Population Health Management (PHM) Advisory Group – Meeting #8

February 8, 2023

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Ethan – 00:00:19	Hello and welcome. My name is Ethan and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the Q and A. We encourage you to submit written questions at any time using the Q and A. The chat panel will also be available for comments and feedback. During today's event, live closed captioning will be available in English and Spanish. You can find the link in the chat field. With that, I'd like to introduce you to Palav Babaria, deputy Director and Chief Quality and Medical Officer of the Quality and Population Health Management Program at DHCS.
Slide 1	Palav Babaria – 00:00:55	Thank you so much, Ethan. Welcome everyone to our February Population Health Management Advisory Group meeting. Thank you as always to our advisory group participants and the people that you are bringing to inform our pop health efforts as well as all of our attendees. We'll remind everyone we have an open chat, so we want to hear from all of you, even if you are not on the advisory group itself.
Slides 2-3	Palav Babaria – 00:01:24	Okay, I think we can go to the next slide. We can go one more. This is our agenda for today. Hopefully all of you received it. A big reminder that we now have a plan for how the Medicaid continuous coverage requirements that were put in place under the public health emergency are going to be unwinding. So the continuous coverage requirement officially ends on March 31st, 2023, and that is the date after which Medi-Cal redeterminations will restart on April 1st. Obviously I think, as everyone has been tracking, there are projected several million beneficiaries in California who may lose their coverage as a result of the unwinding. And we want to make sure that everyone who is eligible for coverage stays on Medi-Cal and that we are making proactive efforts to link those who are not eligible anymore and need coverage to our healthcare exchange.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 3	Palav Babaria – 00:02:19	And so all of you are a huge part of this solution. If you haven't already, please become a DHCS coverage ambassador. You can download the toolkit. There are standard communications and materials that you can amplify via email, social media, et cetera, because we really need to get the message out to all of our members that this is coming, starting this spring. We can go to the next slide.
Slide 4	Palav Babaria – 00:02:43	There's two phases. Phase one has already launched, and this is really communication that our members should be expecting that redeterminations will restart, that there are actions they will have to take, most of them, to retain their coverage, and there will be broad-based multimodal communication efforts. Phase two, it will be starting shortly and it's really that the renewal packets will start going out to Medi-Cal members. And obviously we want to make sure those packets go to the right addresses. We know there's been a lot of movement over the last few years, especially with the pandemic, and so getting updated contact information from Medi-Cal members in every way shape and form is critical. More information are in the links that are in these slides and will be posted publicly. You can go to the next slide.
Slide 5	Palav Babaria – 00:03:33	As always, before we dig into the meaty agenda today, which is really around how we, DHCS, propose to monitor the efficacy of our Population Health Management Program and fidelity to all the requirements that we have put in place as of January, which is a topic I'm very nervously excited about. We do want to start as always with a member story. So I'm going to invite Dr. Lupe Gonzalez and Veronica Estrada, as well as Dr. David Tian to kick us off on our member story for this session.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Dr. Lupe Gonzalez – 00:04:08	Great, thank you. Next slide please. I'm Dr. Gonzalez. I'm the senior director for health education cultural linguistics services here at Gold Coast Health Plan. It's an honor and a privilege to be with you today to share this very important intervention program that we launched, and I'm happy to share the components of this intervention and how it impacted our members. In 2018, Gold Coast Health Plans saw a need to increase postpartum visits and provide supportive services to members and infant, based on the analysis of the NCQA prenatal and postpartum care measure. Given the data analysis, we launched a new program, the Postpartum Health Navigator Program, in an effort to increase postpartum visits in a timely manner. There are a variety of different components, but I'd like to highlight four of the initial components that took place.
Slide 6	Dr. Lupe Gonzalez – 00:05:05	The first one being is that we partnered with the local county hospital to identify which members arrived at the hospital's labor and delivery ward, and reviewed the charts and an anticipated date of discharge in order for us to meet the member. This information was translated daily to our other health navigator, who then met with the beneficiary and newborn in person at the hospital, the day of discharge. The health navigators provided supportive materials to the member. We offered a variety of different supportive materials by a packet, and the health navigator would take time to review the information. The packet include a variety of parenting resources, information related to WIC a newborn enrollment form as well, and the effort of the health navigator was to connect the member back to the primary care service after discharge. The member and the newborn were then provided a telephonic follow- up after discharge to answer any questions, address concerns, and assure the linkages back to the primary care provider. And given that, I'd like to introduce Veronica Estrada to provide the details of the member story. Veronica, next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Veronica Estrada – 00:06:16	Thank you, Dr. Gonzalez, and good afternoon everyone. My portion of today's presentation will highlight how the Health Navigator Program impacted a member at various levels of care. In the year 2019, I had the opportunity to meet a 20-year-old Latina woman at the hospital, the day of her delivery. After introducing myself and the purpose of the visit, the member felt comfortable talking with me and she shared some of her challenges she faced during her pregnancy. One of them was that she was a first-time mom with minimal prenatal care. She also stated that she did not receive prenatal care until her third trimester. She also say that she was a single mom and did not have enough family support system to help her with her baby. So after listening to the member's concerns, I reassured her that she was not alone, we were there to support and provide assistance.
Slide 7	Veronica Estrada – 00:07:17	I reviewed the resources available to her as a Gold Coast Health Plan member. I discussed the importance of postpartum care and reviewed the postpartum member packet, which included a flyer of the postpartum member incentive, which was for a free bag of diapers if the postpartum was completed in a timely manner. In addition, I discussed WIC resources, I talked about breastfeeding, infant well-care screenings, and I went over the newborn enrollment form. I also talked about transportation, behavioral health services and other supportive services available for both mom and the baby. So at the end of the postpartum visit, I let the mom know that I would be following up with her in two weeks after her discharge to assist her with scheduling her postpartum visit. Being the first-time mom, it can be overwhelming and it is expected that more than one telephone follow-up call is needed. And this was the case.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Veronica Estrada – 00:08:21	I had to make several phone attempts to reach the member. I also left voicemail messages, and by the fifth call, I finally was able to speak with the mom. The member was able to attend her postpartum visit, and the baby had his first newborn checkup as recommended. At the end, the member was so happy and she expressed her gratitude for all the support given by the health navigators and Gold Coast Health Plan. I would like to conclude by saying that it was so rewarding to see how programs such as this one can impact a member's life and I want to thank you all for your support, and the great work you all do. Thank you.
Slide 7	David Tian – 00:09:07	Thanks Veronica. And I just wanted to turn it over briefly to let Veronica and Dr. Gonzalez reflect on how it was working with a member who may not expect their health plan to come visit them at the hospital. I know that that came up during our discussion. How was that and what was that like as the person interacting with this member?
Slide 7	Veronica Estrada – 00:09:28	I'll speak.
Slide 7	Dr. Lupe Gonzalez – 00:09:29	Go ahead Veronica.
Slide 7	Veronica Estrada – 00:09:31	With this case, I actually went in, as I mentioned, and the responses that I got from most of the members is that they were really surprised to see a representative from a health plan going into the hospital. One member in particular said, "Wow, I can't believe my health plan really cares for me." And they were so surprised and they were very thankful to see someone, an actual representative going into the hospital. So that was a great, great response.
Slide 7	Dr. Lupe Gonzalez – 00:10:02	And just to add to what Veronica just mentioned, it was also noted by other health navigators that it was not only an opportunity to speak with the member, but also with the member's family. If they had questions about their benefits or additional questions about how to enroll or other resources, it was also an opportunity to speak with the family member about becoming a Gold Coast Health Plan member and any other additional resources we could provide them as well.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 8	David Tian – 00:10:28	Great. Thank you so much. We can go to the next slide for just summary points about how this member story aligns with our Population Health Management Program. This story really highlighted for me the importance and impact of member engagement in transitional care services including post-discharge follow-up, and as you saw in this story, this was a member that had not engaged with care as recommended during pregnancy and really stood to benefit from patient engagement after engaging in care. And so this program also really shows the ability for similar programs to improve outcomes, especially some high impact outcomes that are bold goals for DHCS and our comprehensive quality strategy. And also I think that, as you all know, Population Health Management went live in January of this year, and one of the requirements is transitional care for higher risk individuals in certain populations and people who are peripartum are included in that group. And so more to come on that today in our discussion of monitoring.
