Population Health Management (PHM) Advisory Group Meeting

April 26, 2022

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Slide 1	Mario – 00:00:00	Hello and welcome. My name is Mario, 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 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 Dr. Palav Babaria, Chief Quality Officer and Deputy Director of Quality Population Health Management at DHCS.
Slide 1-5	Palav Babaria – 00:01:38	Thank you so much Mario, really excited to welcome you all today for our second population health management advisory group meeting and really the kickoff today where you will get to meet our phenomenal advisory group. And really start to dig into some of the policy and outstanding questions that we have. So, thank you all for joining. We can go to the next slide. So we're going to spend most of our time really getting to know our members and doing some visioning about what we all collectively hope population health management can do to transform the Medi-Cal program and really achieve the quality and equity outcomes that we believe our members deserve and can achieve through the CalAIM initiative. We'll then transition a little bit to do a deeper dive into screening and assessments, which is just one piece of our population health management framework, but really a critical part. We can go to the next slide. So there'll be several of us from DHCS who are participating as well as our fantastic Manatt team who has been supporting our population health management efforts. So if you see any of us, we're from the department and happy to answer questions along the way.

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Slide 6	Palav Babaria – 00:02:49	Can go to the next slide. I'm going to turn it over to Sharon Woda to lead us through our member introductions exercise. I will also just call out as Mario did. The chat is open and accessible to every single person on this call, not just our advisory group members. We know there is a wealth of experience across our state. And many of you who have joined this call as public members have significant ideas and expertise to add. So we really encourage everyone to please use the chat, share your ideas, participate in this brainstorming activity so that we can make this program as robust as possible. Sharon, I'll turn it over to you.
Slide 6	Sharon Woda – 00:03:29	Thanks Palav. All right. So I have the great position of getting to introduce everyone in the advisory group. We're really excited for the advisory group. This is... we view this as a little bit more of the kickoff and I think to start a really nice dialogue. And one of the things I think you will notice right off the bat is that the group is comprised of people from really different stages and different walks of life. And that was very intentional to make sure that we were bringing together people that represented providers, managed care plans, counties, advocates, community organizations, government organizations, and agencies, foundations, and consumer advocates to really weigh in on population health is very multidimensional. So here is the list of folks on the provider and manage care plans. And of course the slides will be available later as well.

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Slide 7	Sharon Woda – 00:04:26	And if you go to the next slide, you'll see the list of folks available from the counties and the other groups I just spoke about. And what we're going to spend most of the time to do and hopefully folks going to heads up on this, as part of Palav's note that she sent around earlier, is that we're going to ask folks to do a quick minute or so to just talk about as Palav says, what's the top of your wishlist for what you hope the PHM program can accomplish to really transform Medi-Cal for members. So we'll just leave it on that next slide, slide seven. And I will go ahead and go call on people. And I will say if I don't get your name accurate, please correct me so that the group can hear the right pronunciation of your name. And I'm going to start with our provider group because I know a few folks have to leave early in that group. So just going to have Tangerine Brigham from Alameda Health System kick us off. So Tangerine, if you don't mind breaking the ice for us, we'd appreciate it.
Slide 7	Tangerine Brigham – 00:05:30	I'll break the ice when I go off mute. Hi, Tangerine Brigham. I am the Chief Administrative Officer for population health at Alameda Health System. So when I think about my wishlist for this, it is I think the understanding of how population health management could really forge together both health data and our social data, be it either the collection of social determinants of health or other data to really think about healthcare within the context of I think social medicine and how we really do improve health for our population with that lens.
Slide 7	Sharon Woda – 00:06:19	Great, thank you. All right, going to turn it over to Kathy Bristow and Kathy, just a quick note we did hear that you had to leave a bit early, so -

VISUAL	TIME AND SPEAKER	AUDIO
Slide 7	Laura Miller – 00:06:29	Yeah, sorry about that. Thank you so much. Kathy Bristow. I'm the System Vice President for population health operations at Common Spirit Health, which is Dignity Health in California. And I have a national role, but I live in California and I would say at the top of my wishlist is probably more of a guiding principle, to really have... to achieve simplicity and seamlessness for members, patients and providers and move beyond an awareness of payment models for our frontline providers and our patients, so that things just are available and work for them. And I know that's kind of lofty, but it is probably the major pain point that we have in implementing these very important and meaningful payment models, but they get bogged down at the front line.
Slide 7	Sharon Woda – 00:07:33	Okay, great. Right, that's helpful. And wish you could say it, because I'm curious to see if we've achieved a little bit of that simplicity through some of the more recent screening and assessments, even though there's a long way to go there. Okay, all right. I'm going to move on to Dr. Daniel Calac from Indian Health Council. So Daniel, please let me know if I did not say your name correctly.

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Slide 7	Dan Calac – 00:07:59	Yeah, it's Dan Calac like Cadillac. So it's actually from the Pauma Band of the Luiseño Indians. It's actually a shortened version of Calolac, from the area. But I think that the most pressing issue that looking to address in terms of the top one is looking as we've seen in the past couple years, the plethora of public health issues that have really been unmet over the past couple years that the epidemic has really brought to the surface. So, I think one of the first and foremost issues regarding the public health concerns is the level of health literacy that persists not only across the area and all demographics and all financial levels, economic levels, but also as pertains to the rural areas and the danger that a little information has as posed in terms of using the electronic means, searchable engines to find out information that may or may not be verified and appropriate for different clinical concerns. So really providing a good strong base for some of the public health issues surrounding some of the health literacy concerns that I've seen surface over the past couple years.
Slide 4	Sharon Woda – 00:09:30	Got it, thank you. That's good to hear. All right, Dr. Laura Miller from Community Health Center Network.
Slide 4	Laura Miller – 00:09:41	Yeah, I come with this, I think in some ways as a primary care provider and that challenge of how do I see my population? I can see the person in front of me with the A1C at 13, but how do I really take care of a whole population? And I think that there's a deep need for tools, for systems to be able to see their whole population, both their medical and I'm echoing Tangerine here, as well as their social data, their social situations, such that we and healthcare can actually meet people where they are rather than making them come to us on our schedules. I think that's some of the themes that I would like to hit, again lofty, but let's go high.
Slide 7	Sharon Woda – 00:10:31	Let's go there, right? We've got an unprecedented opportunity here.

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Slide 7	Laura Miller – 00:10:35	Indeed.
Slide 7	Sharon Woda – 00:10:36	Okay. Heyman Oo with Marin Community Clinics.
Slide 7	Heyman Oo – 00:10:42	Hi, thank you. So my name's Dr. Heyman Oo and I'm a Pediatrician Primary Care at Marin Community Clinics and also one of the medical directors here. And I think echoing the last speaker, I also focus on the patient as a primary care doctor. So I think that even though population health management has all of these tools, at the end of the day, my vision for this program and service is that my patient will get the care that they need without undue barriers, undue delays without 17 forms, 13 phone numbers waiting for the appointment. And then only being told that they're on a wait list. There's no capacity. That someone would anticipate that they need help with transportation, that they might need a language interpreter. And that when I bring them back in three months, they can tell me, hey, I got to see that person that you referred me to. And then they actually connected me to these other services without prompting. And so I think that's the opportunity that's here, is that the patient gets what they need. And that we as providers are allowed to help in that process instead of having to fight sometimes in that process.
Slide 7	Sharon Woda – 00:11:48	Reduced barriers, and you had a lot of thumbs up and heads nodding when you were talking about the forms and the phone numbers in particular. Al Rowlett from Turning Point Community Programs.

