Population Health Management (PHM) Advisory Group – Meeting #6 (October 2022)

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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.
Slide 1	Julian – 00:00:58	With that, I'd like to introduce Aita Romain, section chief Quality and Population Health Management Program at DHCS. Ada. You now have the floor.
Slides 1-2	Aita Romain – 00:01:08	Thank you Julian. Hi. Welcome everyone. To our October Population Health Management Advisory Group Meeting. We are going to have a packed agenda today. And as Julian mentioned, we welcome everyone's input in the chat box and we hope to have a great dialogue with advisory group members as well as with the public that was able to attend today. Next slide please.
Slide 3	Aita Romain – 00:01:39	So before we get started, I'd like to remind everyone about the end of the COVID-19 public health emergency. The goal of DHCS is to minimize beneficiary burden and promote continued coverage for beneficiaries. And as California plans to resume normal Medi-Cal eligibility operations beneficiaries will need to know what to expect and what they need to do to keep their health coverage. Most beneficiaries will either be eligible to maintain Medi-Cal or qualify for tax subsidies that allow them to buy affordable Covered California coverage.
Slide 4	Aita Romain – 00:02:16	DHCS is engaging community partners to serve as DHCS coverage ambassadors to deliver important messages to Medi-Cal beneficiaries about how to maintain coverage after the public health emergency ends. And that these DHCS coverage ambassadors will be trusted messengers made up of diverse organizations that can reach beneficiaries in culturally and linguistically appropriate ways.

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Slide 4	Aita Romain – 00:02:42	The public health emergency Unwind Communication and outreach campaign is currently rolling out in two phases to prioritize and sequence strategies, tactics and messages across the state to prepare for the resumption of normal eligibility operations. The two phases are outlined here and we encourage everyone to get involved at this point.
Slide 5	Aita Romain – 00:03:05	Next slide please. And I'm going to hand it over to Dr. David Tian, medical consultant with the Population Health Management Division. David.
Slide 5	Dr. David Tian – 00:03:16	Thank you Aita. Good morning and it's my pleasure today to welcome today's dynamic duo of Amy's to share a member story as we do at every advisory group meeting. Amy Scribner is the Chief health Officer and Amy Rossi is Clinical case manager at Health Plan of San Mateo. Since today's advisory group meeting includes a focus on the use of data for risk stratification, we hope that this member experience will ground our discussion. So I'll first hand it off to Amy Scribner to share a bit about Health Plan of San Mateo's risk stratification process. Amy.
Slide 6	Amy Scribner – 00:03:49	Great, thanks David. So just a little bit about Health Plan of San Mateo to start. So Health Plan of San Mateo is a Medi-Cal COHS plan. So we have every live in San Mateo County that has Medi-Cal assigned to us. At HPSM, we also have a CMC/D-SNP plan, a county IHSS plan, and a plan that covers insured community members through the county. The total membership for HBSM is about 167,000 lives. So HBSM embarked on this risk stratification process back, at the end of 2020. We've been using it for just about two years now. We have three different risk stratification levels that we group our membership into. The first is our high risk group, the second is our emerging, or moderate risk group, and the last group is our low risk prevention and early intervention group.

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Slide 6	Amy Scribner – 00:04:47	So we utilize a number of data sources in order to do this risk stratification process. We renew this on a quarterly basis. The first data element that we utilize is HPSM, or a managed care plan data, which includes most of the claims data that comes into us. We also utilize stuff like Z coding in that risk stratification. We pull in HEDIS information, we pull in information from our community based organizations. So these are programs that we've invested in or we also utilize the ECM and community support CBOs and the data that's coming in there. Utilize data that comes in monthly from our Mental Health Plan and DMC-ODS plan, Behavioral Health and Recovery Services. We also get monthly feeds of data from our aging and adult county partners, which includes IHSS, home delivered meals and other data related to aging. And then we utilize what's called the ACG risk score, which is embedded into our case management electronic medical records system.
Slide 6	Amy Scribner – 00:05:52	So from there, we take all that data, mix it together, and then we have a rubric that creates an output of our risk scores. Those risk scores and levels are determined based on acuity, so high, medium, and low acuity and overall utilization, high, medium, and low. And then that put together, gets us to our risk score. Our risk stratification process has had numerous iterations and input from our clinical leadership team. We review it annually to adjust and add any changes like when we added the CBOs for ECM and community supports. As part of this too, the case managers on our integrated case management team who also do care coordination, get an output that additionally has care gaps for each of the members that they're serving under each risk. So now I'm going to turn it over to Amy Rossi, who's on our ICM team.

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Slide 7	Amy Rossi – 00:06:51	Thanks Amy. So I'll share a member story. An 80 year old HPSM member was losing her housing. She had been living with her son's family and they were moving out and informed her that she could not come along. So the member's daughter contacted San Mateo County's Aging and Adult Services for help and then they referred the member to us at HPSM. Our integrated care management team utilized a risk strat database to screen the member. She was found to be high risk and high acuity, based on our claims data, trips to the ED and inpatient utilization data. The assigned care manager, which was me, noted that she was not connected to any targeted services and faced numerous barriers. She did not speak English, she had low health literacy and she was just quite isolated from her community due to the COVID Pandemic. I then referred the member to Community Supports Housing Navigation & Transition Services with Brilliant Corners via our prior auth process.
Slide 7	Amy Rossi – 00:07:58	And during this time, the member grew increasingly anxious, very stressed about becoming homeless. Meanwhile, Brilliant Corners accepted the referral, enrolled the member and identified available housing at a senior supportive housing community. The member moved into her new home in September with the assistance of community resources. After housing was secured, I followed up with the member and her daughter and identified other care gaps, like caregiver support through IHSS and food resources and I will continue periodic outreach. The Brilliant Corner's case manager will also check in with the member regularly to ensure stable housing and that she's doing well in her housing situation. And then on recent follow up, the member's daughter reported to me that the member's mood has improved. She has less muscle tension, she's far less anxious and just really loves her new home. She takes daily walks outside and just really enjoys socializing with others.

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Slide 8	Dr. David Tian – 00:09:12	Great. Next slide please. Thank you so much Amy. This story just really warms my heart because it really impacts, really it highlights how we can use risk stratification and meaningful data to connect members to services that they need the most in their lives when they need them. And in particular, in this case, as the Health Plan of San Mateo identified that member's most pricing need for housing before a crisis point through risk ratification. And in this example, the social drivers of health were really considered and were critical improving health outcomes in preventing social harm and medical harm, both to the member as well as her family.
Slide 8	Dr. David Tian – 00:09:52	And also, I wanted to highlight this great example, the collaboration between local counties and the health plan. You may have noticed Amy Rossi mentioned that the county senior services actually called the Health Plan of San Mateo or made that referral to the patient's daughter, which may not be happening in every community. But that was a really lovely collaboration between community agencies as well as from the health plan over to Community Supports and Housing Transition Navigation Services.
Slide 8	Dr. David Tian – 00:10:26	I think that looking forward, this member story also highlights the potential for collaboration with a Population Health Management Service that we'll talk about at length today and the provision of whole person-centered services. And just wanted to thank both Amy's for coming and sharing this wonderful story today. And as you saw, the health plan and Brilliant Corners were able to help the member get into a new home, which is so difficult in the Bay Area. And this really shows the potential for us to impact our members' lives in a great way. Thank you.
Slide 8	Dr. David Tian – 00:11:03	And with that, I know that today we are short on time, so I will go ahead and hand it off to Palav for the Population Health Management Service recap and question and answer. Palav.