Slide 8	David Tian – 00:11:36	However, I think that one thing that Gold Coast shared with us today is that they were able to, through this program, improve their performance on this measure by 12%, which landed then above the 90th percentile. So kudos to them for that. And in this Train the Trainer model, Gold Coast was also able to train local hospital staff to take on some of these roles. And I know that in terms of programmatic development, that's a sustainability piece that we wanted to lift up as well in so far as this became a collaborative effort between the plan as well as a delivery partner. And so I just wanted to thank Dr. Gonzales and Veronica again, for coming and sharing this wonderful member story. And with that, we'll turn it over for the rest of the program.
Slide 8	Veronica Estrada – 00:12:16	Thank you.
Slide 8	Dr. Lupe Gonzalez – 00:12:16	Thank you.
Slide 9	David Tian – 00:12:23	Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 9-10	Palav Babaria – 00:12:26	Great. So we are going to devote the rest of our time in this meeting to really dig into our proposed draft monitoring approach for the implementation of the Population Health Management Program. We can go to the next slide. First we're going to walk through our strategic approach, and then we will get into the nitty-gritty with specific proposed measures. Please, advisory group members, we'll stop for comment from all of you all, and then everyone is obviously welcome to use the chat throughout as well, and we will get to audience questions as we go along. I will say, the overarching strategy is really aligned with what the department has laid out in our comprehensive quality strategy that we intend to move to a much more data-driven approach to monitoring across the department. And that is what you'll see here. And so we really distilled and identified what we think are really high value key performance indicators or KPIs that we will require plans to report on a regular basis at the reporting unit level.
Slide 10	Palav Babaria – 00:13:28	And we also have pulled a number of quality outcome measures that we already track as a department through our managed care accountability set and our CAPS member experience surveys that are reported on an annual basis. We are hoping that in combination, these metrics will really track how is implementation going, how is it operationally, what is the efficacy of these interventions? They will also illuminate gaps where we need to maybe issue greater guidance or clarifications. We'll be tracking the impact of this program on population level outcomes over time, as well as really guiding where we need to follow up. So how we envision data-driven monitoring is that, yep, this is the first slice. We're really looking at the data, and then we will need to do deeper dives depending on what that data shows us. We can go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Palav Babaria – 00:14:22	So we will really, as I mentioned, use a combination of KPIs and quality measures. The KPIs, largely, are process measures that you'll see as we dig into them. And we really try to distill this so that it does not add administrative burden or overwhelming reporting requirements for our plan partners, but gets at, what are those data elements that you need for operational implementation anyway, and that you should be tracking internally to measure the efficacy of your program. We are also requiring all of these KPIs to be stratified by race, ethnicity and age groups so we can make sure that there is equitable receipt of services and we're not worsening health disparities by implementation of this program. And we'll be reporting KPIs, at the plan level, not reporting unit level on a quarterly basis. We expect the first quarterly reports to come in from quarter three in 2023 for quarter one and quarter two of this year.
Slide 11	Palav Babaria – 00:15:21	So there's 12 new KPIs that we are proposing. There may be additional KPIs that we are interested in after the PHM service is live, and wherever possible, we are aligning the proposed KPIs with IPP measures so that there is synergy between our various incentive programs and our monitoring strategy. On the quality set, there's a lot of quality measures we track as a department, and we really try to distill the ones that get at the key policy elements of Population Health Management Program. We do not envision MCPs having to report additional quality measure data to us. We will use data that we already have at the state. We'll continue to stratify these measures using existing processes, and there will be no additional reporting burden on this front. And go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Palav Babaria – 00:16:16	As you'll see, as we go through the deeper dive of the measures, a single measure can perform multiple functions. So we know some of our measures cover different populations. Some of the measures cover different parts of the Pop Health Program and policy. Some of them are about care coordination for children. Another one may be an outcomes measure around chronic disease management for adults. And so we are trying to group the measures in different categories so that we can get a holistic view of what does population health look like for a specific population, or what is the performance of this aspect of our population health management program and policy, and has that part of the policy been implemented with fidelity and is it working? And so a single measure may live in more than one of these buckets. So as we go through, you'll see that we've really tried to identify KPIs and or quality measures that cover the key areas of our population health management program.
Slide 12	Palav Babaria – 00:17:15	So that includes basic population health management, inclusive of preventive services, primary care engagement and appropriate utilization of services, chronic disease management, and very importantly how the community health worker benefit is being adopted and integrated into overall population health management efforts. There are also specific measures that get at the efficacy of the risk stratification, segmentation and tiering process, as well as the follow-up assessment and connection to services, complex care management, enhanced care management, and transitional care services. The three populations we are proposing to start with, align with our clinical focus areas within the comprehensive quality strategy, and those are children and youth, birthing populations and individuals with behavioral health needs, spanning the entire spectrum of behavioral health needs, not just mild to moderate, but also inclusive of conditions for which members receive care through county behavioral health services. I will flag here, we do intend to add a specific population of focus that is focused on seniors and duals.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 12-13	Palav Babaria – 00:18:21	We are still working on our policy within Pop Health in that space. So that will come at a later iteration of this monitoring approach. And then equity is really a cross-cutting priority across each and every single one of these domains, which is why we'll be stratifying all of them. Go to the next slide. I think this is the last one, then we'll open it up for a little bit of feedback. As mentioned, we use this combination of KPIs and quality measures. For some of these, these are homegrown process measures, and there isn't necessarily a national or state benchmark that we are going to. So our focus will really be on where there are benchmarks, where are MCP performing below those benchmarks, and then for where there are no benchmarks or even where there are, how is performance relative to each other?
Slide 13	Palav Babaria – 00:19:12	So who are top performers, where we really need to dig in and learn what the most effective strategies are and then scale and spread those best practices, and where are there maybe problems and issues where we need to do a much deeper dive and a comprehensive monitoring approach of policies and procedures and how the program has been implemented at the ground level to understand why those outcomes are really lagging. We will also be in a spirit of continuous quality improvement that is well outlined in our comprehensive quality strategy and wanting to strive for the 90th percentile for all measures. Really be looking for year-to-year improvements on all of these domains so that no matter where you are starting, every single measure should be improving over time.
Slide 13	Palav Babaria – 00:19:58	We will leverage existing enforcement pathways that we have. So as all of you are aware for the clinical quality measures that are on the managed care accountability set, we use both monetary and non-monetary enforcement actions through a regular process. We will continue that process and where there are other gaps or issues that are seen in this monitoring strategy, our population of health management division will be partnering with our quality and health equity division to follow up on whatever areas need further attention.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Sharon Woda – 00:20:32	Palav, we do have a couple questions. Do you want to take them?
Slide 13	Palav Babaria – 00:20:35	Great. Yes, I'm going to pause there, and I think this is really the approach. If your question is about a specific measure, I promise we're going to get there, but would love to open it up to the chat and our advisory group on any and all feedback you have on the general approach.
Slide 13	Sharon Woda – 00:20:48	All right. I think you answered this one. I'm going to call it back again. Just on KPIs, how will the monitoring and KPI reporting also include the submissions that MCPS put in their readiness attestation, so maybe just pull out that answer a bit in response to Deepa.
Slide 13	Palav Babaria – 00:21:09	Great question. We did do some crowdsourcing, so all of you in your readiness submissions, sent us KPIs of how you were internally monitoring your plans. The final list of the 12 KPIs that we're proposing today, many of those did come from ideas from the plans, but the proposal is that we do want a single set of KPIs that we can measure across the state and across all plans. So that's the proposal that we're reviewing today. Obviously plans have their own internal supplemental KPIs and other ways that they have of monitoring the program, which we absolutely encourage clients to continue.
Slide 13	Sharon Woda – 00:21:49	I think we'll do a real time question. We've got a couple other in the text, but go ahead, Caroline, if you want to unmute yourself and ask your question.
Slide 13	Caroline Sanders – 00:21:57	Sure. Hi, this is Carrie Sanders at the California Pan-Ethnic Health Network. Hi there. We really appreciate the community health worker integration measure, and we're just wondering if you could say a little bit more about how that measure will tie into the community health worker monitoring more generally. We know that health plans had to share an integration plan with you, and I'm just curious how you're thinking about the two different systems and there's overlap.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:22:41	It's a great question and as all of you're probably tracking, especially for some of these benefits where there's a network and providing the benefit component within managed care, but then also the application of that benefit and how are we using it to address quality and equity. There is a shared monitoring responsibility on the department side between our quality and Population Health Management...
Slide 13	Palav Babaria – 00:23:03	... on the department side between our quality and population health management team and our managed care team. And so there are specific indicators that our managed care colleagues have built in for sort of CHW monitoring. And so the CHW pieces here are really not about that, how are you creating a network and offering this benefit and more about the clinical application of that benefit and how are you using it to drive quality and health equity outcomes? So I think it's a great flag, Carolyn, and this is just half of that puzzle.