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Slide 7	Al Rowlett – 00:12:08	I would ditto all the remarks that have been made and I'll for the second time, really focus on the comments made by, I believe it was the colleague from Dignity. And especially given the unique challenges associated with the social determinants of health. And just being able to understand the utility of healthcare from the perspective of the people that we're privileged to serve and how they might use it in terms of advancing their wellness is important to me. And I think that was represented in those comments. Well, thank you. Looking forward to great work here.
Slide 7	Sharon Woda – 00:12:48	Thanks Al. All right. And then Bhumil Shah from Contra Costa County Health Services.
Slide 7	Bhumil Shah – 00:12:58	Thanks Sharon. I'm Bhumil from Contra Costa Health Services. As some of you know, we are an integrated health department. So with the health plan, hospital clinics, public health. First, I want to congratulate DHCS for this grand vision. This is one of the boldest documents I've seen in terms of aggregating data, risk stratifying, understanding needs deduplicating questionnaires. I'll echo some of the topics already discussed by my colleagues. One thing I would recommend is that we create this as a foundation, the program and the service, not just the prescription and allow enough localization based on local needs. Each county is unique, just in our county we have east west and central region. They could very well be three separate counties. We have food deserts in one area. We have a new migrant population with very few CBOs at local needs. So the interventions could be very different. Also, we may have more information locally. So I think finding the right balance and using this to create that framework as a foundation, while still allowing local innovations based on local needs, that's something I'm looking forward to in this program and service.

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Slide 7	Sharon Woda – 00:14:15	Thank you Bhumil. So a lot of themes on data, not letting forms get in the way of serving the member, better information at the right point in time and the integration of social determinants of health. So all of that's making a lot of sense. All right, we have a couple folks from the provider side that weren't able to join. So Kelvin Vu from Open Door Community Health Centers and Samuel Skootsky from UCLA Faculty Group. So we'll put them on the hot spot next week and see what they have to say. Okay, I'm going to go around now between different groups now. So just when you hear your name, you'll be up. So let's start with Phebe Bell from Nevada County.
Slide 7	Phebe Bell – 00:15:03	Hi, thanks. Phebe Bell. I'm the Behavioral Health Director for Nevada County and also the President of the California Behavioral Health Directors Association. And in addition to all the themes that you just highlighted Sharon, I'll just dive a little more deeply into the interface between the behavioral health world and the primary care world. And just acknowledge the pretty significant reduced life expectancy for folks struggling with serious mental illness or substance use disorders, and hoping that as we better integrate data and align outcomes, that we get to better specific outcomes for people struggling in the behavioral health system and trying to manage physical healthcare needs. And to do that in better coordination with those... between those systems.
Slide 7	Sharon Woda – 00:15:51	Makes a lot of sense. So let's go to Rebecca Boyd Anderson with Partnership Health Plan.
Slide 7	Rebecca Boyd Anderson – 00:15:58	Good morning. As you said, Rebecca Boyd Anderson, I'm the Director of Population Health here at Partnership. I would say at the top of my wishlist is really being able to understand and form alliances to reach our underserved members, the people who have been alienated or mistrustful of the healthcare delivery system for a variety of reasons.

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Slide 7	Sharon Woda – 00:16:23	Better engagement, especially given those mental health items that Phebe was talking about.
Slide 7	Rebecca Boyd Anderson – 00:16:31	Mental health and also disparities, some of the trust issues with the tribal groups. And anyway, there's a lot of them.
Slide 7	Sharon Woda – 00:16:41	A lot of reasons to partner up. Okay. Right, let's go to Dr. Gail Newel, Santa Cruz County.
Slide 7	Gail Newel – 00:16:51	Good morning. This is Gail Newell, Health Officer for the County of Santa Cruz. And although I've spent the last seven or eight years in public health, before that I was a Clinician Obstetrician Gynecologist for 30 plus years. So my biggest experience coming to the table is as a medical provider. I was a medical provider for all of my years in practice. And so I'm excited to bring both the public health perspective and a clinicians' perspective to the group. And my big wish would be that we move really upstream and do a lot of work on preventive care and public health measures, of course, with a special focus on equity. Thank you for this opportunity to participate.
Slide 7	Sharon Woda – 00:17:48	Thank you for joining, especially from the clinic. Alright, let's go to, I think probably the individual that's been on the phone the longest today. So Dr. Dipa Patolia from HealthNet.

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Slide 7	Dipa Patolia – 00:18:05	Hi, good morning everyone. My name is Dipa Patolia. I'm the Senior Director of population health, and I am a Clinical Pharmacist by training. And then as my big wish for this is really as we create a program, to really make sure that it's from the perspective of our members and patients, making sure we don't lose their voice and really iterating as we go, as we get more engagement and participation and feedback. So again, really understanding their needs and not assuming we know what they need to create more patient member-centric programs, that account for member preferences, the unique challenges they may be facing, geographical and otherwise SDH, other barriers to really provide that whole person care and improve outcome. Thank you.
Slide 7	Sharon Woda – 00:18:49	Thank you Dipa. All right, let's go to Katherine Hayes with the California Healthcare Foundation.
Slide 7	Katherine Hayes – 00:18:58	Thank you. I am a Senior Program Officer at California Healthcare Foundation, and I am leading our work on advancing Black health equity in the health system. I have a particular interest in data adequacy for actually really understanding how equitable the care is that we're giving and being able to mark progress across domains, so beyond health disparities. And I'm also working on understanding the care experience and with an eye to engaging and building healthcare literacy, where it's needed so that people have what they need to advocate for themselves and the health system. Thank you.
Slide 7	Sharon Woda – 00:19:46	Thank you, Katherine. So lots of themes also around just building back member trust, being able to address issues of health equity, and really also empowering members with health literacy so that they're also able to drive and participate in their healthcare. Okay, big agenda. So I like it. So big goals. Okay, let's go for the Disability Rights of California, Anna Leach-Proffer.

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Slide 7	Anna Leach-Proffer – 00:20:19	Good morning everybody, Anna Leach-Proffer. I'm an attorney with Disability Rights California. I'm in our healthcare practice group and we represent Californians in a wide range of medical-related individual and systemic cases in addition to doing a good amount of health policy work. And my hope for these PHM efforts is that it'll allow us to identify and then I think specifically target the needs of populations that are experiencing health disparities, including people with disabilities. And I'd really like to see this work be used in combination and really leverage some of the other CalAIM initiatives like Enhanced Care Management and In Lieu of Services. And then just one other thing that I think a couple other folks have brought up, but I would also like to see us tying this into the consumer experience and making sure that okay, there's all these great opportunities out there, but how can we make sure the right people are getting into the right programs and not getting confused by all the options and all the case managers that they may have? I think if we could streamline things, that'd be great. So thank you.
Slide 7	Sharon Woda – 00:21:27	Thanks Anna. Great, let's go with Caroline Sanders, California Pan-Ethnic Health Network.
Slide 7	Caroline Sanders – 00:21:35	Hi, good morning everyone. Cary Sanders at the California Pan-Ethnic Health Network. Yeah, I think for us just really excited to really try to tackle health disparities head on. I think disparities are persistent and have been exacerbated due to COVID-19 and yet despite efforts to combat them, our data systems are not where they need to be in order for the level of comprehensive data sharing to happen, whether it's demographic data or health-related social needs data.

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Slide 7	Sharon Woda – 00:23:19	Thank you. That was helpful and really spoke to that working in partnership as others have spoken with and in being able to leverage data and ways that we haven't before to make things better for the members and all of those partners that are pulling in the same direction. Okay, let's go to Health Plan of San Mateo, Dr. Amy Scribner.
Slide 7	Amy Scribner – 00:23:03	Hi, Amy Scribner. I'm the Chief Health Officer at the Health Plan of San Mateo. So I would say on top of my wishlist, it's similar to what others have shared on data. So receiving more robust and standardized data, specifically getting consistent social determinants of health data about the members to aid in risk strategy. Of health data about the members to aid in risk stratification and tiering so that we can better serve group and individualized needs without having to ask members the same questions repeatedly. And then being able to share that across different providers in the delivery system.
Slide 7	Sharon Woda – 00:24:19	Let's stay in San Mateo and go to Peter Shih from San Mateo County Health

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Slide 7	Peter Shh – 00:24:25	Good morning, everybody Peter Shih with San Mateo Health. I'm also representing CHI Act too. And I really am excited about CalAIM because it's go big or go home. And I appreciate that. The concerns that I think I have is around execution. The policy is great so I hope we can leverage all of everyone's sort of ideas but also execution chops to make sure that we can make these things a reality. I think top of my list is to build on and enhance existing public health infrastructure. And again, through data sharing among disparate stakeholders across the entire state with real time alerts. And I think it's important to leverage existing systems that are robust enough to help make that happen but also help the counties that don't have those systems in place to have that. Because I think I echo a lot of the comments that were shared already around data. And data is such an important tool and a vehicle for us to achieve all these dreams that we want to have in population and health management. But I think it's going to be hard for people to walk away from systems that they've invested a lot of money in already and time and structure to then adopt something completely brand new. So I don't know if that's really the best way to approach it if that's sort of a potential because that's a lot of tax dollars already put in. And so I think we have to be pragmatic and able to execute but also push the envelope. So it's a tough balance
Slide 7	Sharon Woda – 00:26:22	Thank you, Peter. All right, let's go to Maria Lemus.