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Slide 9-10	Palav Babaria – 00:11:14	Thank you so much David. We can go one more slide. So we know that last time we threw a lot of information at all of you. So we're just going to do a brief recap and then really spend the bulk of our time today in open dialogue to answer questions that were posed last time, as well as new questions that all of you may have, as well as just hear feedback from our advisory groups since I know we didn't have time for that last time.
Slide 10	Palav Babaria – 00:11:39	So for those of you who may be new to this meeting, brief recap is that our Population Health Management Service, which is a critical part of our Population Health Management program and strategy, is set to launch in July of 2023. The vision for this service is really the major functions that are outlined here. First and foremost, we know that to provide whole person care, we really need to synthesize and aggregate information from across a member's various behavioral, physical health, dental, pharmaceutical, social service, developmental, and other community based needs. And right now, a lot of that information is siloed in various data systems and repositories. So we envision that the PHM service will help us aggregate all of that data and make it available to the people who are serving our members.
Slide 10	Palav Babaria – 00:12:27	Secondly, we also envision that this Population Health Management Service is going to help us perform key population health functions at the state level. Things like screenings and assessments, risk stratification, segmentation and tiering, which we're going to be doing a deeper dive on later this morning as well as gaps in care reporting, to name a few. And then most importantly, I think for especially all of you on this call, we really see this service as a critical way to provide access to whole person care data for people who are serving Medi-Cal members and really being able to share this integrated data at multiple levels, whether that is the plan level, the provider level, or individual care management user levels, appropriately, following all sort of privacy and state and federal regulations. Go to the next slide.

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Slide 11	Palav Babaria – 00:13:16	So some of what we covered last time is that we last month issued a notice of intent to award where we've selected Gainwell Technologies to implement the Population Health Management Service. As we know, what we are trying to accomplish with this service is pretty expansive and unrealistic that a single vendor could provide this solution. So Gainwell has really pulled together a broad team of partners who provide all the various components of the service that we will need to achieve the vision that we just articulated. So some of those partners, but I think not all, are listed here and all of you will become familiar with the entire team over time. In terms of rollout details, we are going to be partnering with Gainwell and the subcontractors to implement the PHM service. We're still working on contract execution, but it's going to be a three year initial contract.
Slide 11	Palav Babaria – 00:14:06	And as we start to plan what rollout looks like, we will absolutely be reaching out to partners to test aspects of this PHM service over the course of the winter and spring of 2023, with the goal of having a statewide launch of core functionality in July, 2023. I'm sure some of the questions get to this, but I will also caution folks that there's a lot of functionality that can be accomplished in this service. We have no intention whatsoever of launching all of that functionality in July, 2023. This is really going to be an iterative process over time. So what we are really aiming for in July are those functions that are critical to the successful launch and scale up of our population health management program. And we do envision additional functionality to be launched over time. So just want to temper everyone's expectations. And as we start the rollout process, we will become much more granular about what some of those higher priority functions are that will go live first and what are elements that maybe have other dependencies or a longer runway. We can go to the next slide.

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Slide 12	Palav Babaria – 00:15:14	We talked through some of these milestones, but obviously the actual population health management program goes live in January. That is also when we are hoping to start testing pieces of the PHM service and refining and fine tuning. And then in July of 2023, the Population Health Management Service will have its statewide launch for that sort of highest priority functionality that will be going live first.
Slide 12	Palav Babaria – 00:15:38	And I'll also flag, I think we had a flag on the previous slide too, but we are definitely interested in partners who want to be early adopters, who want to help us figure out the kinks and really test and refine the solution for statewide launch. So if you're interested in being one of those partners, please email the PHMsection@dhcs.ca.gov. You'll see the link below. Anyone who's excited about technology and pop health and or has experience in this space, we would love to partner with you.
Slide 13	Palav Babaria – 00:16:14	Great. I think our next slide is the Q&A slide. So Jonah, I believe I'm turning it over to you to help throw all the questions that we got last time and weren't able to get to at us. And also say we'll take new questions too. So Jonah, you can maybe tell folks how we want to get those new questions.

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Slide 13	Jonah Frohlich – 00:16:34	So what we propose is we'll start going through some of the questions that were posed and responses. And as we go, if there's more clarification you're seeking, send us your question, we'll try to answer it on the fly. If anything new comes up that is of concern or you just have questions, we can also do that and we can respond to those as we go. So what I would propose doing is just start with there's certain categories of questions that we got and the first ones are really focused on the data and information available. The questions include what information on Medi-Cal beneficiaries will be available at launch versus... Sorry, first one is, will the service be available and have information for all beneficiaries, not just managed care? And what are the sources of data we're looking at, including information from various programs from other departments including public health, CalFresh, WIC, et cetera. So Palav, have any insights you can share?
Slide 13	Palav Babaria – 00:17:44	Absolutely. So yes, the PHM service will include information on all members. So even though our population health management program is being launched via managed care, the service will have data on everyone including those in fee-for-service, those in carve out programs, those in waivers, those in managed care so that it really can serve the entire Medi-Cal population and not just the managed care subset. Initially, we are taking a phased approach. So initially, the data that will be available will be data that DHCS already has today. That is largely claims and encounter data, but there are other pieces of information that we already have today. We have information about Medi-Cal enrollment and redetermination dates. We already get information from some of our state partners like public health that includes vital records and immunization registries and other disease registries.

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Slide 13	Palav Babaria – 00:18:37	We are working to get additional data from other state partners. So we have said we're particularly interested in things like CalFresh and WIC enrollment and leveraging the service to identify gaps in enrollment where we think people are eligible. We're working with our other public health and social services and other departments to figure out what other streams of information would be helpful so that we can all better collectively take care of this population.
Slide 13	Jonah Frohlich – 00:19:07	Great. And just to respond, it looks like you aren't seeing public health, and looking at one of your chat questions or comments that in the PHM service overview, you don't see public health specifically called out as a stakeholder, on the stakeholder list, which we'll go through that and rectify. Because as you heard, there's a lot of different data we're looking for from public health including different programs and data that Palav just mentioned.
Slide 13	Palav Babaria – 00:19:32	And the flip side that we know our public health partners are serving Medi-Cal members and we definitely want to figure out a way that this data and the service can also help local health departments and jurisdictions in that work as well. And then I am going to ask, I think Linette Scott, our chief data officer, is on the line. So Linette, is there anything that you want to add in terms of just what data we have today, which is what our starting point is going to be?
Slide 13	Linette Scott – 00:19:55	Sure. Can you hear me okay? Okay, great.
Slide 13	Jonah Frohlich – 00:19:58	Yep.

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Slide 13	Linette Scott – 00:20:00	So in terms of data that we have today, as Palav was indicating, we have a lot of information related to fee-for-service claims and encounters as well as eligibility and provider information. But another aspect of what we receive is the data related to the different components of Medi-Cal, not all of which are delivered directly by DHCS. Many of them are delivered by our sister departments. So developmental services, in home supportive services. Also, we're working with public health in a number of ways that we currently exchange data related to things like vital records, blood lead screening, immunizations and other kinds of data. So there's a lot of information that we share with other departments in the agency today and those kinds of things then would be able to be contributing to the Population Health Management Service as well.
Slide 13	Linette Scott – 00:20:56	I saw that there was a question related to HCAI, and so that also is another place where we have a partnership in terms of receiving hospital discharge and emergency data. But we are also working closely with HCAI on their health payer database in terms of providing data to that, that includes Medi-Cal data. So we're working closely with HCAI in kind of both directions in terms of how we understand our population and contribute to the health payer database that they've been developing. So while the HPD and the Population Health Management Service are definitely distinct, in particular in terms of how they will be used and how they support the different work of the different departments, we are working closely with them in terms of intersecting related to data. Thanks.

