "Hey, we have high-cost beneficiaries than you do, and I bet that there's some overlap between them. I'd love to cross-populate our data set and your data set."
Slide 16	Phoebe Bell – 01:12:30	And then it was like, "But I don't know how to break apart my data set because I don't know who's on Anthem and who's on California Health Wellness. And I can't give you my complete data set because some of them aren't your people, and you can't know about them. And you can't give me all your people because some of them aren't my people. And so how do we even do..." And I know other counties have solved that, but those are the basic levels we are kind of stuck at of like how do we even literally exchange data, which is probably embarrassing to admit out loud. But that is the reality.
Slide 16	Tyler Sadwith – 01:12:59	Yeah. We're all in this together. Thanks, Phebe.
Slide 16	Gary Tsai – 01:13:04	I just wanted to add on to, I think, something that all of us have commented with respect to this case, and it's something that we increasingly are talking about, which is the gap between the need and demand or utilization. Right. And so, when we're talking about something like substance use, that's significant because upwards of 95% of people with substance use disorders don't think they need it or don't want it. And so I'm flagging this just as an opportunity, certainly on the county side, but also on the MCP side.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Gary Tsai – 01:13:40	And I'm talking about the plan, but also just the frontline providers that work with the plan to really highlight. If we truly want an integrated system, including mental health and substance use with physical health and the social drivers, there's going to be a fair amount of training that we'll need to do across the health system. So that we're really focusing on these different areas in meaningful ways in order to generate the demand and close that gap between need and utilization because there's no question there's tremendous need.
Slide 16	Gary Tsai – 01:14:15	But there are plenty of opportunities for us to build something without people coming unless we address that gap.
Slide 16-17	Palav Babaria – 01:14:27	Thanks, Gary. Really appreciate the robust discussion. We are going to move on to the other pieces of our agenda, but if there's any other thoughts that we didn't capture verbally, and especially for those of our attendees who are not on the advisory group, please continue to drop stuff in the chat. We are capturing all of it, and we'll incorporate it into our thinking. Can we go to the next slide? So we're going to now just walk through the final PHM strategy and roadmap document. We have a little bit less time for this agenda item because we wanted to focus on the robust discussion that we just had.
Slide 18-19	Palav Babaria – 01:15:01	So I am going to breeze through some of the next slides, but they will all be publicly posted. And obviously, if there's areas where anyone has questions, you can feel free to reach out to myself or the department offline after this meeting. So we released on July 5th the final PHM Strategy and Roadmap document, which hopefully everyone here has seen and read. And also incorporated updates based off the 37 comment letters and feedback from this advisory group and managed care plan meetings that we held. So we're just going to walk through sort of the big pieces that have changed as a result of those updates. Go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Palav Babaria – 01:15:39	So I think main things that we're going to be walking through are in these buckets. So we can go to the next slide. So around the PHM strategy and PNA, we did adjust some of the timelines. So we revised the PHM strategy submission dates from July 2023 to October 2023 for current plans and October 2024 for new plans coming in with the procurement. And we also added some language to clarify how these requirements align with but are also distinct from the existing NCQA requirements.
Slide 20	Palav Babaria – 01:16:15	So the PHM strategy that plans submit to DHCS is similar to the strategy that NCQA requires but also anchors some of these elements to California-specific priorities, which are outlined in our comprehensive quality strategy and the bold goals. And then the PNA, which we will be doing every three years and not annually, is really going to be a much more of a community-based process. And one that aligns with similar needs assessments that are done by hospitals and public health.
Slide 21	Palav Babaria – 01:16:47	Go to the next slide. And I'm just going to go through everything. And then we'll pause for questions. We also made some updates to the gathering member information piece. So we clarified that in addition to just making a good faith effort, which is what our previous language was that we see the PHM service as a part of the broader statewide effort to improve data exchange. And so, we've aligned a lot of this and clarified how the California Data Exchange Framework fits into the PHM Strategy and Roadmap, and data exchange goals that we have.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 21-22	Palav Babaria – 01:17:23	And then, we also added justice-involved and housing pieces of data to the list of required data sources, given the obvious populations of focus that we have for CalAIM. And then, we also added some much clearer language that the PHM service will have a beneficiary component where Medi-Cal beneficiaries can modify, update, and provide information. Go to the next slide. We also sort of clarified some of the areas to updating risk. And so, for the risk stratification and segmentation, we did sort of clarify that the RSS will have specific child-specific needs so that it's not just a one size fits all algorithm and that those child specific needs will be broken out by different age groupings that are clinically appropriate.
Slide 23	Palav Babaria – 01:18:15	And then we also sort of changed and clarified some of the language around the HIF/MET, such that based off of a lot of the extensive feedback that we got around data exchange for the HIF/MET specifically that MCPs have to follow up on any positive assessments or delegate that responsibility. So it's not that the entire HIF/MET necessarily needs to be exchanged, but that someone is owning if there is a positive screen and a member identifies needs that those needs are being met either directly by the plan or by a delegated provider entity.