Slide 13	Caroline Sanders – 00:23:33	Thank you.
Slide 13	Sharon Woda – 00:23:38	All right. I'll ask a couple other, some of the questions I think we're going to get into as you go a little bit deeper. So just trying to stick at this a bit higher level, how is this information shared at local provider offices so they understand the KPIs and quality measures set by DHCS and they can meet their expectations by the MCPs? So not sure we've thought through all of that yet, but would love just any take you have on the forward-thinking there?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:24:04	Yeah, that is a really wonderful meaty question and I think as we all get collectively to a data-driven continuous quality improvement culture for the future, in addition to sort of this bidirectional data between the state and the plans, that same relationship has to exist between plans and providers. And I know many of our health plans today explicitly share provider level reports on a regular basis with their providers. And I know the plans definitely align that to state expectations. So I fully expect many of these will show up in some of those provider level reports. We at DHCS are also really thinking through once the population health management service is live, how do we create dashboards that the entire ecosystem, both at the plan level but also the provider level, can access this data.
Slide 13	Sharon Woda – 00:24:56	Takashi, do you want to go ahead, ask your question?
Slide 13	Takashi Wada – 00:25:00	Great, thank you. This is Takashi from IEHP. I really appreciate that the metrics are aligned to existing data sets. My question though is for reporting in 2023, it's going to be happening during redetermination and that could impact the data and the denominators because we do think that that population that's going to drop out of Medi-Cal is probably low utilizers. So how is that going to be taken into or factored in, and then when do you anticipate the enforcement mechanisms sort of kicking in because that first year may be impacted from the data?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:25:43	Yeah, and I'm going to lift up Bhumil's question 'cause I think it's tied to this, although it's not specific to redetermination is that are we going to set targets based on the 50th percentile or gap closure based on the 90th percentile for Medicaid? And so one, for the clinical quality measures that are on the managed care accountability set, there is already a set pathway which is the 50th percentile and none of that is changing. And the standard enforcement mechanisms that the department has already rolled out will continue. And yes, redetermination is going to affect that, but the benchmarks will also get adjusted over time. I think for some of these others in terms of the KPIs, we will definitely take that feedback back but recognize that in the first year of a program, a baseline isn't always stable for numerous reasons of which redetermination is one. And we looking at comparisons and waiting for some of those things to stabilize will likely be critical.
Slide 13	Sharon Woda – 00:26:45	All right. I think we should move on at this point. Oh, I see. There's another one from Catherine. If you want to go ahead and answer and then we can go on from there.
Slide 13	Catherine Senderling – 00:26:59	Yeah, I just considering that birthing people are part of the target populations, among the target populations, I just wondered whether you considered secondary data from CMQCC and also I know that there's a denominator, there's a response rate problem with HCAPS as there is with CAPS frankly, but whether you considered using those data as well since the hospitalization portion is an important element of the birthing people's experience and outcomes.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:27:32	Great lifting up, I think in general we absolutely want to reduce reporting burden and leverage existing data sources. Some of the challenges with both HCAPS and CMQCCs because they're always administered at the Medicaid population level. So teasing that out from the larger dataset can be a challenge. As we get to the measures, you'll see we do have one measure where we've actually been partnering very closely with CMQCC to pull out that Medicaid specific data. And so seeing how that goes, it's the first year that we've done that, but I think it's an opportunity and a pathway to think about additional maternity monitoring measures if we can get specific data.
Slide 13	Catherine Senderling – 00:28:11	Great, thank you.
Slide 13	Sharon Woda – 00:28:14	Actually, there was one other question that isn't related to the detail in the measures and it's just how will the audit, I assume they mean the monitoring approach tied to incorporate NCQA requirements since the strategy and roadmap spoke to plans needed to meet these standards.
Slide 13	Palav Babaria – 00:28:30	And Ed, can I just ask you to clarify, when you say audit, do you mean this monitoring conversation that we're having or sort of audits that audits and investigations does?
Slide 13	Sharon Woda – 00:28:46	Monitoring. He means this monitoring discussion.
Slide 13	Palav Babaria – 00:28:50	Yeah, so I think we are really focused, as we all know, it's sort of a Venn diagram, the NCQA requirements are sort of the floor and then the state has added additional requirements on top of that. And so we will be looking to make sure that plans are meeting expectations for the state's entire policy guide really and focusing on the areas that are outlined in the policy guidance strategy. If that helps. I don't know if that fully answers your question.
Slide 13	Sharon Woda – 00:29:26	Okay. All right. And we have one from Tangerine saying, just to clarify, there are not being NPLS minimum performance level for these monitoring measures, correct?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:29:38	Outside of the ones that are on the managed care accountability set, that is correct. At this point in time, again, there are no benchmarks for some of these. We're really looking at trends and comparisons.
Slide 13	Sharon Woda – 00:29:51	And then the only other question I have is one about the measures themselves. So I think we should go into that.
Slides 13-14	Palav Babaria – 00:29:59	Great. I know this will be the meat of the discussion, so we can go to the next slide. So we are going to start by PHM program area. So within basic population health management, the proposed key performance indicators that we are recommending start in July of this year are into two big buckets. So the first is primary care engagement and appropriate utilization. So really looking at ratios of primary care utilization to ED visit utilization for children and adults. We know that these are things that are separate but interrelated. So if you have lots of ED utilization and no primary care utilization, that is a problem and a challenge.
Slide 14	Palav Babaria – 00:30:44	Looking at the percentage of adults who had a primary care visit with their assigned PCP within the last 12 months, I will say the goal for this measure, again, not a hundred percent, we know that every adult does not need to go to their primary care provider every single year, but to really just get some baseline data and those trends as well as the percentage of adult members who had no ambulatory visit claims within the past 12 months.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Palav Babaria – 00:31:13	The CHW benefit integration is really the percentage of members who received the CHW benefit. So this is really, again, what is the penetration of this benefit? How far is it reaching? Is it reaching as many members as possible? And then there are proposed basic population health management KPIs that we are really working to implement in future years. Some of this is because we are still working to get the data and some of this will come live with the population health management service. So we are very interested in a vision screening measure for children specifically. This is a key benefit. We know it is underutilized, it is a really critical marker of care coordination and EPSDT and is an element of our program that we have not effectively monitored before, as well as percentage of eligible members who are enrolled in WIC and CalFresh.
Slide 14	Palav Babaria – 00:32:04	And then also the percentage of members who had no well child visits or ambulatory visit claims in the last year but had CHW services. And so this is sort of a tiered metric where we want to look at if people are not engaged at all and not getting services, how are we leveraging community health workers to engage specific populations and get them plugged into care. So I see Kim's hand is that...
Slide 14	Kim Lewis – 00:32:29	Hi Palav, thanks for this. I'm trying to think about how these metrics work with your existing quality measures. And so on the kids' side, the EPSDT screens, which includes vision and behavioral health and a bunch of others, oral health for that matter, that also could be one that doesn't show up well in the plan data or maybe what they're doing because maybe it might be outside of what the plan's responsible for, they may be doing that or paying for that. So it's just trying to understand the kind of front end how these KPIs and the quality metrics of these screenings fit together. And I'm just trying to go through that in my head. So maybe just a little bit on how that will look in terms of information would be helpful.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Palav Babaria – 00:33:20	Yeah, great question. And so for advisory group members, you did get the full nitty-gritty file of the quality measures and stuff, and I recognize if you haven't memorized that entire grid in 24 hours, it's hard to connect those dots. And so we really tried to pick KPIs that fill holes. So for example, to our managed care accountability set, we did actually add an oral health measure in '22 and then it's going to continue onwards. So that is a piece where we are now monitoring and enforcing through managed care. Vision is sort of a notable exception, partly because there's challenges with some of the measures that exist in this domain, but it was a gap. And so adding it as a key performance indicator, even though we don't have benchmarks, is a way to monitor that piece of it that we can't get at through standard quality measures.
Slide 14	Palav Babaria – 00:34:08	But one of our questions, which I know we'll get to at the end, but you all can think through along the way too, is what else did we miss? Obviously we can't measure everything under the sun, but are there other big buckets or categories that people are not seeing reflected in either the quality measures or the KPIs?
Slide 14	Sharon Woda – 00:34:32	There's a series of questions, Palav, around the timeline for the reporting of these KPIs and folks asking if it's an annual event aligned with something. And I think maybe just clarifying the timeline could be helpful.
Slide 14	Palav Babaria – 00:34:52	Sorry, I muted myself. I think for the KPIs we're really envisioning around quarterly, but welcome feedback on that proposed cadence.