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Slide 7	Maria Lemus – 00:26:31	Thank you, Sharon very much. And I'm really thrilled to be here and to represent some of our community-based organizations. Vision y Compromiso is a statewide organization of promotores and community health workers. And we also engage in multiple projects. So we bring the promotore community health worker experience to many sectors, mental health wellness as well as health and chronic disease. And for me, I think it would be the integration of the promotore model, looking at community-based organizations as a solution and a partnership with agency. I haven't seen a real effort of agencies resourcing or funding or supporting existing agencies that are right now helping with access utilization and integration of services. We know that through COVID we were essential workers and we were the ones that were out there doing the work. I think that needs to be formalized in a real way. For me, for us, Vision y Compromiso it is resourcing organizations to formalize that partnership with plans, hospitals, and clinics so that we are the warm handoff in the community. I'd love to see that discussion and realize some of those activities so that as informal partners now we become formal partners in that activity.
Slide 7	Sharon Woda – 00:27:52	Got it. Thank you, Maria. So Dr. Nina Park with Los Angeles County Department of Health Services.

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Slide 7	Nina Park – 00:28:05	Hi there, Nina Park here. I'm the Chief Deputy Director of Population Health for LA County Department of Health Services. I represent the county with my other colleague who's on the call, I think. But also as a provider, we have over half a million patients that are entitled to our primary care clinics. And I also am a primary care provider. My wish list is for better regional coordination. I think many of other folks have already spoken about the amount of data that we have available to us within our region, within our county. And how do we share all that information and have a streamlined process for actually touching the individual patient? I think making sure that we know what the plan's roles are, we know what the provider's roles are, we know what the state's role is. I think we want to make sure that each patient feels that there's a coordinated service provided to them and not get several phone calls from many different case managers about some particular thing. And so looking really forward to streamlining what the patient actually experiences from all of us and all our efforts. I also do share some concern I think Peter had mentioned just in terms of making sure that there's a balance between what each of the areas have already invested in, in terms of Population Health Management and how to balance that with whatever we all together sort of decide that PHM service will look like. Making sure that the risk stratification methodology that we decide to implement actually does make sense and it is applicable to our local region and our local population. And looking forward to all the conversations, I'm excited to be here.

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Slide 7	Sharon Woda – 00:30:26	Thank you, Nina. Thank you for those thoughts. And I think as you were talking, I was thinking that you were channeling Peter as well or on the same page with that, with the talk of the pragmatic approach in regional, let's make sure we know what we're each doing regionally as we also think about building this bigger vision and ship. And we do anticipate the service will be a big part of the conversations of this group as well over time. Okay, let's go to Mike Odeh, First Children Now.
Slide 7	Mike Odeh – 00:30:59	Thanks. Hi everyone, Mike Odeh, Senior Director of Health at Children Now. So for me, I'm interested in developmentally appropriate care across the age spectrum of childhood and adolescents. And so that looks different across ages obviously. But a lot of that means timely preventive care, referral and follow up. And I would include vision and dental care in that. I also think a strategy that addresses the root causes of some of the most burdensome childhood chronic diseases. So things like asthma but also the mental health crisis that's going on. I think looking more upstream, healthy and equitable births, including quality perinatal care. And then finally I'd say care that's family centered and seamlessly coordinated across settings, specifically schools and early education settings where kids spend a lot of time and families interact with that. So that would be my list. Thanks.
Slide 7	Sharon Woda – 00:31:53	All right. Thanks Mike. It's a good list. Let's go to Elaine Sadocchi- Smith with LA Care Health Plan.

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Slide 7	Elaine Sadocchi-Smith – 00:32:05	Good morning everybody. This is Elaine Sadocchi-Smith. I'm the Director of Population Health Management at LA Care HealthPlan. By training, I am a family nurse practitioner. I think on the top of my wish list would be to have a platform or an approach that I think we're all doing absolutely fantastic things for our members and our patients, but we need a much more coordinated approach. We need to make sure that we're breaking down those silos. It's truly an integrated approach, an integrated model of care, a holistic integrated model of care so that we do decrease the assessment fatigue. We do have a coordinated approach to care that we are identifying the members' needs at the right time, getting them the right care and making sure that they are having that impact that we need them to have in a meaningful system. So I guess I second everything that everybody has said and just kind of putting it all into in approach that's doable, breaking down those silos and making sure it's truly integrated holistic model of care. Thanks.
Slide 7	Sharon Woda – 00:33:26	Thank you, Elaine. How about Dr. Bob Oldham with Placer County?
Slide 7	Rob Oldham – 00:33:33	Yeah. Hi everyone, Rob Oldham. I'm the Director of Health and Human Services and Interim Health Officer and Chief Psychiatrist for Plaster County. So wear a few different hats. And I think that when I think about the wishlist, lots of things on the wishlist. And you all have so well already described. But my background, I'm actually a psychiatrist who went back and trained in preventive medicine and have bounced around between psychiatry and kind of public health work for most of my career. And I think a lot of us have been thinking about this problem of how do we change what if Wendell what he would call the small P population health, like the healthcare delivery largely focused on kind of higher risk tiers, if you will, higher risk beneficiaries and really having population health for all, so health for all.

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Slide 7	Rob Oldham – 00:34:24	And really, I think for me, it reinforces some of the work that's already happening but gets more incentives for it to accelerate around linkages with public health, with social services, with community-based organizations. And most importantly as many have outlined, with the people we serve and really understanding everyone and their needs, especially the most vulnerable. And so I think this is really exciting because it takes some of the work, I know I was involved with some of you in whole person care and now ECM, but kind of linking it all together. So we've done some great work on really high-risk populations but kind of taking the next step of having a population health to some degree. And it will be I think we have to start somewhere and I know it's going to be challenging, but by the way, great job on the strategy and roadmap so far. And so I'm just really excited. I think we're starting somewhere, getting started on this idea of doing Population Health Management for all medical beneficiaries. And I think it's an exciting time to really accelerate integration, the work that's already happening but especially integration with public health social services in the community.
Slide 7	Sharon Woda – 00:35:36	Thank you, Rob. Great, let's go to Dr. Amie Miller.
Slide 7	Amie Miller – 00:35:41	So I work with the Public Behavioral Health System. I think we serve some of the most vulnerable people in the state of California struggling with severe mental illness living in poverty. And when I listen to the goals stated here, none of which are possible without consent. So we fall under 42 CFR. We want to exchange data and optimize around the CalAIM space but many people live in fear of regulatory barriers to doing so. So I think one of the things, and I say this to many groups, that we could take on that'd be tremendously impactful is continued guidance in this space or my ultimate nerd dream, a statewide master consent.