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Slide 13	Jonah Frohlich – 00:21:50	Thank you Linette and Palav. There's also this follow on question about, somewhat related to the topic but a little different. Do you require providers or CBOs to use Gainwell for referrals? And I think just to be clear about this scope, it's not anticipated this time that the service is really referral platform. Community Supports particular and ECM, those are all optional services and benefits offered by the managed care plans. And the managed care plans and their partners really are the ones supporting the process for referrals and authorizations. So that's where you'll see the locus of management for referrals and auths for CBOs.
Slide 13	Jonah Frohlich – 00:22:38	There were some additional questions, one more set of questions related to data and data management. One is, which I think is important to clarify is do you envision that the service is really going to act as a health information exchange? And then related, whether and how the service might access electronic health record information or I would say just more broadly, clinical information like vital signs, lab results, et cetera. You care to comment on there, Palav?
Slide 13	Palav Babaria – 00:23:08	Yeah, I can take this one and then Linette, feel free to jump in. So first and foremost, the Population Health Management Service is not a health information exchange and we probably need to put that in flashing lights somewhere on our slides. It will definitely build upon, hopefully over time, the data exchange framework that our health and human services agency is leading. But at the outset, as discussed, it really is just going to use data that we have today in the department, which is retrospective data, it's claims data, it's six plus months old in most cases and not have access to electronic health record or health information exchange.

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Slide 13	Palav Babaria – 00:23:45	Over time, down the road, as our statewide data exchange framework is built up, we do hope to connect to health information exchanges, probably not EHRs directly because there's thousands and thousands of them across the State of California. But to leverage health information exchanges and the data exchange framework to get more clinical information that is more real time because we recognize the value in that. But that will be a down the road phase and not what is available at launch in July, 2023. Linette, what else did I miss?
Slide 13	Linette Scott – 00:24:21	No, that's great. And as you said, we have been trying to reiterate the Population Health Management Service is not an HIE. It feels like we've been saying that since day one when it first came out. That being said, one way to think of the Population Health Management Service is that it really is providing a set of analytic tool sets to help support the Medi-Cal population. And as Palav said, we do see it intersecting with HIEs in the future but it is not in and of itself an HIE.
Slide 13	Jonah Frohlich – 00:24:56	Great. And just a related question, is there an anticipation, expectation that managed care plans and the service will support bidirectional data sharing? So for example, would the plans be able to extract data from the pop wealth management service they may not have? And would the service provide a mechanism to consume data that the plans might have on things like assessments or demographics, that the service does not currently have access to?
Slide 13	Palav Babaria – 00:25:28	Yeah, I would say the short answer is yes. What is envisioned is absolutely bidirectional data exchange. Obviously, depending on the type of data and where it's coming from, there are data governance issues. If you get two pieces of data from two different sources and they say different things, what is the source of truth? So those are all the sorts of decisions and testing that we're going to have to do. But the vision is to be able to have data be updated and accurate in the system.

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Slide 13	Jonah Frohlich – 00:25:57	And this does get Palav, one question really here about there are some complexities about accessing various different types of data, including certain data that's protected in certain state law, like HIV results. There is also, just Phoebe and for others to be aware, 8133 that was passed last year actually has, extends some protections from some of the state laws that allows some of those data to be exchanged for CalAIM purposes. It does not extend the behavioral health data subject to part two.
Slide 13	Jonah Frohlich – 00:26:31	But certain state laws, old state laws that evolved prior to the era of electronic health records and secure data exchange is like HIV test results, and allows for the purposes of CalAIM for some of those data to be shared, as they would be shared for other HIPAA protected health information. But it does still require that there is some sort of an agreement that business associates, et cetera, that these data only be shared for specific purposes. I want to make sure that, that's clear, Phoebe. There's still obviously protections for all of those data to be shared as you would, other protected health information and only for specifying purposes that are allowed under, for example, federal laws.
Slide 13	Linette Scott – 00:27:23	And perhaps the other thing I would add to that is that as Palav has said, this is a phased approach, and part of that we'll be working through some of the things that we have to do to make sure we attach appropriate providence to data in terms of what data has what requirements related to sharing and then having appropriate role-based permissions that allows for the appropriate access to data as well. So those two work streams will be key work streams that we'll be working on with the contractors as they come on board and some of the complexity of some of those might also affect what data is phased out and available as we move through this process. So that will definitely be a key component of the work.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Jonah Frohlich – 00:28:11	Related questions about availability of the service. So there's a question, first of all, about, hey what's the process by selecting the pilots, how's that going to work? That's a new question. Related to it, an older question about how will users ultimately access the service? Would you register for an account? Is there a sort of thought about how a variety of different users, and you may want to, Palav, note the categories of users, like county, behavioral health department, managed care plan, who those types of users are. So the two questions are one now details about the pilot, how will they be selected and two, how will users access the system?
Slide 13	Palav Babaria – 00:28:58	So let me start with the users because I think then it'll make more sense when I answer the pilot question. So we know there are going to be different types of users who need to access the system for different purposes. So there are managed care plans who have lives assigned to them or are taking care of a certain number or subset of managed care members such as county behavioral health. There are provider groups who, some may be risk bearing provider groups where they have delegated plan functions or other provider functions. There may be individual sort of provider practices. Then there's sort of care managers, both on the county side as well as the plan side as well as sort of ECS and community supports. So depending on all those different user types, we will be creating profiles so that people are only accessing information that they need to see.

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Slide 13	Palav Babaria – 00:29:43	If you are an individual provider, you should not have access on the entire Medi-Cal health population's information. You really just need to be able to see information for those patients and members that are assigned to you and that you're actively caring for. Same at the managed care plan level, same at the care management level. And then I think to one of the points about CBOs, there may be other entities that don't need to see the health related information. They have a very specific function or purpose and only need to see maybe demographic information or contact information on that member. And so one of the major work streams will be figuring out what are the different types of users, what are the security restrictions for those users, whose information do they need to see, what spectrum of information do they need to see. Is it everything that's in the system or just a piece of what's in the system, depending on their role and functionality. And that is what we absolutely will be figuring out as we sort do the planning for the service but also the testing.
Slide 13	Palav Babaria – 00:30:40	And I think to that effect, in terms of who we're looking for to be pilot partners, we know this system is going to function differently depending on what existing local infrastructure a plan has or that county has. And so we definitely want a diversity of partners so that we have a plan that has a robust population health management system. And what we really have to figure out is that data exchange because they're not going to sort of using the system necessarily, they just need that data output to get the data into their own system. We also want a plan that maybe doesn't have all that infrastructure and is going to be using more of the functionality of the system. So I don't know that I can give you specific criteria, but we will want to test this product and the service with a wide, diverse range of people, both in terms of experience, infrastructure, local capacity, so that we can really make sure that it works for everyone in a adaptable way without displacing any local infrastructure that's been built up.

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Slide 13	Jonah Frohlich – 00:31:41	Great. And Satya has a bit of a skill testing question here, a really good one. Is there an expectation about percent of members who are expected to be identified as high risk when this PHM service and its algorithms are developed? Any sort of sense about what that might be and in accordance with any kind of NCQA requirement?
Slide 13	Palav Babaria – 00:32:04	So I think we'll get to RSST a little bit more in detail later in this meeting, but definitely, I think at this point, we do not have expectations on what percentage of members will be identified as high risk. Some of that really depends on the algorithms, what pieces of information we prioritize, what outcomes we prioritize. So I would be making up something. I don't think we have any preset notions, but that will be work that our RSST working group and Scientific Advisory Committee will be working through in the coming months.
Slide 13	Jonah Frohlich – 00:32:39	Why don't we move to some of that since we're getting into functionality, some more general questions that were posed about functionality of the service. One specifically, whether stakeholders were asked, whether the service would support various functions like reassignment to new PCP or health plans, member notifications for benefit determinations, access to member health education, and any guidance on what we're expecting today.
Slide 13	Palav Babaria – 00:33:09	So I will say I think obviously, there is a member facing component of this service that will be provided in all the threshold languages. We want it to be useful to members, we want it to be actionable. We know members have other portals that they do access and I think it's really, as we do the user testing and connecting directly with Medi-Cal members, we will be identifying a lot of the answers to those questions. How do members want to use this portal? What are the functions and needs that they have that are not being met by other portals that they may have access to? So we absolutely envision of answering some of those questions with directed member input.
Slide 13	Jonah Frohlich – 00:33:50	Thank you. And Peter, you've got your hand raise. Go ahead.