Slide 14	Sharon Woda – 00:34:59	I think there's some questions here. I think folks should just go ahead and raise their hand too and just ask some of these real time. So I'm going to go with Cary Sanders.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Caroline Sanders – 00:35:23	Hi again, Cary the California Pan-Ethnic Health Network. I just had a question about the CHW integration metric. Again, thank you for including that. Just curious for the denominator, if you're looking at the entire sort of the utilization versus the entire population and/or if you'll also be looking at demand and/or availability of these services just to make sure that the services are filling a gap and perhaps that's your intention with the future measure, but just wondering if... I know we're establishing baselines, but how are we actually ensuring that folks are getting that service if they need it?
Slide 14	Palav Babaria – 00:36:14	Yeah, I think the proposed measure here is against the entire population. So of your entire assigned Medi-Cal population, how many, and not just were offered, but who actually received the CHW benefit. So it really tries to get at that outcome piece of it. Did you actually get the services and not necessarily those middle process steps of did you ask for them? Were you referred, did you finally get it? But can definitely, if there's specific pieces of that that you're interested in and welcome the feedback and we can take it back to our managed care colleagues too to see if some of those pieces are in the monitoring plan.
Slide 14	Caroline Sanders – 00:36:48	Yeah.
Slide 14	Sharon Woda – 00:36:52	Do you want to go next Bhumil?
Slide 14	Bhumil Shah – 00:36:53	Oh sure. Just a clarifying question. So are we going to do this on a 12-month rolling basis? Because some of the measures require 12 continuous months of assignment. So if yes, we can leverage the HEDIS infrastructure.
Slide 14	Palav Babaria – 00:37:05	We still need to develop detailed measure specs, but I think the vision was just a 12-month look back.
Slide 14	Bhumil Shah – 00:37:12	Got it. So as we develop those specs, as much as we can keep them aligned with NCQA, because then we can use with existing vendors existing code we already have.
Slide 14	Sharon Woda – 00:37:19	Dipa.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Dipa Patolia – 00:37:27	Sure. Thank you. So I think my question is around ambulatory visits, kind of understanding a little bit more about your thinking around it. And I think Dr. Nina Park from LABHS added to my question, which I think was a really nice elaboration is, and Dr. Park, I don't know if you want to chime in, but her question was around laboratory diagnostics, nurse advice line, E-visit, patient portal. Are these the things that would be included in that ambulatory kind of monitoring?
Slide 14	Palav Babaria – 00:38:00	Welcome others to chime in here too. I think it's really around ambulatory provider visits. So if someone didn't see anyone and got just a random lab test or a random x-ray, that's not necessarily... What's happening to that, who ordered it, what's the follow up, et cetera. But it's really an engagement of are people accessing outpatient care, not necessarily primary care here, but just some sort of outpatient based care in the last 12 months.
Slide 14	Dipa Patolia – 00:38:26	Great, thank you.
Slide 14	Palav Babaria – 00:38:31	But those are good questions. So we'll definitely make sure to clarify that in the measure specs as they get developed.
Slide 14	Sharon Woda – 00:38:35	Yeah, there's a question I think is probably just a clarifying point too from Jonathan about why aren't we looking at well child visits and prenatal care and other quality measures. So maybe it's just kind of revisiting how that's fitting in here.
Slide 14	Palav Babaria – 00:38:49	So I mean you'll see notable emissions here and it's because if we have a quality measure, we don't want to just duplicate reporting. And so prenatal visits, postpartum visits and well child visits are all existing clinical quality measures that we report on. So those will be incorporated into this monitoring strategy but not as a KPI because we already have data through our quality reporting measures on that front.
Slide 14	Sharon Woda – 00:39:11	All right. Any other questions from folks on the committee advisory group?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Kim Lewis – 00:39:23	Just to clarify that last comment about, so the way that you report the KPIs versus the quality measures might be a little different, process indicator versus the actual measure of clinical outcome. And so I'm trying to think about the denominators may be different, a number of total members as opposed to a score of what the screening results were. So some of them are processed I think and some are more actual measures or more clinical measures that are quantitative, I guess qualitative when I think about it. So I'm just thinking, you're trying to have numbers and you have quality of actual delivery of the care and I'm just trying to think of how that looks. Are you going to create a dashboard or something that you could kind of see this as a full picture or is it more like you just have to look at these in separately?
Slide 14	Palav Babaria – 00:40:21	I think the goal and the vision is to have a unified dashboard that sort of links all these together. I'm not going to commit publicly as to when exactly that dashboard will be up and running, but that is definitely the goal that we are working towards.
Slide 14	Sharon Woda – 00:40:36	Right. Mike, I see your hand raised. Do you want to ask your question?
Slide 14	Mike Odeh – 00:40:41	Yeah, thanks for all this. The PHM policy guide talked about things like closed loop referrals and warm handoffs and where does... I guess, definitions of what those are and monitoring of those things, where does that fit in the spectrum of this or other oversight activities at DHCS?
Slide 14	Palav Babaria – 00:41:03	So I think it's a great question. You'll see as we go through, it is not explicitly in here because those things are really hard to track using available data sources. I know as we prepare for the new contract readiness and closed lip referrals, how we're going to monitor that is definitely work that we are working through as the department but isn't sort of baked yet. So if any of you on this call have ideas of existing data sources that can be leveraged to really understand referrals or warm handoffs in some of those elements, we definitely welcome ideas.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Sharon Woda – 00:41:42	I think we're going to go... We'll have one more question from Tangerine that I'll ask and then go to Rebecca and then I think we'll move on to the next... There's many more slides, so as expected if we need to come back on certain ones we can. So Tangerine had a great question on the percentage of members who received the CHW benefit is going to be tied to expansion of the CHW workforce. How will this be taken to account whether the data could be reported or just how are we thinking? I think about the expansion of the CHW workforce and alignment with the benefit within this KPI reporting framework.
Slide 14	Palav Babaria – 00:42:18	Sorry, Sharon, can you repeat that one more time?
Slide 14	Sharon Woda – 00:42:22	Sure. The question is there a percentage of members who are really going to receive the CHW benefit is really tied to how many CHW workers there are that can offer the benefit, right? So how will that be taken into account as you look at the KPIs and you look at the results, how are we thinking about taking into account that the workforce will expand over time?
Slide 14	Palav Babaria – 00:42:47	Yeah, I mean I think that is where... This is one of those measures where there's no clear goal or benchmark or number that everyone should be striving towards, but I think both the trends, so is that number getting higher over time as well as where are the outliers? So if all the plans are at whatever percentage and then there's a handful that are really far off either higher or lower. I think those are the areas where in a data-driven monitoring approach, we would dig in to say, what's happening here? Why is your utilization so much higher? Where's your workforce coming from? Or their best practices there? Or if it's really straggling, is it that you're not tapping into that growing workforce over time or appropriately investing in sort of training and recruitment and partnership.
Slide 14	Sharon Woda – 00:43:29	All right. Thank you. We will capture that in the notes. So thank you. Duly noted. All right. But Rebecca, why don't you ask your question and then we'll go on to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Rebecca Boyd Anderson – 00:43:43	Actually, it's in a response to Mike's question. Of the members enrolled in WIC and CalFresh, those would be referrals. That would be closed loop referrals among many others. And so I think tracking referrals to some of those specific benefits is going to give some insight into whether people are doing referrals overall. It doesn't capture every single question or every type of benefit, but it gives you kind of an overview.
Slide 14	Palav Babaria – 00:44:15	Really agree and appreciate, Rebecca, you lifting that up for the group.
Slide 14	Caroline Sanders – 00:44:25	Sorry Palav, can I just ask one last question? I apologize.
Slide 14	Palav Babaria – 00:44:30	No apologies needed. That's why we are all here.
Slide 14	Caroline Sanders – 00:44:33	I know there are a lot of slides to get through, but just really on the percent of members who had no well child visits or ambulatory visits in the prior year, but had CHW services, will you be just utilizing measures from health plans on that? Will you be looking at community-based organizations or others that may be providing those services without charging for those services to enrolled members? How are you envisioning that? And I imagine for example, that there might be some reverse referrals happening as the benefit is implemented. And I would think we would want to capture that as well.