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Slide 7	Sharon Woda – 00:36:23	No, I think that's a good point and I know there's a lot more forthcoming on the consent side. But it's a good point to raise with all the emphasis on data and information sharing. Okay, let's go to Susie Smith with San Francisco Human Services Agency. And then Kim, I'm coming to you last. So just letting you know, a heads up you'll be after that.
Slide 7	Susie Smith – 00:36:43	Thank you. Susie Smith. I'm the Deputy Director for Policy and Planning at the San Francisco Human Services Agency. And I'm really glad that data sharing and legal and regulatory barriers finally came up because I think that is the biggest challenge that we face is trying to be able to get health information and vice versa, to be able to share social services information within the law. And I think that sort of conceptually we've actually have been able within the DPH side in San Francisco share a lot of data within that system. And adding the help, adding the human services side would be really important. I think the other piece though is operationalizing it. It's one thing to have integrated data and it's another thing to be able to connect it to the systems that people are already using as was stated earlier and to be able to like the person that's acting to make sure someone and can actually act on that data and make an informed decision to prevent adverse health outcomes. So if DHCS and CDSS are able to combine database systems and issue guidance, that really can help us get over some of the barriers that on the ground we face to be able to combine data and act on it appropriately, that would be an amazing outcome for all of us.
Slide 7	Sharon Woda – 00:38:00	Thanks, Susie. Dr. Tim Ho with Kaiser.

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Slide 7	Tim Ho – 00:38:09	Hi everyone. I'm Tim Ho. I'm a family physician representing the provider side of the Kaiser Permanente house. There's a classic picture that shows two providers of care, people who are wearing lab coats and scrubs who are trying to mop up a very, very wet floor. And in the background is a sink that's overflowing. And so to kind of maybe summarize a little bit of what has been said from all different kinds of wishlists, what's top of my wishlist is to somehow have the bandwidth and the courage to be able to continue mopping the floor while at the same time being able to balance turning off that faucet and opening up that drain. Thanks everyone.
Slide 7	Sharon Woda – 00:39:02	We did consider a meme for this group but I think we'll need a meme each time. Okay. All right. And let's go, I think I've hit everyone but if not, please let me know in a message if you're a panelist. I think the last person I have is Kim Lewis with the National Health Law Program. So Kim, take it away.
Slide 7	Kim Lewis – 00:39:32	Hi. Kim Lewis from the National Health Law Program. We are a national nonprofit that works on behalf of low income and underserved populations on Medicaid and other low-income health programs. So it's good to see all of you. I think for me and for our office, we would want the Population Health Management Program to have a more consistent and better way to incorporate recipients' needs and preferences and experiences using both their data and their experience outside of the healthcare system to develop a more holistic plan and approach to care that not just improves their outcomes from a more of a kind of measurement HEDIS perspective but more from an experiential one that they actually perceive the healthcare system as helpful to them and that it's actually making improvements to their lives as opposed to experiencing as one that is daunting and complex and perhaps even too confusing to be able to get help from. So it would be really kind of in that vein.

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Slide 7	Sharon Woda – 00:40:42	Thank you, Kim. And thank you everyone for sharing and really taking this exercise I think to heart. And a lot of things you heard on SDOH on the better data sharing. I think Kim you said it well, it's not just whole person care and better healthcare, it's a better way of life and really making sure that we're helping even outside of the healthcare system. For that heard a lot of themes around being more upstream, more tied to the public health data and infrastructure and knowledge that we have in treating members. Really building off also the existing system. So I think a lot of questions around how this builds off the good things that are already working to kind of get us to where we need to be. Lots of discussion around like just better coordination, both regionally and across when we want to look at bigger data and perhaps some more formalized partnerships with community partners that have not traditionally been healthcare providers. Conversations around thinking about this all through the member's experience and how many forms they fill out to even get to an appointment on both from the provider and the member's side. And also looking at things that are age appropriate because obviously designing this system is going to look a little bit different for children than it would for adults and other population groups within and in between all of that. So Palav or Aita or anyone else from DHCS, any other themes you wanted to point out or mention?
Slide 7	Aita Romain – 00:42:15	Not at this time.
Slide 7	Palav Babaria – 00:42:20	Yeah, I couldn't have said it better than this brain trust and we definitely need a collective meme to capture all these thoughts.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 7	Sharon Woda – 00:42:28	Yeah. And for those, I'm not able to talk, continue to chat your thoughts because I'm collecting those as well. And I think at this time I'll turn it over to Aita to talk a little bit more about the advisory group. And then we'll move on to talk a little about what you guys just said around screening and assessment and the fatigue and some early steps we can take there.
Slide 8 -9	Aita Romain – 00:42:51	Thank you, Sharon. Next slide please. We're going to talk a little bit about the charter for the Population Health Management Advisory Group just to set the stage for some of the deeper conversations that we are going to have later on in this meeting. Next slide please. So just as a reminder that the context for the Population Health Management Advisory Group is that we have the program and the Population Health Management service and that we are looking to design both of these elements of the Population Health Management system to meet the needs of members across the continuum of care. The program as well as the service are going to evolve over time. And we really want it to be dynamic and meet the needs as it changes, but we also want meeting our larger vision for reducing disparities as well as having members live longer, healthier and happier lives.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 9 -11	Aita Romain – 00:43:59	We are working to meet this vision by working in close collaboration and consultation with stakeholders like you in different forums which includes this one. So the Population Health Management Advisory Group is comprised of a cross section of stakeholders as you guys have introduced yourselves and offered your wishlist which we will definitely take into consideration and add to some of the work that's already being done. Next slide please. So the meeting format and expectations. So we have these meetings open to the public because we want to hear your voice. We have an open chat box where we'd like to hear your thoughts. If the advisory group members also want to add to the chat, we welcome that. We will be taking that back and using that to advise us not just from these meetings but going forward. Not just for the near future but along the way as we build out the program and service. Next slide please. We really want your feedback on the Population Health Management strategy and roadmap document. It is now posted online on our Population Health Management website. And we asked for public comment to be sent to the CalAIM@dhcs.ca.gov mailbox by Monday, May 16th, the morning. And in this document, we are really trying to define and describe the Population Health Management concepts and terminology that we're going to use throughout the program and service development to really get this vision off the ground and really moving.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 11	Aita Romain – 00:45:57	And as you guys mentioned, this is a very large vision. So if you see elements in the strategy and roadmap document that is very broad that you would like to help guide our specifics later, we really welcome that feedback. If you see specifics mentioned in the document and you want us to make sure that certain elements, whether that's subpopulations in medic health or whether that is just systemic elements that you want to make sure we don't forget, please mention that in your comments and send that at your earliest convenience. We will be really looking towards you as well as individuals in the public that might not be on camera to really offer your feedback. And we're going to comb through each and every comment. So use whatever system works best for you, whether that is an Excel sheet, whether that is commenting directly on the PDF. We welcome comments in all formats.
Slide 11	Aita Romain – 00:46:59	This roadmap is really looking at 2023 and beyond. So there are things that will change as it mentions, it's a draft document. And so we're really looking to you to help us finalize that in the best way. This document also uses member vignettes to guide and really make clear how this is working in real time. If you see any ways that you want to incorporate your own member vignettes on how you would see the system working, please add to that as well. And again, we want all stakeholders to have a chance to comment on it. So if you have community advisory committees that you'd like to reach out to and share this document with them, we welcome their input as well. Next slide please.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 12	Palav Babaria – 00:47:51	So I think to really make sure that we are centering as so many of our advisory group members called out, centering this program really on the member experience and the member needs, we really want to be on the member experience and the member needs. We really want to be intentional about bringing some of those lived member experiences to each of our advisory group meetings. And as many of you who attended our last meeting will recall, we shared the story of Colleen who's one of our medical members, that had her life transformed by one of our whole person care and ECM programs. So today we're going to take a slightly different tech at this, to really walk through what we envision the member journey to be like through our PHM programs in granular details. So we can go to the next slide. So this is an overview. You all are going to be bored of this slide by the end of all of our advisory group meetings. But this is the PHM framework, at least as we envision it working today. So on the left is really the start of the process, where we gather information about members. This is done through screenings, this is done through data aggregation and collection, especially leveraging our population help management service. We then take all of that information to understand risk really proactively. And I know someone had made a great call out in a separate meeting where, when we talk about this risk, it's not just medical risk or clinical risk. It's really about the social risk that we know drives so many of the disparities across our state and within our delivery systems. So looking at, how can we use all of that data, with clinical data, but also social data from other systems to do effective risk stratification and segmentation. We recognize that, that will generate risk tiers, where we classify folks into high, medium rising risk or low risk categories.