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Slide 13	Peter Shih – 00:33:54	Great, thanks. Appreciate the conversation and you've touched upon a lot of the things that I think would necessitate a longer pilot period because there's just a lot of challenges. It's iterative, we're not getting all the functionalities, you want to see how it's adopted. I think these are all of practical way of approaching this and I appreciate that. I think across the entire state, there's just people that are in different spots. Some people are like, "Yes, let's bring this thing down. Let's use it because we don't have nothing right now." And so others are like, "I don't want any of this because we are already doing a lot of this. This is going to be disruptive, more burdensome because too many logins, the state still has not solved the problem of what can be shared, what can't be shared. Are we doing a universal consent? How are we tackling this?"
Slide 13	Peter Shih – 00:34:56	So I think no one can argue what this effort is. It's wonderful motherhood and apple pie, you can't argue it. But the challenge though is the execution and we all want to work with the state and the health plans. Like I've said before, we are all hot messes right now. We're all trying to get our arms around all of this and everyone's trying to do their best to cooperate and to try to find solutions and not just to whine and complain. But I think that there's just practical things that we have to be cognizant of and maybe allow people to volunteer to be pilots, make the pilot period longer. Because one thing that sticks out for me is it's not necessarily going to connect to the HIE, some people who have CIEs, right? So these are all good things, but if we're going to work out some of the bugs, it should take a longer pilot period and encourage people to come on from the large, the small, the medium, all of them so that they can inform the learning.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Peter Shih – 00:36:02	So that's what I think is going to help us be more successful because we're going to learn new things along the way. And the plans are burdened with a lot of things that the state has asked them to initiate and whatnot. CBOs here in San Mateo are also learning, grappling with the change in CalAIM and how to claim. And then we have jail health things coming too. And so I just think that this would be super helpful, but it needs to be dragged out, I mean the pilot needs to go longer. And the fact that it's 90 days or at least as long as it takes the data to get in into the system is also going to be challenging. So my two cents on that.
Slide 13	Palav Babaria – 00:36:43	Totally appreciate that feedback. And definitely, at future meetings, what we hope to bring you is of proposed sequencing of what are those must haves on July 1, 2023 that the pilots are going to focus on. But as we've alluded to, there's definitely other pieces of functionality that will have a much longer runway where that pilot period absolutely can be and will be much longer.
Slide 13	Jonah Frohlich – 00:37:11	And then I think there's another question from Susan, about 2024 after the procurement transition. Will both primary master plans and some contracted plans be able to interact with the service or access only between, will it only be between PHMS service and primary plans. So maybe if you can talk a little bit about who is expected to be able to be granted access to the service, that might help clarify that.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:37:36	Yeah. We recognize there are multiple levels of delegation, not just from primary plan to subcontracted plan, but also to IPAs, to provider groups, et cetera. And so as we figure out the role-based access, we will need to grapple with that. How do we get the information to the people who need it, even if it's going through multiple layers. The department doesn't always have visibility into what those multiple layers are. So I think some of that will be a practical challenge of what information do we have, where we can grant access to the right people and are there new workflows we have to put in place to understand who access is being delegated to. I know that's probably is sort of a non-answer. We want to get people access but we have to do it in a way that is thoughtful and still ensures security and privacy.
Slide 13	Jonah Frohlich – 00:38:31	Bhumil, you had your hand up.
Slide 13	Bhumil Shah – 00:38:34	Yeah. Sorry, I just type it in. Given this is going to be a phased approach, could we start with what are the defining the metrics for the population health management program as a whole? And then for each metric what data is needed to be successful? So I just made it up, say the priority is child immunization. Assuming the plans and the providers would want to have a complete history of immunizations or data from care, PBM, other sources that have it. So one approach is like let's start with the data we have, versus the other approach is what is our priority and what data is needed to support it. We can actually use it for interventions. Could that be an approach? Can we start with defining these are the priorities for population health management in 2023 and 2024. And now that these are the priorities, this is what we need to support those priorities.
Slide 13	Palav Babaria – 00:39:35	Yeah, I think that's a great point. And I know the population health team is working on what our monitoring approach is going to be for the entire population health management program. So we can definitely bring that back to this group and then also more explicitly, think about how that ties to the PHM service as well.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Bhumil Shah – 00:39:54	Thank you. And then I have a few interest questions, but I was also going to ask this question. Given that there are providers and plans and urban counties and rural counties, huge diversity here, I'm just trying to figure out how... So there's no one size fits all approach. So could we start with understanding what are the biggest pain points or unless it's already done, for large providers versus small rural plans? What are the top issues right now? And maybe you could use that to set the priorities. So some kind of a polling or future meeting where each one says this is our biggest pain points when it comes to population health management data.
Slide 13	Palav Babaria – 00:40:41	Short answer is yes, we can definitely do that. I know we've done some listening tours and focus groups, but I love the idea of a poll. So we'll take that back.
Slide 13	Bhumil Shah – 00:40:50	Okay. Yeah, even this advisory panel is essentially that. We have a lot of diversity in terms of size and urban rural and so on. And Jonah, I had three other questions in the chat, but I don't want to dominate this so maybe I can come back to it.
Slide 13	Jonah Frohlich – 00:41:12	I think we have time. So if you want to voice them, then we'll go to Dipa next. Go ahead.
Slide 13	Bhumil Shah – 00:41:18	So one question obviously I had was that if, say beneficiaries are going to go into this portal, doing any kind of screening or assessments, we want to make sure that data is available at the point of care in the system the providers already use because that's the only way that data is going to be actionable. We have seen paths that nobody wants to log into one more portal and look things up. So it was more a question but also a request that we make sure that once the data is collected from the beneficiary, it flows back into the touchpoints with the beneficiary at the point of care. So it becomes actionable. Knowing that you have food insecurity is important, but if it's not available at the time in their screen or when the case manager is talking to them and requires a portal, there's a chance that it may be overlooked and it needs to be in the systems that are already in.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Bhumil Shah – 00:42:08	So I know Palav, you said there are 1,000 systems in place, but if somehow we can get this back into the systems in play, that's when it's going to be most actionable.
Slide 13	Bhumil Shah – 00:42:19	And then other question was, is this an opt-in service? Say if we have some good data on just this involved population already. So is when I figure out, is it depending on the data source? Is it like an opt-in, like yeah, this is an area of deficit and let's opt in versus oh this is a great, we already have claims data and we don't need to, which is more real time and we don't need it. So just figuring out is it an opt-in type of service or is it, we take it all?
Slide 13	Palav Babaria – 00:42:52	Great questions. So I think in terms of the opt-in piece, there are a few areas in the population health management strategy and roadmap where we explicitly say plans are required to use this. So for our managed care plans, the output of the risk stratification, segmentation and tiering, use of that as a starting point is required for all plans. But we very purposefully have not put that level of detail and requirements on all of the functionality of the service. So I think for other elements, unless it's explicitly called out right now in the roadmap, it is really, this will be available. Plans can choose to use it or not as they see fit for the other functionality.
Slide 13	Bhumil Shah – 00:43:31	Got it. Okay. Yeah, the example is like say we are on Epic and we have carrier data. So it's real time data flowing. So do I really want claims that are three months old? Versus in some areas you may have a deficit. Last two questions, I think you already addressed this, but we talked about risk stratification, and what is the risk we are stratifying for? That would be helpful, whether it's cost versus unnecessary ED visits, because all that could lead to different... The same person could be stratified differently depending on, it could be a high risk individual, but who's not seeking ED visits. So there could be low cost, but at high risk, versus other way around.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Bhumil Shah – 00:44:05	And the last question is given that we do this a lot at the county level and even such a small population, we have issues, where this patient is not really homeless or this patient is not, they're two patients who are the same, they need to be merged. So will there be a technical help desk we can reach out to if we find data discrepancies or data quality issues?
Slide 13	Palav Babaria – 00:44:28	That is a great question. So on the last one, we will have a consumer contact center to help resolve some of those issues. I think the merging of files or logins, password, et cetera. But we will definitely take that back and add that to our list for more granular data integrity issues of what the best resolution process is for that. And then to your earlier point on risk stratification, I think we'll get to in our next segment, but the short answer is this is what our RSST working group is going to be focused on. What are we solving for and predicting for with the risk stratification, segmentation and hearing process. And I can say the vision for it is really identifying people who will benefit from the services and interventions that we have to offer. But there's a lot of different ways to get there. So more to come on that.
Slide 13	Bhumil Shah – 00:45:17	Thank you.
Slide 13	Jonah Frohlich – 00:45:19	Great. Dipa, do you want to go ahead?
Slide 13	Dipa Patolia – 00:45:22	Sure, sure. I'll make it quick. Thank you.
Slide 13	Dipa Patolia – 00:45:24	So we do have extensive data analytics that leverages data from millions of individuals and I've continued to integrate bias testing, SDOH, medical and behavioral, et cetera. And this allows us to really stratify and use that information for prioritization. So really, just to make sure that the PHM service allows us to pull discrete data in structured formats to layer onto our own data and risk stratification methodology will really bolster our ability to do a refined job. So really excited about the work and really wanting to make sure that the data becomes available in user-friendly ways. And if there's any opportunities for us to inform some of that.