Slide 23-24	Palav Babaria – 01:18:47	And then, we also clarify that plans can leverage ECM and CCM assessment tools or components of those tools to meet the assessment requirements for SPDs but that they must use the specific LTSS questions that are in APL 17-013. Go to the next slide. We also made a few changes to basic Population Health Management and care management programs. We added in clarification that basic Population Health Management ultimately is the responsibility of the Medi-Cal Managed Care plan. However, obviously, some elements of this can be delegated.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Palav Babaria – 01:19:24	And so that is outlined in more detail in the final roadmap. And then, we also outlined areas that we think probably should stay at the managed care plan level unless there's specific financial arrangements with providers to take on the full responsibility. In the care management programs we also added clear language that someone cannot be enrolled in ECM and CCM at the same exact time. These are really programs that are seen to be on a continuum. And that consistent with NCQA requirements, CCM can be delegated as long as the provider entity or whichever entity the CCM delegated to is NCQA certified. And that is an NCQA requirement.
Slide 24-25	Palav Babaria – 01:20:05	We also encourage managed care plans to contract with providers to provide care management continuums for both ECM CCM so that we can have an actual continuum of services at every level and that members don't experience disruptions if they're stepping down from ECM or stepping up from CCM. Go to the next slide. Transitional care services. We have obviously done a deep dive on that today.
Slide 25	Palav Babaria – 01:20:34	But we did sort of clarify, specifically for mental health plans and DMC-ODS, when they're the primary payer, what the responsibilities of the managed care plans are. That they are still required to cover basic transitional care services and have a care manager who's going to be coordinating with county behavioral health plan care managers on some of these transitions of care. And that they're also responsible for ensuring that the physical health follow-up is completed.
Slide 25	Palav Babaria – 01:21:04	And then similarly, when we have dual eligible members who are enrolled in a Medi-Cal Managed Care plan. And then some type of Medicare plan, whether that's fee for service, a Medicare advantage, or D-NPS, that there's similar clarification of who is responsible for what. So for anyone that is not in a D-SNP plan, the Medi-Cal plan will cover all of transitional care for dual eligible members who are in a D-SNP plan.

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Slide 25-27	Palav Babaria – 01:21:32	The D-SNP is responsible for assigning a care manager whose responsible for all transitional care activities. And some of this goes back to sort of what the language is in our D-SNP contracts as well. And then, we can go to the next slide. I'm going to pause there because that was a whirlwind tour. And before I pass it off to David to talk through the program guide, any questions on those updates? Tangerine.
Slide 27	Tangerine Brigham – 01:22:02	Yeah. Thanks so much for going through the updates. One of the comments we made had to do with how to ensure that the population Health Management Framework is real in real-time for all of us. And have you sort of struggled with the data lag issues that are inherent around the transfer of data, be it the social services' data, the health data, state, health plans, local, if there's really to drive care planning and the like? I don't know. Were there any modifications in that area or recognition of that challenge?
Slide 27	Palav Babaria – 01:22:48	Certainly, I think a recognition of that challenge. And I will say when we've been talking about it internally, and I don't know how well we articulated this in the final document, but that there was a difference between sort of timeliness of data when you are doing analytics or risk stratification. Versus, I need to know someone got admitted to the hospital last night so that I can deploy a care manager.
Slide 27	Palav Babaria – 01:23:08	And so, certainly, I think for some of these like creating the population needs assessment or the PHM strategy, some of that data is going to be outdated. They will be based off of claims data and really a look back and analysis that's maybe six months old, or whatever that is. But in the data requirements, we specifically put in things like using ADT feeds at the plan level because that is much more immediate, real-time data that can and should and needs to be leveraged for actual provision of services and care coordination.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 27	Palav Babaria – 01:23:42	So I don't know that we made any revisions, but I do think everyone acknowledges that sort of the timeliness of data and how fresh it has to be differs based off of what you're trying to accomplish. And the expectation is that for, especially things like transitional care, there needs to be... you need to be hooked up to your local HIE or be receiving ADT feeds from all of your contracted hospitals and providers or some alternative. Nina.
Slide 27	Nina Park – 01:24:12	Yeah. Along the same lines there, in terms of the risk stratification. And I believe that there is some reference around how the risk stratification that gets done or the segmentation that gets done in the PHM service ultimately will inform or impact the eligibility for certain programs such as ECM or CCM at some point.
Slide 27	Nina Park – 01:24:38	So I guess I just wonder about that in terms of the time lag or the data lag again, as to how we would deal with that situation where we actually have the data that shows that a particular member is eligible for ECM. However, whatever the PHM service has sort of ultimately come up with some data that is not up to date is informing whether or not somebody's eligible.
Slide 27	Nina Park – 01:25:09	That wasn't really addressed. And I know that we submitted comments around that, but I didn't see any adjustment to that particular section in the final document.