Population Health Management (PHM) Advisory Group Meeting

April 26, 2022

Transcript

VISUAL	TIME AND SPEAKER	AUDIO
Slide 13	Palav Babaria – 00:49:37	And that for some populations, especially those that are flagged as high risk or rising risk, there's going to need to be further assessment, to really understand what is happening with that member? Why are they in this bucket? What are their needs? How do we meet those needs? We also recognize that some members are not going to need the high risk or rising risk and deeper assessment and will just need basic services or population health management for all, as one of our advisory group members mentioned. So based off of what we learn about members, their risk level and what their individual specific needs are, we envision members being connected to the right services at the right place, at the right time. So that will include basic population, health management for everyone, independent of their risks tier and care management, which is inclusive of both complex care management and enhanced care management for certain select populations. We also include transitional care services in there as needed, which are really designed to help when members are transitioning between different levels of care. Whether they're being discharged from the hospital to home or a skilled nursing facility or being discharged from an acute rehab to home. We know that those periods of transition can be really risky for our numbers. Also underlying all of this, you'll see the era that's going at the bottom is the population health management strategy and the population needs assessment, that each health plan is going to be completing. To really understand what are the unique needs of the community in which those plans are operating, what are the diversity within that community from a language, race, ethnicity, sexual orientation, gender identity, and disability status perspective. So effective programs can be designed for what those local needs are.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 13	Palav Babaria – 00:51:23	So we really see, I think to Camille's point earlier, that there needs to be enough flexibility to adapt this framework to what the local needs are and what the local setup is. And we really see that being done through this comprehensive population needs assessment, which then informs the population health management strategy. We'll also call out that we know our public health colleagues and many of our hospital systems have been doing population assessments for a long time. And we explicitly want better coordination, collaboration and integration of those plans with this CalAIM population meets assessment. Let's go to the next slide. So what does that mean? An individual member. So we're just going to walk through Linda's vignette here so that people can see what this sounds like in connection. So Linda is, and otherwise relatively healthy woman who has her first prenatal appointment. She has a comprehensive history and physical done by her provider and is diagnosed with gestational diabetes. Based off of that encounter with her obstetrician and provider, the health plan receives that information. So the health plan gets this new diagnosis of gestational diabetes that bumps Linda's risks here, because it's a new piece of information. A care coordinator then, with Linda's health plan reaches out because of that flag of gestational diabetes and connects Linda to WIC services so that she can really look at her diet and focus on eating fresh foods and vegetables, and really addressing her gestational diabetes with lifestyle modifications and access to better food, as well as the doula. So that's number three. So even though Linda's gestational diabetes didn't push her into a high-risk tier, that information did allow for some effective flagging of this member and her needs using data.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 13	Palav Babaria – 00:53:15	We did not ask Linda a million questions about her history. This all happened in a more automated way and really enabled outreach that linked her to additional services to which she is eligible for. And I will call out, I know many of you on this call already know this, but we know that WIC enrollment, which all of our medical members are eligible for, happens far later than it should. And the prenatal time is really a great opportunity to be increasing enrollment into WIC services. So then at 28 weeks, Linda is unfortunately diagnosed with high blood pressure and depression during one of her prenatal visits. At this point, given this constellation of new diagnoses, she's referred to a high-risk pregnancy specialist and becomes eligible because of this elevated risk for being enrolled into complex care management, which is a care management program offered by her health plan.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 13	Palav Babaria – 00:54:06	So that's the number four and five that you see on this diagram. Then at 37 weeks, Linda's diagnosed with preeclampsia and admitted for labor induction. Supported her doula, who has been supporting her throughout this entire journey and that she was connected with earlier in her care, she very fortunately delivers a healthy son, Jacob. Her complex care manager helps with the transitions from the hospital, making sure that she has everything that she needs at discharge, understands what follow-up is critical, especially for that postpartum care, given her elevated risk and healthcare conditions. We know that a fair amount of our maternal morbidity and mortality occurs in that postpartum period and isn't always effectively addressed in our current delivery systems. So then Linda's health conditions fortunately have resolved. Linda and Jacob received dyadic services during Jacob's well child visits, which is also a new medical benefit that we'll put a huge plugin for. And Linda very fortunately, no longer needs support from her complex care manager. Her plan continues to monitor her and support her family through basic population health management, but she's discharged from the other care management programs.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 13-14	Palav Babaria – 00:55:16	So I want you to keep this vineyard and the flow in mind as we dig into the assessments. And I see a great question from Hillary, which I'll just answer before we move on; where does Jacob's enrollment into Medi-Cal happen? So glad that you asked that question. Because as we look at our infant well child visits, and how we effectively really make sure that infants in our program are getting everything that they need, we are well aware of a gap. Which is that often our infants are not enrolled into Medi-Cal managed care for several months after birth and stay on their mom's Medi-Cal. Whereas, there are some counties, and I'll give a shout out to Yale New and Santa Cruz folks who figured out expedited enrollment and workflows that really get that infant enrolled at the hospital prior to discharge. So that is workflow and best practice that we are looking at scaling through our DHCS and health plan and children now sponsored affinity group that we are participating in right now. So we're to come on that in future sessions. Sharon, I will turn it over to you.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 15 - 16	Sharon Woda – 00:56:27	Sure. So next. All right. So I think now we're going to go into an overview and discussion of specifically the screening assessment. So everything we're about to talk about is in fact, in the PHM strategy and roadmap paper. So it's all up for your feedback and your dialogue and considerations within that. So would love to get your take on that. One thing I will say, I want to respond to Carmen's note. Yes, we know. We need to see they add behavioral health language in the mental health treatment. We would agree with that. We were trying to keep it a bit simple for the purposes of today, but I agree. When you start to look through and cross the behavioral systems, those are the types of activities that we have to really track and really think about how everything we're talking about in population health really integrates across delivery systems and different payers. I think is a big focus, once the baseline PHM items are in play. So just to say, we agree with you and we acknowledge that. All right. So let's talk a little bit more about the overview and discussion of the screening assessments. Let's go to the next slide. All right. So maybe I'll talk here a little bit probably about the goals, and then maybe I can hand it back off to you for some of the other items. Okay. All right. So as you'll see in the strategy and roadmap document, all of our goals, the department really sat back and thought about the goals from really the members perspective and lens. To think about, where are we trying to head and where is our true north here? So a lot of this are things that we heard from you just on the beginning of this call. When you think about screening and assessment goals, we really want to have a way of building trust and meaningfully engaging with members and not just throwing forms in front of their face and asking them to fill out lots of information. Same information often time and time again.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 16	Sharon Woda – 00:58:24	It's a very hard charge given the state of California and the multiple delivery systems. And you guys know that better than anyone because you're on the front lines. But the goal is to really build that trust and meaningfully and engage, it's to gather that timely and accurate information about the member and not just about information about the member, but also on their preferences and needs. So trying to make sure that their voice is heard in that. We need to gather and share information in a member-centered way that will enable plans and all stakeholders to really be able to better target the right service for the members. And really eliminate to the extent that we can, even the bias that we see in some of the existing forms with how some of the responses triage services and interventions. Obviously, all of this has to be done in a way that safeguards privacy. So we've got some data folks on the phone really listening in and we definitely heard the concern earlier and the ability to do that. And I think one of the things you'll see throughout everything is we have to really think about how we're improving health equity and actively reducing bias. So how we're actually asking questions, how we're capturing information, how we're sharing that information, every step of the way really needs to be due for a lens. Of is this meeting the member where they are? Best engaging with historically marginalized populations in groups that may not engage as much with the healthcare system as a result of not really wanting to engage in this way with these forms and such. In the past, I will say that for the window, the PHM world that we live in, we are trying to discern between a screening and an assessment.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 16	Sharon Woda – 01:00:12	And I will say it gets really confusing. So if it's ever confusing on this group, just ask. Because we're trying to put some stakes in the ground to say, screening is a process or a questionnaire for examining the possible presence of a particular risk factor or problem. So a lot of times when we refer to it, we're talking about initial screenings or a PHQ-2 or PHQ-9, like shorter term screenings. And when we're saying generically the word assessment, we're thinking more comprehensively about a comprehensive process. It's more comprehensive than a screening and something that is more in depth and involves a number of questions to really define the nature of the program and really be used to develop specific recommendations or care plans. So again, we know that lines can be gray at times, but we are trying to discern a little bit between this, so that we can try to be clear in our language moving forward.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 17	Palav Babaria – 01:01:11	Great. We can go to the next slide. So this is where we're going to pause for our first discussion section. I know that every single person is on this call, including our audience has issues and challenges that they have raised before with how we do current screening and assessments. So this is the opportunity where you get to raise every single last one of those issues. We have heard through the whole planning process for CalAIM, that change is really needed. That there is a high degree of screening and assessment fatigue that our members are asked to fill out same forms, repetitive questions over and over without necessarily follow-up and changes to the services and care that they're receiving. We know that the existing mechanisms are burdensome, that they don't gather really timely, accurate, or actionable information in a dynamic way. We've also heard loud and clear that the existing mechanisms and questions are not always evidenced-based. And we also are well aware that existing data currently is collected in ways that cannot always be shared across the member's care teams or delivery systems, only reinforcing those silos and repeated assessments and assessment fatigue. So we're going to pause here and open it up to our advisory group, but also our public attendees to please just drop in the chat, other challenges that you have experienced, or that are associated with screening and assessment that we should be aware of and capture so that we know the pitfalls and what we're trying to solve for.
Slide 17	Rebecca from Partnership – 01:02:59	Hi, this is Rebecca from partnership. I would say one of the challenges with the screening tools that we have is that they don't assess whether it's the member's priority concern. And so we may identify a need and an intervention associated with that need when it's not even where the member wants us to be focusing our efforts.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 17	Palav Babaria – 01:03:26	Thanks Rebecca. And Caroline, I see your hands up.
Slide 17	Caroline Sanders – 01:03:32	Yeah. Thanks. I think a couple things to point out, we looked at some of the Z codes earlier in the year. And Z codes are helpful, but they're not necessarily trauma-informed. So just a plus one to what you had just talked about, I think we need to really think about how we're collecting this data in ways that are not trauma-informed, that really taken to account individual biases and needs. Also a couple of other things we've heard just generally around data is the lack of shared standardized categories for how people share some of this data can make it difficult to know how to collect it as well. But those are just some of the things that I would add.
Slide 17	Palav Babaria – 01:04:36	Thank you, Carolyn. Laura, I see your hand up.
Slide 17	Amie Miller – 01:04:47	Yeah. Thank you. I put this in the chat, but I think one of the challenges is we ask all of these questions and then we just move on. There's no mechanism to really triage prioritize and actually deliver on what we're asking about. We did a brief pilot of the prepared tool and one of the main things is staff didn't want to ask the questions because they had nothing to give. So I think that's a huge piece we need to look at. I think it flows right in with a whole lack of trauma-informed nature of the questions and the questionnaires.
Slide 17	Palav Babaria – 01:05:30	Oh, sorry. Go ahead Kim.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 17	Kim Lewis – 01:05:33	I was just going to add that I think one of the challenges is getting the right screen at the right time, at the right age, for the right reasons. How do you individualize the needs that are presenting in front of you and not just see it as a cookie cutter approach to, okay, well you turn one, then we're going to do this screen? And then we're going through the motions, maybe put the point that was just made about being consistent about when is that screen needed and when is the assessment or follow-up from that screen needed? And having it be less regimented and more driven by the needs of the member and what's showing up at the time.