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Slide 13	Dipa Patolia – 00:46:12	We're also going to be, we'll continue to leverage our portal and other capabilities to provide that data downstream while integrating with data sets. And this includes provider facing capabilities that interface with EHR software, that integrate with provider portals. And to kind of echo what Bhumil just said, all of this makes the data available at the point of care, which is critical for that patient care.
Slide 13	Dipa Patolia – 00:46:36	So again, just going back to the point of just making sure that the data that goes in and comes out of the PHM service uses a structured format that can then integrate into core systems, operating procedures and operating systems. So the question is, how will the service ensure that it's using structured formats, discreet data so that when it does get to the end user, that it's in a usable way, an actionable way. And if that's something that the pilots will be focusing on, just looking forward to that opportunity to explore that further with the pilots and leveraging our IT and data teams in that process as well. So that was my question and more of a comment, some of a question.
Slide 13	Palav Babaria – 00:47:20	And as a non-data person, I'm going to phone a friend and ask Linette and our Gainwell colleagues, Brett Barton and Larry are on the call too, if they want to speak to the data formats and interoperability pieces.
Slide 13	Linette Scott – 00:47:34	I can start and certainly. The more structured the data, the easier it is to use. So we will definitely be leveraging standards including the HL-7 USCDI standards associated with HIPAA, 837s, et cetera. So all the normal standards we will be leveraging to the greatest extent possible. And the data that we currently have in our data warehouse that we'll be starting with is all structured data. So we would certainly be looking to leverage that as much as possible.
Slide 13	Linette Scott – 00:48:08	As we move forward in future phases, there could be data that's less structured for various kinds of reasons, depending on the source and where it's coming from. But certainly, thinking towards tracking with the interoperability requirements, HIPAA requirements, and all of those standards will be a key component.
Slide 13	Jonah Frohlich – 00:48:34	Anything from our colleagues, either KPMG or Gainwell. Thank you.

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Slide 13	Brett Barton – 00:48:43	Yeah, this is Brett Barton with Gainwell. Sorry everybody, took me a minute to get off mute there. Clearly, our solution will be able to handle unstructured data. Obviously, we need to work through those details. We need to really take a look at what data is valuable in that perspective. What's its potential to help everybody and just kind of work through those details. But we can clearly support unstructured data. It's just a matter of what data is valuable for everybody to use and how to present it in a valuable way.
Slide 13	Veronica Adamson – 00:49:17	Yeah, I would just echo what Brett said. This is Veronica from Gainwell as well. I think really, it comes back to the points that have been made over the last half hour, which is what's going to be really meaningful and drive the outcomes that we need. And as a result, what are the data points and the data formats that need to be accounted for in prioritizing those, as Brett mentioned, based on the potential for good that they can drive as well as the complexity. But totally agree with what Linette said in terms of the way of looking at it to begin with.
Slide 13	Jonah Frohlich – 00:49:52	Great. And just following question, talking about X12. These are standards, administrative standards, like X12, or interoperability standards like HL-7, FHIR, USCDI. So essentially, the federal standards that have come out through interoperability requirements, HIPAA, et cetera, will be used to the extent possible wherever possible for any kind of requirements for other data consumption or data delivery.
Slide 13	Jonah Frohlich – 00:50:24	One more question before we go, I think into RSST and maybe I'll ask Palav if you want to do a quick recap and then there are a series of questions we received. There's also one we can come back to Tangerine, your question you posed earlier about RSST. So we can come back to that before we do, I think there is one question about super service from Kim and how will this work? How will this, this being like the service, work and fee-for-service, who will have access to it, what's going to be shared? Do you have anything you can share at this point, Palav, about that?