Slide 27	Palav Babaria – 01:25:20	Great question. So I'll go back and take a language or look at the language because I don't think I've memorized it off the top of my head. But the intention is really that the state-level risk stratification and segmentation process, which, again, is not going to be live on January 1. So whatever happens, January 1 is really at the plan level.
Slide 27	Palav Babaria – 01:25:37	We'll have a statewide process, hopefully by July of 2023, is really setting a common floor but is not prohibiting anyone from receiving services if that is what is determined to be appropriate and eligible at either the plan level or the provider level.

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Slide 27	Palav Babaria – 01:25:55	Because we recognize exactly to your point, providers and plans will have additional information that the state does not have or has not made its way to the state yet. So we're really looking at setting a common floor and not defining sort of the ceiling or restrict using that as excluding any members from services.
Slide 27	Nina Park – 01:26:15	Yeah, that sounds great. And I guess an additional comment about what we were hoping to see in the final document around additional description about the scientific advisory committee. And I assume that that information is coming along at some point. But interested to know more about how that's going to pan out and what the process will be.
Slide 27	Palav Babaria – 01:26:40	Absolutely. That piece of it has been slower going than I think we were hoping for, but it is coming to this group. I promise. It just wasn't ready in time for the final publication. Okay. David, I know we only three more minutes, but I'm going to turn it over to you.
Slide 27	David Tian – 01:26:57	Great. So I will do this quickly. And so, I just wanted to give folks a preview of two documents that will be coming out from our population health team so that everyone knows more about the work that we're actively doing. The first document is going to be, let's see. Did we go... Can we go back to the... one more program? Thank you.
Slide 27	David Tian – 01:27:18	So the program guide is a document that's going to be coming out later in August that it sets forth more comprehensive requirements and goes into more detail to our Managed Medi-Cal plans. The specific elements that are already mentioned in the roadmap, in the Population Health Management Strategy and Roadmap. Importantly, there are a couple things I want to highlight. One is that there will be no new policy set, and these are actually responsive to questions, comments, etc. that people have submitted.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 27-28	David Tian – 01:27:45	So thank you for participating in that process. And also to fight for the folks who are tracking this, there will also be a requirement for Managed Medi-Cal plans via a base All Plan Letter that will link the program guide to the 2023 Medi-Cal, Managed Medi-Cal contract. And then, the other details are there for you to review later. Next slide. Separately, there's another deliverable that we be working with the managed care plans, and that's the Readiness Deliverable.
Slide 28	David Tian – 01:28:17	So in October, the Managed Medi-Cal plans will be required to submit a Readiness Deliverable to DHCS describing specific components of their population health management programs into a test that they're ready for the launch of the pilot and the go-live of the program. I should say the launch of the program. The pilot is more kind of optional and et cetera. So some of the key details here to apply for you, the managed care plans will be answering specific questions and attesting to certain parts of the roadmap that we will ask them to expand on. And let's see. This whole process will align with the deliverables already required by NCQA.
Slide 28	David Tian – 01:28:58	So we're aiming to minimize duplication. And we're also importantly requiring all plans to identify key performance indicators for their implementation. And we will be specifying this more by the end of August in another document that we are providing to the Managed Medi-Cal plans. That's it.
Slide 29-30	Palav Babaria – 01:29:18	And I just want to underscore that sort of last bullet in there because, as all of you know, one of the key guiding principles for our comprehensive quality strategy was really using data-driven improvement. So in all of our compliance and monitoring and evaluation for the PHM program, we intend to be putting a data-driven approach in place, along with everything else that we need to do for readiness assessment.

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Slide 29-30	Palav Babaria – 01:29:46	So I know we have one to spare. So Sharon Woda, maybe we'll turn it over to you if there's anything that David or I missed and or questions that folks have. And I will just say, looking ahead. We can go one more slide. We are going to be canceling our August meeting, because we need to get all of this other stuff out the door. And then, this group will be reconvening at the end of September for our next advisory group meeting.
Slide 31	Sharon Woda – 01:30:11	Yep. That's right. And then, if you go back, I think this just gets us all on track for all of the Looking Ahead. Sorry. No. Next slide. There you go. All of the things to look at moving forward. So already called the Program Guide and The Readiness Submission closer to the end of the year. There'll be a supplemental reporting guide, and then there'll be amended ATLs, which we'll also, by the way, see in the program guide will be in an update of all the amendments to the APLs that are forthcoming.
Slide 31	Sharon Woda – 01:30:41	So I think people will find that quite useful, a little bit more tactical. So as always look forward to your feedback, don't want to go over on this meeting because I know it's important use of time. But Palav, any closing remarks. I think we're ready to...
Slide 31	Palav Babaria – 01:30:53	No, we really just are so grateful to this advisory group and everyone else who's joined us and really weighed in on the chat and otherwise. This is really helpful feedback for us to incorporate, especially as we try to operationalize everything that we want to achieve in the Pop Health Program. So thank you.
Slide 31	Julian – 01:31:16	Thank you for joining. You may now disconnect.