Slide 17	Palav Babaria – 01:06:24	Great comments. Oh, should we get everyone's hands we're up?
Slide 17	Sharon Woda – 01:06:24	I think that Bhumil has his hand up.
Slide 17	Bhumil Shah – 01:06:29	The previous panelists said is, not just the, do we have interventions? And also the quality of interventions. Because sometimes we ask, there's food insecurity, we refer them to a food bank. Those things can be Googled. So it's, how are we acting like a search engine or are we truly solving issues? And it works for some people. But it's just being that traffic police officer, hey, here are your needs, here are other people who sending you to. Obviously, those are challenges, there are other challenges in their lives, which as a result, they haven't been able to do that already. So it's I think a, how do we go to more meaningful interventions and then ask questions based on where we have good interventions, rather than asking questions without having good interventions.
Slide 17	Palav Babaria – 01:07:14	Really great points. Maria, we will take you as the last comment. And then I do want us to get to where the future lies, but those of you who have more challenges, please keep dropping them in the chat and we will capture them all.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 17	Bhumil Shah – 01:07:26	Thank you. I just want to elaborate a little bit on the screening and the diagnosis. That it's a diagnosis that's in a minimal diagnosis, and there isn't any support for it. So I walk in, I'm diagnosed with diabetes, eat better, exercise, boom! And then I walk out the door. And I think there's an assumption that the person is going to do it, or if they're not going to do it, they'll come in when it's gotten worse. And that section of time is so critical. That there isn't really a real time follow-up. There's maybe a message that's sent. But I think those are lost opportunities to really change and transform someone's health at that moment.
Slide 18	Palav Babaria – 01:08:16	Thank you so much. So when we get to the next slide mostly because we have such great expertise on this call, we want to dig into what do we do about this problem and how do we do this differently moving forward? I think we'll flag those of you when you read the PHM roadmap, there's clearly different capabilities that are going to be available in January 2023. Then where we hope to land in the future state when our population health management service is fully up and running, when our statewide data exchange efforts are further along. And so we're going to focus on the nearer term in this, but definitely, all of this feedback and input will also help us shape what that further long-term vision looks like. So good news is that, in effective in January 2023, we are streamlining what the HIF/MET, IHEBA/SHA and HRA processes look like, to really eliminate duplication and burden while still meeting the federal state and NCQA requirements that we have. So I'm going to walk through this, but Sharon, Aita, and others, please jump in if I forget any major points.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 18	Palav Babaria – 01:09:27	So for the HIF/MET, a few things, one is we really want to ensure that there's effective data sharing. So that whoever is collecting this information, whether it's the MCPs or the plans, depending on what that delegated arrangement looks like, that whichever entity is collecting the HIF/MET information is sharing it with the others. So that we are not just duplicating the HIF/MET questions over and over again. Obviously, plans have been allowed to delegate the HIF/MET to the provider level that will not change. And we will also expect the provider-led screenings to be shared back with the MCPs within 90 days of enrollment. I will flag that this is a federal initial screening requirement. As the PHM service comes on board, this is an area that we are absolutely open to and interested in revisiting, but we will need to keep the HIF/MET in place to meet these federal requirements until we come up with a replacement solution. In terms of the IHEBA and SHA, we are proposing to eliminate the existing IHEBA and SHA mechanism and really spend our efforts and energies on focusing on strengthening primary care.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 18	Palav Babaria – 01:10:35	We have heard loud and clear that the current IHEBA/SHA process, is often done on paper, often not in a format that can be shared or is duplicative to all of the comments that we just heard, not always evidence-based and not always resulting in meaningful interventions for our members. So the way we envision really rolling a lot of this into a more robust primary care approach, is for children that content and elimination of IHEBA/SHA does not really eliminate any of the required elements that are already outlined in our EPSDT and bright future schedule. So all of those appropriate screenings and interventions will still be done and audited and monitored through EPSDT. We also are going to continue providing the initial health appointment, but we're going to change how we measure this. I think historically the IHA, which is done within the first 120 days of enrollment, has a very exhaustive list of requirements that have to be done in that first visit.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 18	Palav Babaria – 01:11:34	And I've heard from providers in my own experience in the healthcare delivery side, I think if you actually tried to do every single one of those things, you'd be spending 10 hours with each patient for a new patient appointment. So we don't want to get rid of the IHA, but really change how we measure this. Where this is really about, have you had engagement with primary care? Those specific elements will be abolished and they can and should be done per all of the other clinical guidelines over time. But it really, the way we're going to be... Their clinical guidelines over time, but the way we're going to be measuring this is by looking at child and adolescent, well child visits and the adult preventative visits HEDIS measure. Given that one of the major priorities of our population health management program is really recentering primary care, trust and launch relationships with primary care, as well as utilization of primary care as a protective factor.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 18	Palav Babaria – 01:12:26	For those of you who are talking about trauma informed care, we've been having great conversations with the colleagues who've been working on our ASIS efforts and really finding amazing results around how protective primary care in those trusting relationships can be over time against trauma. The last piece is the MCPS are still going to be holding network providers accountable for all of the preventative screenings for adults and children as recommended by the USPSTF taskforce and the Bright Future schedules. Those have all been built into DHCS's audit and compliance monitoring strategies. The other recommendation is around currently there is two APLs, I believe that really outline a lot of specific HIRA processes for SPD populations. Our recommendation is to eliminate the current HRA process for SPDs while still maintaining the standardized LTSS referral questions that are contained in APL 17-013 for just select high risk members.
Slide 18	Palav Babaria – 01:13:32	Similar to the HIF/MET expectations, the expectation would be that whoever it is that is conducting these assessments, whether that stays at the plan level or is delegated to the provider level, that there is information sharing and transmission of those results to the other entities so that these questions are not duplicated and asked. MCPs obviously may want to keep an existing HRA tool on the books if they find it valuable and effective, but they would not be required to do so by the department. I'm going to pause there. Sharon, Aita, did I miss any highlights that you want to call out before we move to the discussion?
Slide 18	Sharon Woda – 01:14:08	You didn't, you did a good job.
Slide 18	Aita Romain – 01:14:12	Very comprehensive.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 18	Sharon Woda – 01:14:20	We didn't have any questions about this either yet in the chat, folks may just be digesting as well. I think we sort of covered the January 1 '23, so maybe we can talk next about the vision for the service and then we'll keep looking for the questions around this.
Slide 19	Palav Babaria – 01:14:38	Great. Yeah, what I just covered, like I said, is the near future, what would happen on Jan 1, 2023 when the population health management program goes into effect, which streamlines some, but not all of the current screening requirements. Then we can go to the next slide. This is where I'm hoping we'll start seeing more traffic in the chat and from our advisory group. I think the long term vision is really once we have the PHM service, which again is going to be our state level service that really aggregates, synthesizes and collates data across multiple sectors and delivery systems across the state, we're really interested in how can we leverage the service. Initially, and you'll see this in more detail in the population health management strategy and roadmap, initially when Cal lane was conceived, there was talk of an IRA or an individual risk assessment, which would be a standardized screener across the state.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 19	Palav Babaria – 01:15:34	When that was envisioned the PHM service didn't exist. With the PHM service, there is I think an incredible opportunity to take a much more forward thinking, data driven, less analog way of doing this. A lot of the comments in the chat and from our advisory group earlier, we recognize we need data that goes far beyond claims and far beyond the clinical delivery system setting. The PHM service has the ability to pull data from across sectors, from across departments and really sort of pre-populate relevant member information that previously the only way to get at that was by calling people up or having them fill out a form and asking them the questions themselves. We want the groups to think bold here, if we could actually get relevant information from our educational systems, from public health, from other public registries, from social services agencies at the local and state level. What are all those questions that we can eliminate asking people about over and over because someone else, even if it's outside of the health sector has already identified a need or that members linked into some program or service.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 19	Palav Babaria – 01:16:47	In addition, what are the other big data ways that we can think about leveraging HIE's, data exchange, frameworks, EHR records, again, to share and aggregate this data as opposed to asking people the questions over. I think the question becomes, if we can do that successfully through the service and really make it the sharing hub for this information, to some of the earlier comments, what are those questions that really are value add, where we can provide a meaningful in depth intervention and that we would want to still do sort of more detailed screenings or assessments around? What are those topics and where should they be done? Should they be done at the state level? At the time of medical enrollment? Should they be done in the provider office? Should they be done by a CHW in the field? Should they be done by a PCM provider? Obviously, I think that who's asking and what their training is and the time and the place are really critical. Are there more chat questions, or we can open up the discussion questions with the time that's left?
Slide 19 - 20	Sharon Woda – 01:17:52	I think given the time that's left, we should move on to discussion. There are some very good questions, we'll try to answer them with tax and what we can't, we'll loop back to them. Let's go on to the next slide.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 20	Palav Babaria – 01:18:11	Great. I think I covered most of this, but with the time that we have left, we want to open it up. Knowing what we're proposing for the short term, and then as well as the longer term vision, once the PHM service is live and launched and scaled, we would love to hear feedback on, do these proposed changes achieve the goals of streamlining existing screening and assessment processes and reducing member screening fatigue while also building trust? Do these propose changes better leverage evidence-based tools? If there are tools that all of you think are more evidence based, or we should be pointing to that are more explicit, we should capture those here. Second, recognizing really the powerful role of primary care. How else can we really get at this member engagement with primary care and community providers? I know many people, when we did our introductions talked about rebuilding that trust, especially with communities that have historically been discriminated against, marginalized, experienced genocide and how do we center primary care as a part of that rebuilding trust. Regarding the sharing of the HIF/MET information, between MCPs and providers, sort of what's the best form of this information to be shared. We imagine that neither MCPs nor providers want some crazy multi page PDF emailed to them once a month. What should the requirements around that data sharing look like? Then any other ways that you all can think of should be fostering member trust and improving member engagement as one of the key goals of screening. Let's open it up to our advisory group, you can comment on any or all of those questions. Kim, I think I saw your hand go up first.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 20	Kim Lewis – 01:19:56	Yeah, thanks. I have a more elemental question around eliminating the IHEBA and the Shaw, and I think what you plan to replace it with a more individual health assessment, I may be missing that from looking at the past slides from March. I'm thinking about the balance between consistently collecting required information and how it's reported so that we're getting consistent information across plans and across age groups, et cetera. It's not so organic that you can't actually do data collection in the aggregate and the need to be more responsive and more streamlined, and also more user friendly in the way that we collect this information as patients come in the door. Trying to think through that balancing, and maybe you could help me on that.
Slide 20	Palav Babaria – 01:20:51	Yeah. Great question. I think the short answer is when we looked at all of these screenings, I think the IHEBA and Shaw is the one that consistently in feedback rose to the top as the least useful. That it became really a check the box, exercise, people filled it out, or didn't fill it out, no one's looking at it and no one's doing anything with it, largely because of its paper-based process. Through that stakeholder engagement, I think the thought is that eliminating that one will not actually make the status quo any worse than it is today because most entities have not found it to be a useful tool that is guiding any clinical intervention, nor is the data being aggregated or shared. Obviously, the goal over time would be to replace this paper form with something that is much better through the service, that is electronic, that can be shared between different settings and entities. A lot of what the IHEBA and Shaw tried to get at is captured already, I think in USPSTF and Bright Futures guidelines, really focusing on those elements is the highest yield elements of that form. Does that make sense?

