Population Health Management (PHM) Advisory Group Meeting

April 26, 2022

Key Takeaways

PHM Advisory Group members stated that their priorities for the PHM Program and Service were to:

- Support the integration of physical, behavioral and social care – as well as the associated data – to help address members' identified needs, improve the member experience, and provide whole-person care.
- Improve coordination between delivery systems (e.g., physical and behavioral health care) and across partners, including the State, MCPs, providers, and community-based organizations (CBOs).
- Emphasize timely preventive care and follow up.
- Prioritize the collection, use, and exchange of health and social data to support population health priorities, including streamlining existing screenings and assessments and facilitating an integrated and equitable model of care.
- Address health disparities, improve health literacy, and advance health equity.
- Builds off of existing, successful approaches to serve as a foundation upon which local entities can layer in their own interventions and innovations based on their knowledge of the local context.
- Prioritize more upstream initiatives that are tied to public health needs.
- Develop a holistic population health approach that provides age-appropriate care and meets the needs of different populations, including children and youth, and individuals with behavioral health needs.

The PHM Advisory Group discussed challenges with the current screening and assessment processes, including:

- Language, health literacy, and technological barriers prevent effective screening.
- Information collected during current screening and assessment processes do not lead to members' needs being addressed; timely follow-ups and connection to interventions or services based on screening and assessment results should be in place.
- There is a general lack of trust from members about the goals and utilities of screening and assessment when they are not conducted by trusted providers or staff.
- The current delivery system does not effectively provide access and referrals to services that will address social needs identified from screenings or assessments.
- There are existing challenges associated with collecting race/ethnicity information, given low rates of individuals who choose to respond to race/ethnicity questions.
- There is a general lack of real time Sexual Orientation and Gender Identity (SOGI) and Social Drivers of Health (SDOH) data, such as an individual's homelessness status, which significantly drive health outcomes.

Key Takeaways

DHCS discussed the approach for streamlining screening and assessment in the near term:

- Effective 2023, DHCS is streamlining Health Information Form (HIF)/Member Evaluation Tool (MET), Seniors and Persons with Disabilities (SPD) Health Risk Assessment (HRA), and Individual Health Education Behavior Assessment (IHEBA)/Staying Healthy Assessment (SHA) to eliminate duplication and burden and balance continuing federal, state and NCQA requirements by:
  - Clarifying HIF/MET results should be shared between MCPs and PCPs or other providers and MCPs may delegate HIF/MET to the provider level;
  - Eliminating the existing IHEBA/SHA while strengthening primary care and preserving protections such as EPSDT screenings
  - Eliminating the current SPD HRA process while maintaining protections for individuals with LTSS needs.

Over time, the introduction of the PHM Service will further reduce duplication and member burden

- DHCS is exploring how the PHM Service can host screening and assessment functionalities that pre-populate relevant Member information previously collected from MCPs, providers and other entities.

PHM Advisory Group members discussed how screening and assessment should further be improved:

- **Build member trust and engagement.**
  - Screening and assessment should be trauma informed.
  - Consider how questions are framed and incorporate member preferences, especially related to SDOH-related conditions.
  - Include an opt-in option for members to be contacted by MCPs so that health plans can offer resources.
  - Community Health Workers (CHWs) have shown great success in gaining trust and communicating with members. They should be recognized as a provider that can bill for their services.
  - The expanded primary care workforce (including social workers, CHWs, doulas, behavioral health staff, etc.) along with CBOs are the best way to reach and gain trust from members. However, the primary care workforce and CBOs face limited capacity and exhaustion from current responsibilities, especially because of the COVID-19 pandemic. Appropriate value-based payments and additional resources are needed for them to perform screening and assessment functions.

- **Gather timely and accurate preferences/needs for all members to connect the member to services they need/want.**

Key Takeaways

- ◦ Health education and training for providers is needed to administer screening and assessment tools so that members may respond to screening and assessment questions in an accurate and meaningful way.
  - ◦ More resources are needed to develop infrastructure and expand bandwidth in the delivery system to conduct screening and assessment.
  - ◦ The current screening process should be more efficient, given comprehensive individual information is normally collected in a 10-20-minute visit.
  - ◦ Referrals to other state programs are needed based on screening results (e.g., referrals to CalFresh or CalWorks).

- **Gather and share data in a member-centered way that will enable plans to better target services and reduce bias.**
  - ◦ Data collected from screening and assessment processes should account for biases.
  - ◦ Assessment results should be shared between behavioral and physical health providers and MCPs. To allow for seamless data sharing, standard data categories and definitions and an improved consent management process is needed.
  - ◦ The HIF/MET screening should be an automated process. Results should also be easily shared between providers and plans, for example, by utilizing integrated data fields in Electronic Health Record (EHR) systems.
  - ◦ The PHM Service should support all EHRs at the state level and be able to communicate back and forth with local EHR systems.
  - ◦ Screening and assessment results should also be monitored and tracked over time.