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Slide 13	Palav Babaria – 00:50:54	Great question. So I think that will be one of the groups where the responsibility for fee for service and where those individuals are accessing care both lies with the member but then also the department. And we do have programs that look at various aspects of fee-for-service care. They aren't necessarily the full scope of population health management that we're talking about in our program, but I think we're looking internal to the department to see those individuals in smaller programs that are overseeing or looking at fee-for-service right now, how can they also leverage the Population Health Management Service to improve care and outcomes for this population.
Slide 13	Jonah Frohlich – 00:51:38	Great. Palav, do you want to do a quick recap on RSST process? There's a few slides here or we can go straight into questions that were posed and answer those that come up.
Slide 13	Palav Babaria – 00:51:49	Let's just do a quick recap in case there are folks here who weren't at the last meeting. I promise I won't talk for too long.
Slide 14	Jonah Frohlich – 00:52:01	Okay, great.
Slide 14-15	Palav Babaria – 00:52:03	Great. Keep going. So just as a refresh, part of what we are hoping to do is really have a standardized state PHM service led approach to risk ratification, segmentation and tiering. This is very much aligned with CalAIM. Obviously, as we've heard on this call, there are plans and providers who are already doing this in a very robust, detailed way today. But we want to make sure that we have a standard yardstick and single approach that we are applying across the state to really ensure that consistency of experience, consistency of access to services for our members across the state, which we all know is a major goal for CalAIM.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Palav Babaria – 00:52:43	So we have put together a group of experts, which is hopefully getting off the ground soon, which is our RSST working group who is really going to be helping us make critical recommendations about goals, answering Bhumil's question, what is the purpose of this algorithm, what are we solving for, what are we trying to predict for? And then to develop this algorithm in combination with Gainwell and Arcadia, which is providing this sort of pop health analytics piece of the service to really use historical data to test this algorithm to run the models. And then by July, to deploy it statewide in the PHM service. Obviously, like most of the service, we are committed continuous quality improvement. And so this algorithm, with learnings, will absolutely be refined over time. And especially as we get new data types, more feedback from people using the algorithm, it will, I'm sure, go through future iterations as well. You can go to the next slide.
Slide 16	Palav Babaria – 00:53:44	And so the RSST work group we are working to put together, this will be a series of national and state experts in the field of risk stratification, segmentation, and tiering and predictive analytics who represent a wide array of perspectives. They're going to be really getting in the weeds on a weekly basis with the department and with Gainwell and Arcadia Analytics to really spearhead the early recommendations and framework and decision making.
Slide 16	Palav Babaria – 00:54:12	At the same time, we will be standing up the scientific advisory council, especially those of you who have lots of experience in this space. Please put forward yourselves or your colleagues for nomination. And then all of the output of that RSST work group will be brought to the SciAC for further feedback input, especially from those who are doing this in the real world setting on the ground to help us refine our thinking before the July, 2023 launch. We can go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Palav Babaria – 00:54:42	This one just sort of shows the relationship. So we really see the work group, the scientific advisory council, and this PHM advisory group being kept in the loop and informed of these efforts. Obviously, sort of the further down you go, the more time and in the weeds you are with risk stratification, segmentation and tiering. But ultimately, DHCS will be providing final decision making and oversight over all of these activities. We can go to the next slide.
Slide 18	Palav Babaria – 00:55:10	So this is our second call for the meeting. Thank you to those of you. We did get a bunch of responses after our last meeting. But if you are interested in being on the Scientific Advisory Council or know someone who should be on here, please send a nomination email to the PHMSection@dhcs.ca.gov. And this is going to be a relatively technical council. So we do need people who have experienced designing and developing RSST approaches and tools, those who have lived real world experience using outputs of such tools to inform care management, care coordination, care delivery, and especially those who have lived experiences as Medi-Cal members and advocates or receiving services in the Medi-Cal delivery system. We definitely want some member perspective and voices in this. Great. And go to the next.
Slide 19	Jonah Frohlich – 00:56:04	All right. I think we have questions. So why don't we go back to the last session because we have a lot of other questions that were posed by the group. We'll start with the hardest first, which comes from Tangerine.
Slide 19	Palav Babaria – 00:56:19	Oh, Tangerine. I should've known.
Slide 19	Tangerine Brigham – 00:56:24	It wasn't purposeful. I have a head cold. Forgive me.
Slide 19	Jonah Frohlich – 00:56:31	Tangerine, do you want to raise your question? It's a really good one, I think one we're going to grapple with a fair amount.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Tangerine Brigham – 00:56:37	Yeah, it's essentially, we understand that the PHM service is using retrospective data, but we also understand that the state is using that to do the risk stratification and segmentation and the tiering and that tiering will be used by the health clubs to really understand where sort of care management falls for any particular person. If it's just community supports versus basic care management versus ECM. But given that the data is retrospective, how do you ensure that its current so that we're acting on either providers or health plans information that is most useful given the structure of what I understand to be the lag in the data.
Slide 19	Palav Babaria – 00:57:32	Yeah. Just so everyone's up, we have three to six months of claims lag across our delivery systems. And so Tangerine, to your point, the data we are using is going to be by definition, three to six months old. I think there's a few ways in which we're thinking about this. One is that for anything that needs real time information, if you need to know if someone was admitted to the hospital yesterday to work on their transitions of care planning, the service is not going to solve that problem for you. And so that's why we've been very clear in the population health management strategy and roadmap, things like ADT feeds, other real time data sources. We expect our plans to be absolutely working on getting those services and investing in that infrastructure because the service is not going to solve for those problems.
Slide 19	Palav Babaria – 00:58:15	I think the areas where the service is going to be helpful, when we think about the risk stratification, segmentation and tiering, we really do hope to use predictive analytics where it says based off of these previous patterns, we predict this thing's going to happen in the future where maybe the three to six months of claims lag is not such a big deal. And then we also are saying this is the floor and not the ceiling.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Palav Babaria – 00:58:37	So if someone was flagged high risks based off of three month old data, it is unlikely with no intervention that all of a sudden miraculously three months later they are low risk. So I think that's a starting point. What the algorithm will miss is anyone who's had new events or something that has happened in the last three to six months that hasn't shown up in our service. And we absolutely will expect and encourage plans that you're going to find those members, right? Because you get more timely data or the member reaches out to you or a provider refers to you, that plans absolutely will need to, if there's new or current information that just isn't in our service yet, they'll have the flexibility to serve that member as they need to.
Slide 19	Tangerine Brigham – 00:59:19	Thanks.
Slide 19	Jonah Frohlich – 00:59:24	Great. This is actually just a quick question for the team. I don't think these materials are posted on the PHM website. Do we have a timeline for when those might get posted? If not, we just need to get back to the group, I think, with when they will to go up. Does anyone know?
Slide 19	Tangerine Brigham – 00:59:44	It would be nice to post up soon though.
Slide 19	Jonah Frohlich – 00:59:48	Yeah. Okay. We'll see what we can do to get them posted as soon as possible. Thanks. So a question that has come up and I think is of some concern or just clarity would be helpful about, how does what the service is going to be doing in terms of its functions, especially with the risk stratification, segmentation and tiering work, how's that going to dovetail, interact with capabilities that the plans have? So if the plans are all, and we've heard Palav say we've got all these algorithms. We've got this algorithm, we invest a lot in this, we're consuming more data, starting to from EHR. And the question I think is that how is this going align? Is this going to be duplicative? So what's the current thinking about how this interacts with existing functions?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Palav Babaria – 01:00:38	Great question. So I think the vision for the service as a whole is to not displace local infrastructure that is being built, whether that is at the plan level or local sort of data exchange and population health management infrastructure, which is why that interoperability conversation is so critical. We need to make sure that the data goes in and out and is shared. But if people have their own local systems they want to be using, that is fine. They don't necessarily need to log in and use the system in its native format.
Slide 19	Palav Babaria – 01:01:06	For the risk stratification, segmentation and tiering algorithm piece specifically, the expectation will be that the plans use the output. Is that the only output that they have to use? No, the department has not said that, but that will be the single yardstick by which the department is doing its monitoring an ongoing assessment of the program, or one of the yardsticks.
Slide 19	Jonah Frohlich – 01:01:34	Great. Can you talk a little bit about the Scientific Advisory Committee, specifically qualifications? What are we looking for? What kind of qualifications of the members are we looking for and is there any suggestion about what types of organizations we're seeking for the SciAC, Scientific Advisory Council?
Slide 19	Palav Babaria – 01:01:58	So I think the member piece we'll definitely take back and issue a little bit more guidance on, because I think we do need to give some thought to is that how do we support members in being active participants of that group and make sure that they have the background and the context because they will be coming from a very different place than potentially other members of the Scientific Advisory Council. So thank you for flagging that for us.
Slide 19	Jonah Frohlich – 01:02:26	Great. And there's some additional kind of tricky questions here that are starting to come in. One is around taking into account risk stratification, particularly for hard to reach populations who aren't using services, but we need them. And maybe this is a methodological question that others on the call can answer, but any sort of initial thought about how those will be treated in the service?