VISUAL	TIME AND SPEAKER	AUDIO
Slide 20	Aita Romain – 01:21:54	Palav, I just also want to mention that the IHEBA and Shaw were collected at the provider level and that we found that there was not sharing of that information with plans. There's an effort to really do that data sharing element through that population health management service that wasn't being done with the current format of the IHEBA and Shaw.
Slide 20	Sharon Woda – 01:22:20	Heyman, why don't we go to you next? You're on mute.
Slide 20	Heyman Oo – 01:22:27	Okay. How about now? Sorry. Got it. I think I'll comment on the third question about what's the best form for the information to be shared and bring up the point that wherever possible, I think automation is key. Our community health center over the last couple of years has actually been very much engaged in rolling out ASIS screening. I use that as an example that our EHR is NextGen, which is fine. It's not great, it's not bad. It just is. A lot of different systems have different EHRs, we were very mindful, whatever we entered into the EHR had to be retrievable data in standardized forms so that if we had to do evaluations or reporting, we would be able to do it in an automated way. This is way above my area of expertise in the technological requirements, but given that there's so many different EHRs and healthcare and the systems that managed care plans use to aggregate data, the fact that they actually have to be able to talk to each other somewhat automatically or relatively easily, I think is critical. Otherwise, you're paying somebody to transcribe things that are on paper or in another system into another system, which is an added barrier to being able to share this data. I don't know what the solution would be, because that's a technological solution, but having that ability to pull things from notes and texts and whatever in an automated way, I think would be the most critical piece for this being successful.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 20	Sharon Woda – 01:24:09	Thank you for those thoughts, I don't think we disagree with them. All right. I'm going to go next Dipa.
Slide 20	Dipa Patolia – 01:24:18	Sure. Thank you. I think what would be really important when it comes to screening is identifying when there's multiple gaps or multiple needs and how to layer in the interventions to support our members and patients in one go. To do that really, it does take that comprehensive look into all the different struggles that member or patient may be facing, whether it be transportation, housing, food insecurity, so on and so forth. I think the data components of that need to be linked. I think to the last question around fostering member trust and member engagement, accounting for their preferences will be really, really critical and having the right contact information obviously is going to be a rate limiting step. If both of those can be solved for then we really can start to reinforce the why behind the importance of these screenings, getting creative about getting these screenings done. I know we have telephonic outreach, in-home outreach, we want to try to meet our members where they're at, more community-based solutions to get some of these screenings done. When it comes to data collection, I know I said this before, things like SOGI data, really explaining the why, continuing to reinforce why we're collecting the information and how it's going to be used to better serve our patients and our members' needs. I think that'll get us a long way in terms of building and maintaining that trust and getting this information to provide better value. Thanks.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 20	Sharon Woda – 01:25:55	Thank you Dipa, that was helpful. Also, the point about not having it be a static form and having it lead down a pathway that really informs the interventions. Okay. I know we have five minutes left. I'm going to say we're going to go to Peter next and then I see Bhumil and Cary's hand also up.
Slide 20	Peter Shh – 01:26:17	I'll try to be quick so I give my other colleagues a chance to speak. Echo what's been said, it'd be great to have one screening form, one assessment form across the entire state with sections only filled out by people who had the expertise to fill it out. Then I would echo the importance of having appropriate training for everyone so that they know how to fill out the section and obviously, a culturally competent way of getting the information from the clients or the patients. I think if we can get one form, one platform, then it makes it a lot easier for folks because there's a lot of people redundantly asking the same things over again. If I was a client, I'd be like, I've already been asked this, this is the eight time I'm being asked this. Something that would again, not limited to who can fill it out, but in the sense of having people who are qualified to fill out each section, so that they only go to the screen that is for them. We have community-based organizations, providers, actual clinicians, because with ECM and community services, we have all these different types of providers who are not used to doing screens. We want to train them to do that, to fill out the complete assessment, complete screen form. I think that's super critical.
Slide 20	Sharon Woda – 01:27:46	Thanks Peter. Cary?