Slide 14	Palav Babaria – 00:45:29	And I saw all the FQHC, CHW questions. So I think the goal with this one really is utilization of the CHW benefit. So if there is a CHW embedded in an enhanced care management team, that is not billed to the CHW benefit, that's sort of a different thing that we're monitoring through the enhanced care management monitoring approach. So it really is who is getting CHW services through the CHW benefit. And yes, that does require some sort of encounter or claim to hit the managed care plan and then subsequently come to the department and I will phone an FQHC-

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VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Palav Babaria – 00:46:03	... subsequently come to the department. And I will phone an FQHC friend if there is one. But my understanding is even if it's not reimbursable outside of the PPS rate, those things can still be coded so that the data is being transmitted through. And I know for our FQHC, APM, we're looking at sort of how do we improve that coding. Because it has dramatic implications, not just for some of this monitoring, but for quality measures, et cetera.
Slide 14	Caroline Sanders – 00:46:31	Thanks. I may have other questions, but I appreciate that.
Slide 14	Palav Babaria – 00:46:42	Great. Should we go onto the next one?
Slide 15	Palav Babaria – 00:46:53	So this is around our risk stratification, segmentation and tiering process. We recognize obviously that in current state, because the PHM service is not live, this is not sort of a standardized approach from plan to plan.
Slide 15	Palav Babaria – 00:47:07	So we are proposing that once the PHM service risk stratification, segmentation, and tiering functionality is available, we then monitor the percentage of medium, rising and high-risk members identified through our standardized statewide algorithm who are enrolled in complex care management. As well as the percentage of high-risk members who are enrolled in enhanced care management.
Slide 15	Palav Babaria – 00:47:31	And again, the goal is not 100% here, we know that that is not feasible. But it is an outcome measure of once someone is flagged as medium, rising or high risk, are you getting in touch with them? Are you doing an assessment on them? And then are you enrolling them in appropriate services to address whatever it was that got them into that rising risk or high risk bucket? And we would be looking for trends and outliers. So welcome feedback on this front.
Slide 15	Bhumil Shah – 00:48:14	Sorry, if I could go? So usually medium and high risk is a sliding scale. We just stratify our members and then often based on resources, the interventions, we draw a line of what is high versus medium. And generally we try to enroll as many, because say we have X number of case managers, we draw the line somewhere there so we can enroll all the high risk.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 15	Bhumil Shah – 00:48:37	So how would we go about objectively defining what high and medium risk is? Because, as I said, currently we draw the lines based on the resources available.
Slide 15	Palav Babaria – 00:48:49	Yeah. I think that will come... The reason this is proposed to happen after the PHM service is live is because that information will come from the state. So we will say, "Here is who is medium, here's who's high. Go forth and contact them and connect them to services."
Slide 15	Palav Babaria – 00:49:03	And more to come, our RSST working group has started work, our scientific advisory committee, we're still finalizing membership. So that will get stood up soon. But one of the questions those groups will be grappling with, and recommendations that will come back to this advisory group, is exactly that, Bhumil. You can't make everyone high risk because you don't have enough resources and there are practical constraints. So that work will come out of those working groups and advisory committees.
Slide 15	Jennifer Eder – 00:49:35	Rebecca, would you like to ask your question?
Slide 15	Rebecca Boyd Anderson – 00:49:39	Yes. It's based on what Bhumil just said. Yes, the percentage of members that are assigned to those high risk groups. I mean, right now we have, I would say, it's fairly common to be staffed for up to 2% of a plan's population to be considered high risk. And those 2% can take up most of the bandwidth. And then if you include the next up to 5%, it suddenly exponentially increases the amount of work that needs to be done.
Slide 15	Rebecca Boyd Anderson – 00:50:11	But if medium and rising risk could conceivably be 60% of the health plan membership. And it's just not financially feasible to provide encounters with those, that high level of members.
Slide 15	Palav Babaria – 00:50:31	Yes. Totally understood, Rebecca.
Slide 15	Jennifer Eder – 00:50:38	Kim, would you like to go next?
Slide 15	Kim Lewis – 00:50:39	Sure. It's a question about how the state... I mean, I think of high risk members, I guess, of getting VCM. But maybe not all of them do, they mostly get... I guess they could get CCM.

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VISUAL	SPEAKER – TIME	AUDIO
Slide15	Kim Lewis – 00:50:53	I'm wondering if this would be stratified by the populations of focus? So that we could kind of understand who's getting it as opposed to just the numbers of members. And if that was part of your intention?
Slide 15	Palav Babaria – 00:51:10	That's great feedback. Definitely all of these KPIs that we're talking about will be stratified by race, ethnicity, and age. But I think that doesn't necessarily cover all those populations of focus, so we can definitely take that feedback back.
Slide 15	Jennifer Eder – 00:51:28	Tangerine, would you like to ask a question?
Slide 15	Tangerine Brighton – 00:51:31	Yeah, thank you so much. I just wanted to clarify the two bullets. And it could be that the data we've received from our health plans to date on the distribution of folks who are in the high, rising or low. And it's very clear that individuals in the high would get ECM. And I don't recall the graphic that showed the three categories of gathering the data, the risk stratification, and then the actual service. But how would someone potentially who's high risk be in both the complex care management program and the ECM?
Slide 15	Palav Babaria – 00:52:15	Great question. And so ECM and CCM are separate and distinct, you can't be in both together. That is well articulated in the policy guide.
Slide 15	Kim Lewis – 00:52:22	I think this is really just a recognition that the ECM criteria are sort of based off of diagnosis and not risk. So conceivably there could be someone who is high risk because of other reasons and they don't meet the ECM criteria, and those people ideally should be served through the CCM program.
Slide 15	Tangerine Brighton – 00:52:44	Okay. Thank you.
Slide 15	Jennifer Eder – 00:52:52	Any other questions on this slide? If not, I think we should keep moving.
Slide 15	Palav Babaria – 00:52:58	There's more fun measures to come. So if we can go to the next slide?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Palav Babaria – 00:53:03	Okay. So this is to dig deeper into actual care management. So these are the proposed KPIs that we would start collecting this July. So for CCM, as you're all aware, for complex care management we really aligned with the NCQA criteria. So what complex care management looks like will vary from plan to plan.
Slide 16	Palav Babaria – 00:53:24	So what we are looking for is for plans to tell us, using your own criteria, what is the number of eligible members? And then what is the number of enrolled members? So essentially what is your penetration rate using your own criteria for CCM.
Slide 16	Palav Babaria – 00:53:39	And then for ECM, we would do something similar. What is the percentage of members who are eligible for ECM who are enrolled? And then for each of the populations of focus, what are those sub-rates?
Slide 16	Palav Babaria – 00:53:52	And then for the ECM related KPIs, we are looking to leverage the already existing quarterly implementation monitoring report that we get for ECM and community supports to calculate this data, versus actually adding more reporting burden for the MCPs.
Slide 16	Palav Babaria – 00:54:09	And then ultimately, when the ECM birth equity population of focus goes live, that ECM population of focus would also be added.
Slide 16	Sharon Woda – 00:54:24	Right. Any questions?
Slide 16	Jennifer Eder – 00:54:25	Tangerine?
Slide 16	Tangerine Brighton – 00:54:29	Yes? Oh, sorry-
Slide 16	Sharon Woda – 00:54:31	I think your hand's still up.
Slide 16	Tangerine Brighton – 00:54:31	I apologize. My apologies.
Slide 16	Jennifer Eder – 00:54:37	That's okay.
Slide 16	Sharon Woda – 00:54:40	Any other questions about the KPIs for care management?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Palav Babaria – 00:54:49	And hopefully the intent is clear here, right? There's no point in having all these amazing services if no one is actually getting to them. So we really want to make sure that everyone who is eligible for these services is receiving them.
Slide 17	Palav Babaria – 00:55:06	Okay, let's go to the next slide.
Slide 17	Rebecca Boyd Anderson – 00:55:09	Sorry, my hand is a little bit late.
Slide 16	Palav Babaria – 00:55:12	Oh, sorry, Rebecca. We'll go back.
Slide 16	Rebecca Boyd Anderson – 00:55:14	And actually I'm just saying, why would a high-risk member be enrolled in both CCM and ECM? I think there's also a... It's similar. But you've got a lot of populations in focus where a single member may fall into multiple populations of focus, and we want to make sure the denominator is accurate. And that the plan, if they meet three criteria then we should get credit for three numerators, not just one single numerator with several different denominators.
Slide 16	Palav Babaria – 00:55:46	Got it. That is really helpful feedback. And we'll definitely take that back to figure out how we operationalize that.
Slide 16	Kim Lewis – 00:55:53	One quick question. I'm sorry, Palav. About the data that DHCS will provide plans on the existing quarterly implementation monitoring report. Is this, just so I'm clear, their own assessment of the members that should be getting it? Or is this based on the plans reported numbers themselves? And are they then going to be compared to what the DHCS sees as eligible members within the services, versus what their plans are actually doing?