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Slide 19	Palav Babaria – 01:02:51	Yeah. So I think certainly, there is a lot that's been published about how if you only use utilization data, you will introduce bias into your algorithm because we know that utilization is skewed. It doesn't necessarily represent the total population. There are specific, especially racial and ethnic in other subgroups that have different patterns of utilization. So we are very committed that as we, our RSST work group and the Scientific Advisory Committee review these materials that we are protecting against that algorithmic bias. And one of our proposed members is actually a nationwide expert in this field. So we are confident that the group will be able to really come up with the right methodology to protect against algorithmic bias.
Slide 19	Jonah Frohlich – 01:03:37	Great. Would you anticipate that community based organizations, I assume those would be like ECM and community supports providers, those who are actually still delivering the services, might they be able to access any kind of member information through this? Let's just say a Meals on Wheels provider is referred a patient but they don't have much information. Might they, in the future, be able to go into the service and access more information about that member?
Slide 19	Palav Babaria – 01:04:02	I think the short answer is yes. We want to get the information to the people serving our members. There's obviously complexity there in terms of how do we define that user type, what information can they access, can they not access? So it may take us a little bit to get there and figure out all those details.
Slide 19	Jonah Frohlich – 01:04:22	Great. One more question Palav, that came in the last time, and it's a complicated issue. The question is, can supplemental managed care plan data modify an individual's risk tiers determined by the service? So if a service identifies a group of members or an individual member as high risk, plan has other data that might suggest otherwise, can the managed care plan identify it? What is expected.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Palav Babaria – 01:04:50	Great question. And I think this one is relatively well articulated in our program guides. I refer folks there. I think at this point we are not envisioning manual overrides of tiers because I think anyone who works in data, right? It's like once you get into the manual override feature, you are not using big data, you're not leveraging the system as it is intended. So we would ask plans, what is leading to that member being high risk? Is it that you knew they were in the ED yesterday and that just hasn't hit our claims yet? Then, as long as the claims and the encounters are processed appropriately, they will flow into the system and that person will be captured as high risk three months down the road. If there's other things that you are discovering, they're homeless, they have food insecurity, whatever it is, really focusing on appropriate coding and encounter data and capturing that information in the discrete fields that exist across various systems, will be how those pieces of information are captured most appropriately.
Slide 19	Jonah Frohlich – 01:05:49	Great. I think there's one more question, at least that I have noted, that we haven't answered either from last session or here. And this is around source of truth about the relationship. So does the department have a source of truth about the relationship between the providers slash case workers to the various organizations as a whole? I think what this question is asking is if there's the source of truth between the member and a case worker, which is a really good question. Does the department of access to it. Where is the source of truth right now for that relationship?
Slide 19	Palav Babaria – 01:06:31	And Linette, you can keep me honest, I do not think we have that information today at the department. I know that we are receiving some primary care assignment, but I don't even think that is fully complete. So I think those are the complexities, right? So we know exactly what plan members are assigned to and then once we start to go levels deeper to be able to get other people below the managed care plan access, we have some work to do to figure out how do we identify those people, how do we make sure people who don't need a member's data aren't getting it, et cetera.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Linette Scott – 01:07:07	Yeah, I would agree with that, Palav.
Slide 19	Jonah Frohlich – 01:07:13	Okay. Unless there are other questions here about the pop up management service we can go, our next topic is around beneficiary contact and demographic information. So last call for questions or comments before we switch topics.
Slide 19	Palav Babaria – 01:07:32	And I will just say for the SciAC, for non-members or non-Medi-Cal member participants, we just really want some nerds. So find the biggest nerds in your organizations and send them our way and we're going to have a lot of fun together.
Slide 19	Dr. Yoshi Laing – 01:07:57	Yes, send us your nerds. I guess next slide for me.
Slide 19	Palav Babaria – 01:08:07	Yoshi, maybe while we're waiting for the slides, you want to introduce yourself to this group?
Slide 20-21	Dr. Yoshi Laing – 01:08:10	Yes. My name is Yoshi Laing, I'm a family physician and relatively new medical consultant to the PHM team. And I'm helping leading our efforts right here around beneficiary contact and demographic information. So, without this, all the initiatives we're working on are going to be a lot harder if we don't succeed with this. So last week we got together, our new stakeholder work group. And this group is going to help us understand how to best collect, share and use beneficiary contact and demographic information.
Slide 21	Dr. Yoshi Laing – 01:08:52	A little bit of background. So in February, 2020, this group was brought together but then of course hit a major bump in the road called COVID-19. So that work was put on pause and now we're bringing the band back together, getting the group back together to give us input on how to best collect, update and share BCDI. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Dr. Yoshi Laing – 01:09:21	All right. So the work group, the purpose of the work group is to help us identify options to improve how the data is collected, updated, and shared, and at the same time, maintaining compliance with all the applicable state and federal rules. And then the tasks of the work group members are to give us updates on their respective BCDI efforts to discuss challenges and barriers and to identify potential solutions that we may need. And then also offer input options, recommendations for next steps. We'll be meeting monthly, at least through December, on Zoom. And next slide please.
Slide 23	Dr. Yoshi Laing – 01:10:09	All right. And then there's two high priority drivers that are central to this work. So the first one is data to support Medi-Cal enrollment and redetermination. So that means supporting beneficiaries so that they can update their information to either enroll, re-enroll, and that includes but is not limited to the PHE unwinding. And then the second driver is data to support population health, care management, program outreach, RSST, like we just talked about for example. So that means Medi-Cal, MCPs, counties, providers are going to have access to accurate, complete, timely data to do things like risk stratification. So this advisory group right now will be kept informed about the BCDI work group activities at all our future meetings. And that is the quick summary of what we're working on. And then I think we'll probably have time for questions, but I'll hand it back to you Palav.
Slide 24	Palav Babaria – 01:11:27	I think there's time for questions if we want to pause and see what thoughts folks have.
Slide 24	Jonah Frohlich – 01:11:41	Thank you. Dipa, so ahead.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Dipa Patolia – 01:11:43	Thank you. So I think we've been thinking about this a lot internally, and I guess brainstorming opportunities to modernize the signup process, whether that be by paper or online. Making sure that we're systematically capturing email addresses, cell phones, home addresses, and then thinking about opportunities where members may be allowed to opt-in to texting and other campaigns to support their needs and gather this information in a more user friendly way, as well as collecting alternative contact information through ADT and all the various sources as well as emergency contact information.
Slide 24	Dipa Patolia – 01:12:27	I know last time there was a really great thought brought up around tapping into the Medi-Cal Rx systems and seeing if there's member information that could then be disseminated back to the plans and providers. And then just following that thought process of allowing patient members to opt in to health plan communications during the redetermined nation process when that happens will be really, really critical. We're being very comprehensive in terms of how we're capturing information and all the different modalities by which we can capture it.
Slide 24	Dipa Patolia – 01:13:06	And then just one more comment is we've started work on quick one-pagers, cheat sheets of how to collect information, how to input information, both member facing and provider facing, that I think will really narrow down all the steps that are required. So really a step-by-step one page guide that I think could hopefully be used more widely and create more of a streamlined way of capturing that information. So those are just uncommon, but really hoping that we can be very systematic in modernizing this sign up process.
Slide 24	Dr. Yoshi Laing – 01:13:50	Thank you, Dipa. That's helpful.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Jonah Frohlich – 01:13:57	I think there's a question here about, from Michelle, about interoperability standards for demographic data. So will this work go beyond that? But I think, Michelle, you might be referring to things like USCDI, some of the interoperability rule requirements, which I think is what the state, and Linette you might want to speak to this, but I think that's generally the direction the state would be going in, in terms of using that information for this purpose and using the extent that's possible. There's a great need to get this information updated as soon as possible by whatever means possible. So we may not necessarily want to say we will only accept it in the standard formats if we have an opportunity to get better data to keep people enrolled in Medi-Cal or to engage them in pop health. But Linette, any sort of reaction to that?
Slide 24	Linette Scott – 01:14:57	Yeah. Perhaps, something to just add. Historically, our Medi-Cal eligibility data system and the data that's collected that way would not necessarily be directly aligned with the US core data for interoperability. As we move forward, we are certainly looking at how we can align with that because with the interoperability rule, it has become a requirement in terms of how we look at these different standards. So as we move forward, we'll be working on reconciling historical information and the way data has been collected historically with how standards have evolved and changed moving forward. So that will be part of the work ahead of us.
Slide 24	Jonah Frohlich – 01:15:50	And then Beth asked a question, maybe this is actually more directed back to the pop health management service than it is BCDI. But the question is will the initiative help when there's transition of a member patient going from one county to another in moving that care plan from point A to B. This feels a little bit more like, Palav, it's more of a question about what the service might be able to enable then, BCDI. But do you want to comment on that?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Palav Babaria – 01:16:18	Yeah. So I think globally where we all recognize that there are lots of challenges of getting timely updates to contact information to demographic information, to allowing members to change those pieces as well as a lot of manual bottlenecks. So we had our first BCDI working group and we heard from county and provider partners that sort of the thousands of records plans sometimes will send their county partner that have to be reviewed, one by one, by a human being. It's just very hard and challenging. And so I think this initiative really is looking holistically at the whole process and saying where are there pieces where there's a better way where we can use automation, where we can really leverage our people power to do the things that only people can do, such as county to county transfers, which are very complicated. So I think we're looking at all of the problems and where this initiative can solve probably not everything but as many of those problems as possible.
Slide 24	Jonah Frohlich – 01:17:25	Peter, please go ahead.
Slide 24	Peter Shih – 01:17:28	Yeah. I definitely think that we need to focus on a real effort to not just get the beneficiaries to put in good data but also the counties to be able to have almost training on how to ask these questions to get the demographic information because I'm just doing a deep dive of our demographic information here in the county and there's a lot of fill in the blank or refuse to answer or other. And that just creates a lot of challenges for us to be better informed on what to do with information that's coming in on each beneficiary.
Slide 24	Peter Shih – 01:18:09	So I definitely think that there should be investment of time and resources to help pitch everyone on the benefits of having accurate demographic information from the beneficiaries and what information they're putting in to the PHM in the future. So I think absolutely, whatever best practices out there in the country or other places we should try to leverage and make sure that there's good data coming in so that we can have good analysis and good information for us and make good decisions.