VISUAL	TIME AND SPEAKER	AUDIO
Slide 20	Caroline Sanders – 01:27:53	Yeah. I want to say appreciate hearing all the thoughts from folks on this group, including plans and providers and creative solutions to getting this information. On the member trust and member engagement, just a few thoughts and obviously we'll put this in writing as well. Training at all points of care, that includes not just the use cases that highlight best practices for collecting this information, but also potential problems or what not to do. A crosswalk to explain how Z code should be used to provide or delineate health related social needs so that it's not so subjective for providers to figure out what A leads to B, what that means. Explanation for consumers of why the data's being collected, but also information on how the data that's being collective is actually being used. We often talk about telling people this is really important, but then we don't then follow up to say, here's how this data has actually resulted in better health outcomes. I think that concrete closing the circle or the loop is really important. Also, finally allowing members to enter in their data and correct contact data. Particularly, demographic health related social needs data can be also self-reported, which is really the gold standard here. That's really going to necessitate a consumer-friendly interface, whether it's by computer, text or phone. As others have mentioned, available in multiple languages so that people can really access it regardless of their language spoken. More to come but thank you for asking.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 20	Sharon Woda – 01:29:55	Thank you, Cary. I think for the final word, we're going to go to Bhumil and then I think we're going to have to wrap up quickly with Palav. I know there's lots of questions, we will follow up with the answers to some of these questions because they're coming fast and furious as we would expect from the group, just to follow up on that. Okay, go ahead Bhumil.
Slide 20	Bhumil Shah – 01:30:15	I'll keep it quick, two quick points. As we build this service, we'll have to support various formats to share the information with the providers. HL7, flat files, XML, the reason I say that is each EHR will be different locally and this information needs to be available at the place of service. If it's sitting in a flow sheet or sitting at the scan unit somewhere, no one's going to look at that. We need to support every EHR that's used or every system that's being used by providers. That was my first point. Second was more of a question, is DHCS going to help amplify some of the messaging? There'll be localized outreach as part of engagement and building trust, but also there's a lot of communication that happens directly and at the product state level from DHCS. Wondering if there'll be the amplification of messaging that, "Hey, if you haven't seen your PCP, haven't had your screening done, you should do that." Putting that out as a question, given the resources the DHCS has.
Slide 20	Palav Babaria – 01:31:18	I think the short answer is, yes Bhumil, we will be amplifying the message. I think how and through what channels is still T BD. I know... Sorry, go ahead, Sharon.
Slide 20	Sharon Woda – 01:31:38	Nope. I was going to go where you were.

Population Health Management (PHM) Advisory Group Meeting

April 26, 2022

Transcript

VISUAL	TIME AND SPEAKER	AUDIO
Slide 20-24	Palav Babaria – 01:31:41	We knew this topic was going to generate lots of interests and we promise this will not be the end of this conversation, sorry to all of you that we did not get to you. Go to the next slide. Just want to put in a plug for our next steps and timeline. Keep going. Sorry. Keep going. There we go. This shows what the upcoming milestones are. his advisory group will be meeting monthly, please, if you haven't already go to our PHM webpage, make sure that you're getting the updates and registering for our next webinar, which hopefully will be in May. We will also be doing an all comers webinar to do a deeper dive into our population health management service. We'll be releasing the IFP for that within a few weeks and then hoping to select a vendor by the end of the summer. Obviously, that will be critical to all of the conversations that we are having here. We can go to the next slide. Also, putting in a plug, you've heard us mention multiple times the PHM roadmap and strategy document. Please, please, please submit your comments by May 16th. I know some of you eager beavers have already asked for an extension, we are on a really tight timeline as all of you know, there's a lot going on at the state right now. I wish we could grant an extension, but we really need all of your comments in by May 16th. Really look forward to all of your feedback in writing and also at our next advisory group meeting. Sharon, did I miss anything?
Slide 24	Sharon Woda – 01:33:07	You got it all. Thank you. Thank you all. We're looking forward to continuing the dialogue and discussion. Have a great day.
Slide 24	Peter Shh – 01:33:16	Sharon, is there a way to post some of the comments in the chat to us so we can see it? There are some really good points made and your answers to those questions. That'd be great.

VISUAL	TIME AND SPEAKER	AUDIO
Slide 24	Sharon Woda – 01:33:26	Sure. Let us take a look and see what we can do to summarize it and summarize some of the easy, I'll say easier questions, some of the questions are really hard and really require a dialogue, I can't say we'll answer all questions.
Slide 24	Peter Shh - -1:33:39	Great thank you very much.
Slide 24	Sharon Woda – 01:33:46	Okay. Thank you.
Slide 24	Palav Babaria – 01:33:46	Thank you all.