Slide 16	Palav Babaria – 00:56:24	I'm going to see if any of my ECM colleagues on this call know in current state what is coming in on the report, and if the eligible population is being defined by plans or DHCS. Because I don't know the answer to that question.
Slide 16	Palav Babaria – 00:56:37	I will say future, future state in the population health management service we would like to have state defined eligibility, or at least estimates of that. But we're not quite there yet.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Palav Babaria – 00:56:51	But otherwise we can take that question back, Kim, and get back to you.
Slide 16	Shaw Natsui – 00:56:53	Palav, this is Shaw. We can confirm that, I believe we're collecting as reported by plan for eligibility.
Slides 16-17	Palav Babaria – 00:57:10	Okay, great. Well, let's move on to transitional care services. Because, as you all saw in the sneak preview, there's a lot in this bucket.
Slide 17	Palav Babaria – 00:57:16	So I think we all acknowledge that this is one of the areas that is most complicated in the population health management policy, because it does involve so many players in our healthcare delivery system and a lot of silos.
Slide 17	Palav Babaria – 00:57:31	And so the first two measures that we proposed reporting on, starting in July 2023, are really process measures to see how plans and facilities are leveraging sort of modern real-time data notification to identify members.
Slide 17	Palav Babaria – 00:57:48	And, as we've been talking about, so much of our reporting really uses claims. The problem with claims is they take months to come in. And if you're working on transitional care, a month's timeline is really way too late. So the first one is the percentage of contracted acute care facilities from which managed care plans receive ADT notifications. And the second one is percentage of contracted skilled nursing facilities from which MCPs receive ADT notifications.
Slide 17	Palav Babaria – 00:58:14	And the denominators for both of these would obviously be sort of the number of facilities in each of these categories that an MCP has contracts with. And then the top would be from which ones they're actually getting ADT notifications.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Palav Babaria – 00:58:27	The third one is really percentage of transitions for high-risk numbers that had at least one visit with their assigned care manager post-discharge. And then the next one is the ambulatory visit within seven days of post-hospital discharge. So there's lots of evidence in the dual space, in the Medicaid space, that this really is important for health outcomes. And again, this is any ambulatory visit, not necessarily primary care. There are times where a specialty visit within seven days post-hospital discharge is appropriate. And then the next few are really looking at some of our long-term care populations of focus. So we would want to look at the percentage of members enrolled in the ECM adults living in the community and at risk for long-term care institutionalization, and the adult nursing facility residents transitioning to the community. To look at what percentage of those referrals into that ECM program were made by the members assigned transitional care manager.
Slide 17	Palav Babaria – 00:59:28	And again, this is a reminder that the transitional care manager should be assessing every individual for ECM eligibility. And the thought here is if you're doing that for all the high-risk members, and eventually all members, an increasing proportion of referrals should be coming from that assigned transitional care manager who is able to establish that relationship with the member during their hospitalization and then connect them to ECM.
Slide 17	Palav Babaria – 00:59:52	And then similarly, percentage of members who are enrolled in CCM based off of referrals from the assigned transitional care manager. So they are really process measures of how effective is that transitional care manager in enrolling members into qualifying complex care and ECM programs?
Slide 17	Palav Babaria – 01:00:12	And then eventually we do want to get to a length of stay measure. But we all recognize, I think, there's a little bit of work to do in this space before this measure is ready for prime time.
Slide 17	Sharon Woda – 01:00:27	Right. So what questions do folks have around the transitional care measures? Dipa?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Dipa Patolia – 01:00:34	Yeah, thank you. So I guess my question is, so if instead of ADT if we have an alternative process that's established for timely notifications, will that count towards meeting that requirement? Really using more human touch, more verbal notifications or work-ons in those cases?
Slide 17	Palav Babaria – 01:00:56	So I think the short and blunt answer is, unfortunately not. We are really striving towards ADT feeds. And a big part of this is under the CalHHS data exchange framework it is very clear around the use of ADT notifications. And that requirement exists for both acute care facilities who've already had that requirement for some time, as well as skilled nursing facilities, effective January 2024, is my understanding. So we're trying to create alignment, so we are matching up all of the requirements across the state.
Slide 17	Sharon Woda – 01:01:37	Other good questions on the transitional care measures?
Slide 17	Kim Lewis – 01:01:46	I have a question, but it's not about the transitional care service. It's about maybe what else we're not tracking on the KPIs? So now it's maybe the right time.
Slide 17	Palav Babaria – 01:02:02	Yeah, go ahead.
Slide 17	Kim Lewis – 01:02:06	Oh, okay, all right. I was waiting for an okay or a no.
Slide 17	Sharon Woda – 01:02:07	Sorry, go ahead. Yes.
Slide 17	Kim Lewis – 01:02:10	Just on the populations of focus, like SMI, serious mentally ill, or SED population, seriously emotionally disturbed, or other members that are going across the specialty and the planned mental health service delivery system. And whether there's any kind of indicators we can be tracking about those referrals? Getting connections, plan numbers? I'm wondering if you've thought about that and how that might get captured? Or if that's somewhere else that's impacting.
Slide 17	Palav Babaria – 01:02:46	Great question. And David, if you're on, feel free to jump in too.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Palav Babaria – 01:02:49	So within the quality measure set, Kim, that you have, there's a number of measures that track back to behavioral health, both mild to moderate, but also sort of SMI/SED. And there's some that sort of really tackle that intersection. So people with a serious behavioral health diagnosis, have they had their diabetes screening if they're on medications that predispose them for diabetes? Really great measure, looking at both of those systems.
Slide 17	Palav Babaria – 01:03:11	And then as everyone on my team knows, the FUM and FUA measures, which are follow-up post-ED visit for either a mental health or substance use disorder, depending on which one you're looking at. I call them the talking measures, because it really is how are the EDs and the plans and the physical health side connecting and referring those members and helping them receive appropriate services on the behavioral health side?
Slide 17	Palav Babaria – 01:03:35	So those measures are both in our KPIs, they're on our managed care accountability set. And then we're also reinforcing them on the behavioral health side through our BHQIP program.
Slide 17	Kim Lewis – 01:03:46	Yeah, that's what I think helpful. But I don't know that there's measures specifically... I know about sort of the measures that are collecting post-hospitalization follow-up within 30 days and all of that.
Slide 17	Kim Lewis – 01:03:57	But I'm thinking more like referrals between the system, and somebody needs a specialty service that's not within the plan purview, but it's identified as a need by the plan and how that gets tracked. As opposed to the other measures, that are we getting enough quality measures?
Slide 17	Palav Babaria – 01:04:14	Yeah. No, I think that's totally fair. And I think similar to sort of Mike's question earlier, similarly around children's measures, as we, DHCS, implement the closed loop referral criteria, definitely we'll be thinking through how exactly are we going to monitor exactly what both of you have asked about.
Slide 17	Palav Babaria – 01:04:34	I think in the interim, it's really through some of these selected measures that, yes, don't capture that whole universe of referrals, but still get at how is that communication and referral pathway working for this subset of the population?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Sharon Woda – 01:04:52	So David?
Slide 17	David Tian – 01:04:54	Palav, I can jump in here and just say that a lot of these measures are also benchmarked on integrated plans. And so far as a lot of the national benchmarks for some of these NCQA measures don't account for this kind of leap across delivery systems. So I think that a lot of the design work and our CalAIM efforts here are tailored towards how to measure and improve those kind of unique elements of our care delivery system in California.
Slide 17	Sharon Woda – 01:05:25	There was another question from Erica around the policy guide refers to the ECM provider being the transitional care coordinator or care management person, where applicable. And would those members be factored into the KPI percentage? And I think we were thinking more that the denominator would be around new ECM enrollments here. But if you can go ahead and confirm, Palav?
Slide 17	Palav Babaria – 01:05:48	Yep, exactly. Yeah, we're going to look at when someone enters ECM, where did that referral come from? So if someone's already in ECM, they're not going to be re-referred to ECM, so they just wouldn't be part of the denominator at all.
Slide 17	Sharon Woda – 01:05:59	All right. And Dipa, your hand's raised?
Slide 17	Dipa Patolia – 01:06:07	Yeah. Just a quick question on bullet three, the percentage of transitions for high risk numbers, and kind of their follow-up with the assigned care manager.
Slide 17	Dipa Patolia – 01:06:17	Trying to understand the measurement around that, the numerator, denominator. Especially when it comes to all the various care management processes out there, ECM, plan, so on and so forth. So what would be the best way for us to make sure that we're tracking that appropriately?