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Slide 24	Dr. Yoshi Laing – 01:18:45	Peter, when you say pitch everyone, do you mean I tell my patient, "Hey, I need a good phone number to reach you in case there's something wrong with your lab results"? Do you mean that?
Slide 24	Peter Shih – 01:18:56	Yeah. I think up and down, bad data, it means bad information out to those of us who are going to be making decisions. So I think everyone in that chain of interacting with the patient beneficiary should double check the information. It's worth the time and I think there really needs to be a big push because if the data's not good, people won't use the system. And I think the adoption is so important. And to Bhumil's point of what's the data quality reconciliation and addressing that up front and of course, across different county lines. Here in the Bay Area, it's very porous. We have the Caltrain and the BART just moves people back and forth very easily. And so if there's opportunities to reconcile and check data, if I have a client coming from Alameda coming here, how does that reconcile when they move locations. Things like that. I definitely think a big push on this is our opportunity to get the better data coming into our systems.
Slide 24	Dr. Yoshi Laing – 01:20:24	Thanks Peter. And we have Katherine.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Katherine Haynes – 01:20:29	So I began working on this in 2006, in anticipation of the implementation of Senate Bill 853. And I think that one of the mistakes that we've made is the same mistake we make with vaccinations, which is we tell about harm or protections from harm but we don't actually enlist the enrollees in a campaign. We don't enlist, we don't rely on altruistic messages, we don't use asset framing. We tell them how we won't use it to hurt them. And so I think that we've missed the boat because despite everything that's going on in the world right now, I think there is altruism and I think there are groups of people who have linked fate, who have a vested interest that we may not have articulated their vested interest in sharing the data. And so I would urge us to think about how to do this from the psyche of the person that you're asking to give the data. What's in it for them really and what's in it for their people really? It's discouraging to me, that all these years later we're still wrestling with the same old thing.
Slide 24	Dr. Yoshi Laing – 01:22:02	Yes, that's critical, Katherine. Thank you for pointing it out. Bhumil, hello.
Slide 24	Bhumil Shah – 01:22:13	To Peter's point, most recently because of the mass vaccination for the state immunization registry, we've seen a lot of the race, ethnicity data is unknown, declined to state, just plain wrong because people are just signing up online, skipping the field or picking whatever first came. The point is not all data sources are equal. We need to be careful as we create this. And same thing for addresses, right? There were restrictions about who would get their vaccine where, so people would give other county addresses. And so we don't want to override that.
Slide 24	Bhumil Shah – 01:22:49	So I'm sure this will be part of consideration is that what data sources and they're not equal, what trumps what. And there'll be a need too, a technical help desk to address these, right? Because same thing happened with the immunization card, people are calling in, even the immunization wouldn't line up correctly. So given this is a much larger data set, there needs to be some mechanism for individuals themself or providers to call in and address data issues.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Dr. Yoshi Laing – 01:23:24	That's why Bhumil's on our group.
Slide 24	Jonah Frohlich – 01:23:32	Any final questions or comments before we wrap up and go to next steps.
Slide 24	Dr. Yoshi Laing – 01:23:39	Thanks everybody. All great points. Appreciate it.
Slide 24	Jonah Frohlich – 01:23:46	Palav, you want to take us home here? Next slide please.
Slide 25	Palav Babaria – 01:23:51	Absolutely. So hopefully nothing on the slide is used to anyone but just to remind us of milestones that we have before us. So we are actively receiving PHM readiness submissions from all of our planned partners and really look forward to delving into those. And then we will be officially retiring APLs 17-012 and 17-013 in December, as well as amending the IHEBA/SHA and Individual Health Assessment APL so that all of the guidance now aligns with what we have outlined in our population health management program guide. Go to the next slide.
Slide 26	Palav Babaria – 01:24:32	January. Obviously, 1/1/23. Some people may be celebrating the new year. The rest of us are going to be launching the Population Health Management Program and then hopefully launching testing with multiple partners. There will be new APL guidance coming out around the population needs assessment and population health management strategy, as well as publication of our monitoring strategy that I alluded to in quarter one, 2023. We recognize there's probably going to be some revised pieces that go into effect later in 2023. And then in July we will have our statewide launch of the PHM service. Go to the next slide.
Slide 27	Palav Babaria – 01:25:13	I think that was the end and then we look forward to seeing everyone in December. You'll notice we sort of stretched out the timing a little bit just given the holidays that are coming up. So this will probably be our last meeting of this calendar year.

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Slide 28, 19	Jonah Frohlich – 01:25:30	And just two more things before we go. One is Mike Ode asked if the PHM responses will be shared publicly and I'm going to ask if we can go back to slide 19, very briefly, Julian, to show a couple of questions that we have. I don't know the answer to Mike's question and I don't know Palav, if we've made that determination yet with the department.
Slide 19	Palav Babaria – 01:25:52	I don't think we have made that determination. So we will take that back, Mike. Thank you for raising the question.
Slide 19	Jonah Frohlich – 01:25:59	Great. I understand we intend to post these materials this week. We have a series of questions that we have up, that we are actually seeking guidance on. I expect that our SciAC and our RSST work groups will start to address some of these. But if any of you have some thoughts you'd like to send our way about any of these questions around the RSST program goals, we'd certainly welcome that feedback. If you could send it our way, we'd absolutely appreciate it. And we'll be seeking comments from our various advisor groups as we go, to get these answered. Any final words, Palav, before we go?
Slide 28	Palav Babaria – 01:26:40	No. I just really appreciate everyone being here. I recognize there are more questions than there are answers on these topics. But that is why we need each and every one of you to help us come up with thoughtful, useful answers as we move forward. Thank you, all.
Slide 28	Jonah Frohlich – 01:27:00	Thank you.
Slide 28	Julian – 01:27:02	Thank you for joining. You may now disconnect.
Slide 28	Bhumil Shah – 01:27:04	Thank you.