Slide 17	Palav Babaria – 01:06:42	I don't have a great answer for that one. So welcome input from the team in terms of where we thought the data source was going to be for this one.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Amy Salerno – 01:06:55	Yeah. I think the data source is complicated. And I think part of it is saying that transitional care services are expected to be delivered for high risk members for 2023. And as part of transitional care services, a requirement is follow-up post discharge and ensuring that happens.
Slide 17	Amy Salerno – 01:07:18	And so just trying to track for as much as the plan is tracking to make sure that that requirement is met, like how are you monitoring that internally? I think whether that's a phone call or an outreach that's successful, where they actually connect with the member.
Slide 17	Amy Salerno – 01:07:39	And just making sure that those connections and follow-up post discharge are happening according to the requirements and the policy guide. I think there's a little... So it would be a plan reported measure at this time.
Slide 17	Sharon Woda – 01:07:55	All right. Seeing no more questions. Maybe we go ahead and move on to the next slide?
Slide 18	Palav Babaria – 01:08:24	Great. So I know we kept alluding to all of these quality measures. So the total number of quality measures that the department tracks obviously is larger than this across numerous programs, but this is sort of the subset that we would like to pull into and integrate into a unified pop health dashboard.
Slide 18	Palav Babaria – 01:08:43	So it includes depression screening and follow-up for adolescents and adults, looking at Well-Child visits for infants as well as children and adolescents, developmental screening, lead screening, childhood and adolescent immunizations, topical fluoride for children, prenatal and postpartum depression screening, and follow-up for our maternity population-
Slide 18	Palav Babaria – 01:09:02	... partum depression screening and follow up for our maternity population, colorectal cancer screening, chlamydia screening, breast and cervical cancer screening, looking at emergency department visits that are avoidable, looking at adults access to preventive and ambulatory health services, which is a HEDIS measure. And then the two specific CAHPS measures listed here, we pulled those out really for alignment because these are the same CAHPS measures that we are using in other value-based payment programs across the department. So I'm going to pause there and see if anyone has feedback on these or omissions.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Jennifer Eder – 01:09:41	And Palav, there's one more slide of quality measures on the one if we want to just maybe go through those.
Slide 18	Palav Babaria – 01:09:46	Yes, sorry. Thank you for the reminder. I thought we'd squeeze them all into one slide, but apparently not.
Slide 18	Jennifer Eder – 01:09:55	Can we go to the next slide?
Slide 19	Palav Babaria – 01:09:59	Great. And look, there's more. So Kim, I think this is where some of those measures around behavioral health that are referring to. So depression remission or response. So this is not just screening, but how well is your depression actually controlled including for adolescents, asthma medication ratio, looking at poor control for diabetes, blood pressure control, antidepressant medication usage. And then the specific subsets around follow-up care for children who are prescribed ADHD medication, pharmacotherapy for opiate use disorder, follow-up after ED visits for mental illness or substance use, plan all-cause readmissions which ties back to transitional care and a number of other population health management policy domains, potentially preventable, 30-day post-discharge readmission and then prenatal and postpartum care for our maternity population as well as the C-section rate. And this is the one that we've been partnering with CMQCC to really get Medi-Cal specific data and rates calculated. Great. Now we can open it up. And Mike, I see your hand's up.
Slide 19	Mike Odeh – 01:11:07	Yeah, thanks, a request and a question. The request is to have the asthma medication ratio data disaggregated by age so that we know how kids are impacted versus adults. And then a question about it didn't look like the CAHPS survey ... it looks like it was just for adults, and curious, why not include CAHPS for kids getting needed care?
Slide 19	Palav Babaria – 01:11:34	Oh, yeah, great. So I think the CAHPS was just an oversight. We definitely want to pull it from both the adult and children's surveys. And then asthma medication ratio, we'll definitely take that feedback back. We do use native HEDIS and core measure specs, so I don't know off the top of my head if they're disaggregated in there, but if they are, we definitely are able to disaggregate.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Jennifer Eder – 01:12:03	Any other questions on quality measures? There's a recommendation for a metrics technical advisory committee, Palav.
Slide 19	Palav Babaria – 01:12:23	Noted. I think we are working on forums where we can bring together all of the various DHCS programs to align these measures, so more to come on that.
Slide 19	Jennifer Eder – 01:12:32	All right, should we...
Slide 19	Caroline Sanders – 01:12:43	Hello, this is Cary. Oh, sorry, this is Cary Sanders. Maybe you touched on this, but can you say a little bit about how you'll be reporting out these measures within the PHM framework? Knowing that these are measures that are being measured on the managed in other places as well, but I'm just trying to understand what we can expect to see from these measures within the context of PHF.
Slide 19	Palav Babaria – 01:13:14	Yeah, so I think the vision is why we want to marry the KPIs with these quality measures is because then you can see the whole picture and the story. So if at a given plan level, let's say the well child visit rates are really low, and then you look at the KPI and you're like, oh, we have huge proportions in the same plan of children who've had no ambulatory encounters or primary care visits. That's a different story than well child visit rates are low or lead screening is low, but they are engaged, and people are showing up. And so I think from a monitoring perspective, being able to combine these outcome measures of what's actually happening to health with the process measures of are people using care? Are they getting enrolled into CCM? Are they getting enrolled into ECM, right?
Slide 19	Palav Babaria – 01:13:57	If you really do ECM and CCM well, your global burden of diabetes control and hypertension control should improve, right? That's the whole point of these care management programs. It's not just to have a care manager for the fun of it but really move the needle on these health outcomes. And I think if you're not looking at all the data together, it's hard to know where to probe and what the root cause of the issues are.
Slide 19	Caroline Sanders – 01:14:22	That's great. Thank you.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Jennifer Eder – 01:14:30	We just put this slide back up here just to show the different buckets that Palav was just speaking to and the various KPIs and quality measures will be looked at and reviewed within these buckets.
Slide 12	Palav Babaria – 01:14:44	And I do want to respond to Lynn's question in the chat around postpartum depression screening if it's captured from the infant visits. And so this is one of our new e-Recorded measures where our plans have to collect actual data from electronic health records and then report on the outcomes of those screenings, whether it's the PHQ nine or two or other screening tools. I will say from my time on the delivery system side, the infant screening of the mother, screening of the parent at the child's infant visit is really dependent on how providers document that at the healthcare delivery system level. And so if that is only documented in free text in an infant's chart and not tied back to the mother's chart or captured in a structured way data wise, then it probably is not going to show up in these measures.
Slides 12, 20	Palav Babaria – 01:15:36	And so I know Bhumil and others on the advisory committee spend hours and hours of their time trying to solve through these problems. But if you work in the delivery system side, I will put in a plea for using structured data fields and making sure the right information gets into the right members' charts if we're going to really capture accurate data on any of these measures to be honest. Great. So now I know we only have a few minutes left, so none of this is new, but we did organize the KPIs and quality measures into buckets. So this really gets at I think the vision of how do we tie these things together in a view and then get a holistic picture of how is the pop health program working for children and youth? Are we seeing gaps? What are the trends? What is the performance compared to other plans? So I'm not going to read all of these, but you can see them, and these slides will be posted. Not surprisingly, we have a lot of measures in the children and youth domain because this is a major area of clinical focus for the department and will continue to be a major area of focus in our PHM monitoring. We can go to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 21-22	Palav Babaria – 01:16:46	Similarly, for birthing populations, these are the existing KPIs and quality measures. I will flag this is an area where the department is continuing to really do additional work. And so I expect in future years there will be more measures coming and a much more robust dashboard coming down the pike. And we are looking to see how we can partner with other data collection efforts, both at the public health department but also through CMQCC to get additional data to inform this picture. You can go to the next slide. And then for individuals with behavioral health needs also, hopefully not surprisingly, this is a major area of focus for the department across the entire spectrum of behavioral health. So these are all of the existing quality measures and KPIs. But if you all see things that are missing or areas that we haven't covered sufficiently, we welcome feedback from you all. You can go to the next slide.
Slide 23	Palav Babaria – 01:17:46	So I think just in terms of the equity piece, as mentioned already, every single one of the measures that you have seen today for the KPIs, we would stratify by race, ethnicity, and age. We recognize for some of them the ends are going to be small, so we will also be thinking through how we can make some of this data publicly available. But depending on denominator and numerator our sizes, all of those stratifications may not be able to be publicly published. And then for our clinical quality measures, there's a subset of them that are outlined on the managed care accountability set that we started stratifying by race and ethnicity in 2022. And we've added some additional measures, and we'll continue that process to be able to get really robust stratify data at the plan level on key clinical quality measures.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Palav Babaria – 01:18:34	And go to the next slide. So I think we've covered some of these, but I just want to open it up to our advisory group members. Does this make sense? Do you feel like this captures the breadth of the PHM program? Are there key KPIs or areas of the policy where you think something is missing? Is there any other feedback on just reporting burden from everyone on this call where you see opportunities to streamline the measures more? And then areas that we know that are gaps. A lot of the work in the new procurement and also in the pop health policy is really how do we tailor our health education and messaging and engagement of members to meet their unique needs in a really culturally and linguistically relevant way.
Slide 24	Palav Babaria – 01:19:23	And I think we recognize that we don't have a great marker of that member education and engagement in the existing KPIs. So if y'all have thoughts on that, we welcome that. And then we also continuously want to make sure that we are really pushing our interventions even more upstream so that we're not just chasing things really when they're too complicated or not intervenable. So are there areas that you see that are missing in that domain?
Slide 24	Jennifer Eder – 01:19:58	Kim, I see your hand raised.
Slide 24	Kim Lewis – 01:20:00	Yeah, just one more thought in addition to what I've already raised before, I wonder about evaluating and looking at care or case management that's being provided outside of the managed care plan system. I mean, there's obviously case management, targeted case management, intensive care coordination. There's different ways that case management or care management services are covered and provided in claim for across the system. And I wondered if you had thought about any kind of assessment of where that's being provided outside of the plan in addition to what may be also provided in the plan. Just so you're looking at the coordination of those services externally and internally from the plan side.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Palav Babaria – 01:20:52	I think it's great feedback. Obviously, this is really about the PHM program, which is exclusively inside the plan, but we can definitely take that feedback back. And I know as we think about the ECM for kids rollout, that intersection and coordination is even more critical. So we can try to think through where that might fit into that.
Slide 24	Kim Lewis – 01:21:10	Yeah. I mean it might impact what they're getting from the plan. I think it's part of the picture I'm trying to paint here of how it could impact the plan related services.
Slide 24	Jennifer Eder – 01:21:29	Rebecca?
Slide 24	Rebecca Boyd Anderson – 01:21:31	Yes, thank you. One of the things that you had mentioned, Palav, was that we wanted to make sure that every single person who qualified for some of these healthcare services was receiving a healthcare service. And I just kind of want to back off from that, I would say has the opportunity and the choice to receive it. But I think with all of our good intentions, it's really easy to force people to drink the water. We've taken the horses to water, but now we're shoving their heads in the water. And I just think it's important that we honor people and have a way for getting credit as a plan that we offered them. And they said, no, thank you.
Slide 24	Palav Babaria – 01:22:14	Yeah, I totally agree with that sentiment, and it was probably poor word choice on my part. So it's certainly no intention that number is going to be 100 because we know there will be some members that will refuse. I will say, I think partly why we are focused on the outcome measure and not just who did you offer it to is because we know we have communication and trust issues with certain populations across the Medi-Cal program and where, you can do a cold call and someone says no, and that's not sufficient. We need to reach them in a way that's with a trusted messenger, with a care manager that really understands their experience, and that there's a desire for that member to participate in that program.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Palav Babaria – 01:22:59	And I think for even in the first year of ECM, we've seen a lot of variation and feedback from the plans where depending on who's doing the outreach for ECM, they're seeing widely variable acceptance rates. And so I think those are the things that we need to build upon. So agree with you. The goal is not everyone 100% is going to receive it, but I think our definition of who wants something has to be more nuanced than we offered it, and they said no. If that makes sense.
Slide 24	Rebecca Boyd Anderson – 01:23:25	It does make sense. But along those lines, and I'm thinking of this specifically as we look across our plans experience with say, well child immunizations, we only get credit if the member is pro-immunization. And if you have a large vaccine hesitant or selective vaccine population, there's no place to get credit for, we got that member to the provider office, that member engaged with the provider, the providers also need the opportunity to respect those choices and say, I prefer you get a vaccination, but most important is that we keep working together in the interest of your child's health. And some of those measures are just really, I understand them from a public health standpoint and from an idealistic standpoint, but I think that there needs to be some grace offered for we tried and we're respecting the choices of the members.
Slide 24	Palav Babaria – 01:24:29	Yeah, absolutely. And I think nationally, HRQ and others are looking at some of within our CG CAHPS and member experience surveys, how do we get at that trust of members? And I think those are critical data points that we also need. If there is trust and then its members, yeah, I don't want this, that's a different thing than I don't have any trust with this provider or this system or this plan and then, saying no.
Slide 24	Rebecca Boyd Anderson – 01:24:58	Agreed. Thank you
Slide 24	Jennifer Eder – 01:25:03	Cary.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Caroline Sanders – 01:25:05	Thanks. And this is really sort of a plus one to Kim Lewis's comment. And then I know we sort of touched on this earlier, but to question three, it'd be great if we could figure out, if DHCS could figure out how to measure referrals across systems of care, folks on programs in CDSS and counties and then who are getting into health programs and vice versa. And also for folks who are being referred to the health system from providers or CHWs who are not maybe tied to a provider. So more in comments, but just thinking through here, are there other ways to measure how these systems of care are interacting?
Slide 24	Palav Babaria – 01:26:05	Thank you. And yeah, definitely hear loud and clear that we really have to think a little bit broader and looking at those interconnections, referrals, and handoffs across multiple entities and systems.
Slide 24	Jennifer Eder – 01:26:20	I think we have time for one or two more questions. Catherine.
Slide 24	Catherine Senderling – 01:26:24	I was thinking about member engagement, and I'm wondering whether there is anything in the patient-centered medical home literature that are indicators of connection and engagement that could be used. And the key thing that I think is difficult, as somebody who has more experience with Kaiser than anything else, is what level is appropriate? Is it of measurement? What's the unit of measure? Is it the interaction with the plan or is it the interaction with the provider? And I think that may be harder to measure. But I would want to be looking for indicators of proactive connection. And actually, proactive connection of the patient to indicate patient engagement, and those can be measured in many of the families we measure media engagement. That there may be something in the CalAIM funds work and others to look at as a guide.
Slide 24	Palav Babaria – 01:27:33	That's great feedback. Thank you.
Slide 24	Jennifer Eder – 01:27:34	And Dipa, I think you can be the last question.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Dipa Patolia – 01:27:42	Great, thank you. So I think for number three, piggybacking on the prior comment, there's going to be things that the plan is also doing to improve engagement with our members. And then one of the things that I think is more upstream is engagement with provider, making sure members are seen by a provider that they can relate to that meet their personal preferences. So I know that's something we're implementing on our end is really partnering, matching up a member with a provider that they are more likely to visit and be seen by. And I think for number three, it'll also, if we have a session of sharing our lessons learned, I think it can really help us benefit from one another in terms of the what's working, what's not lessons learned. So really looking forward to that if that's a possibility in the near future. So thank you.
Slide 24	Palav Babaria – 01:28:34	Absolutely. We love sharing what's working. So that sounds great.
Slides 25-26	Jennifer Eder – 01:28:43	Great. So why don't we go to the next slide, one more. And I know there was a question about the kind of deadline to send in any comments and feedback. I think, February 17th, hear you that this is a lot, and you need more time to digest. So in the follow-up email that we send out, we will provide this subject line and the email address, and the deadline will be February 17th, so Friday, February 17th. So hopefully that gives folks a little bit more time to digest and send in feedback.
Slide 26	Palav Babaria – 01:29:26	And just to be clear, because I did see Takashi's question about targets and benchmarks and stuff. So other than the managed care accountability set measures for which plans are held to the 50th percentile, which is a long-standing process, I don't think there is any concrete strategy or proposal about targets or any of that stuff at this time. The first reports would come in July, similar to ECM and community supports, I think we fully anticipate we will need several quarters of data to better understand what's going on. But I think what plans could and should expect is that as we get that data, if there are outliers or things, we'll be meeting with you. And we'll be talking to you and really digging deep to understand what's going on and what story that data is telling us. So I hope that helps.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 26	Jennifer Eder – 01:30:24	All right. Well, I think that brings us to a close. Palav, do you want to close us out?
Slides 26-27	Palav Babaria – 01:30:31	Yeah. No, just thank you all so much for the really thoughtful feedback and helping us embark on our future of data-driven monitoring here in QPHM. And look forward to all of the written feedback that folks are able to provide by the 17th. Thank you.
Slide 27	Kim Lewis – 01:30:47	Thank you.