Population Health Management (PHM) Advisory Group – Meeting #13

February 12, 2024

Transcript

Contents

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Transcript

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Transcript

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Alice Keane – 00:00:11	Hello and welcome. My name is Alice and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the Q&A. We encourage you to submit written questions at any time using the Q&A. The chat panel will also be available for comments and feedback. During today's event, live close captioning will be available in English and Spanish. You can find the link in the chat field. With that, I'd like to introduce Palav Babaria, chief quality and medical officer, and deputy director of the quality and population health management division at DHCS.
Slides 1-3	Palav Babaria – 00:00:52	Hi everyone. Thank you so much for joining us today for our Population Health Management Advisory Group. February meeting. We've got some really exciting updates teed up for our transitional care services policy that went live January of 2024, as we look forward to implementation throughout this year, as well as some high level previews into our community reinvestment policy. We can go to the next slide. So this is the agenda. I'm going to pass it over to Dr. Bonnie Kwok, who is going to walk us through our transitional care services policy, and tee up some discussion questions for our advisory group. Bonnie.
Slide 3	Bonnie Kwok – 00:01:33	Morning everyone. Thanks Paula. Sorry I'm a bit under the weather, so please excuse the voice. I'm Bonnie Kwok, obviously at DHCS in the population health management division. I'm the transitional care services lead. We will do a deeper dive on some of the updates on the transitional care services policies in the last six months or so, and then we have a set of discussion questions. The policy updates should look familiar to you, and if there are any questions at any time, please just drop them in the chat and we will do our best to get to them. If you can move on to the next slide please.
Slide 5	Bonnie Kwok – 00:02:24	This is an overview of the updated transitional care service policies. We had a two phased approach. We started with our high risk population on January 1st, 2023, and now transitional care services has launched for all members starting January 1st, 2024. The focus of today is transitional care services.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Bonnie Kwok – 00:02:51	A reminder of what the definition of transitional care services is. It's when a member transfers from one setting or level of care to another, but it's not limited to and includes discharges from hospitals or other acute care facilities such as skilled nursing facilities and to the home or community-based settings, including some community support services and post-acute care facilities. Next slide please. Excuse me.
Slide 7	Bonnie Kwok – 00:03:25	Our goals for transitional care services, including having a member transition to the least restrictive level of care that meets their needs and preferences and have members receive the needed support and care coordination to have a safe and secure transition. Next slide please.
Slide 8	Bonnie Kwok – 00:03:51	As a review, these are our phase requirements that started on January 1st, 2023. So one of the main highlights for our high risk members for transitional care services is that all high risk members should have access to a single point of contact or a transitional care services lead care manager. Starting this year, January 1st, 2024, the plans are required to ensure that transitional care services are complete for all members and there's a different set of requirements for high risk versus our low risk members, which I will get into shortly. Next slide please.
Slide 9	Bonnie Kwok – 00:04:34	This is how we defined who is in the high risk bucket versus the lower risk bucket. For the high risk population for transitional care services, we have those with long-term services and supports needs. Those who are enrolled in enhanced care management and complex care management, children with special healthcare needs, all pregnant and postpartum individuals up to 12 months postpartum, seniors and persons with disabilities, and members assessed by the plan as high risk in the risk stratification, segmentation and tiering process, and also those who have severe mental health conditions or substance use disorders and those members transitioning into and out of skilled nursing facilities. Lastly, members identified as high risk by the discharging facility such as a hospital or skilled nursing facility. Everyone else are considered lower risk for the purposes of transitional care services. Next slide please.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Bonnie Kwok – 00:05:57	I think I was accidentally muted. I'll start over for this slide. So these are our transitional care services requirements for all members in yellow. In the blue, are requirements for our high risk members and in green for our lower risk members. So focusing on the yellow, plans are required to know when a member is admitted, discharge or transferred to have each member evaluated for all care settings appropriate to their needs and preferences. To ensure that a discharge planning process is completed for all members, and that all members have a primary care provider follow-up post discharge. Also ensure referrals to enhanced care management, complex care management, community supports, and home and community-based services programs and other waivers. Also, to ensure timely prior authorizations preferably while the member is still in the facility.
Slide 10	Bonnie Kwok – 00:07:03	Moving to the middle bucket, for our high risk members transitional care services requirements. Plans must ensure that a member has the single point of contact or again, a transitional care services lead care manager for the duration of the transition. The care manager is responsible for outreach, assessing a member's risk, reviewing the discharge summary, ensuring that that information from the discharge summary and their facility stay is shared with members and follow-up providers. Ensure that a medication reconciliation is completed post discharge. For those with substance use disorders or dealing with severe mental health conditions, those members should receive treatment after discharge. Also ensuring that completion of all recommended follow-up care as outlined in the discharge planning process, including having a primary care provider visit post discharge, that should be completed as well. Again, to ensure that for members who need that additional care coordination support post discharge, that they are assessed for eligibility for ECM, CCM and community supports, and referred within a 30-day post discharge timeframe.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Bonnie Kwok – 00:08:27	Last but not least, moving to the right, our green bucket here for lower risk members. Plans must have a staffed or dedicated telephonic transitional care services team for a minimum of 30 days post discharge. The purpose is to make sure that a member can complete that primary care or ambulatory visit, post discharge and have a medication reconciliation done, and also have access to staff who can answer their questions for their transitional care needs. Again, to ensure that for those members who may be eligible for ECM, CCM and community supports, that they are screened and referred as appropriate. Next slide please.
Slide 12	Bonnie Kwok – 00:09:16	We're going to jump into our discussion for our three priority areas for 2024. Our goal is to provide technical assistance, especially for Medi-Cal managed care plans, and our goal for this year is engagement with key stakeholders and subject matter experts to really learn more about best practices or emerging or innovative practices, as well as opportunities for improvement in the existing transitional care services policies. So we're hoping that we can hear from you all today as Population Health Management Advisory Group members to inform us on where we can strengthen and clarify our transitional care services policies in the following three priority areas, and how transitional care services can also support the increase and enhanced processes for referrals to ECM, CCM and community supports, as well as other services that our members may need. Next slide please.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Bonnie Kwok – 00:10:35	These were the three areas that I was referring to for 2024 that are our priorities of focus. In no particular order, the first is making sure that our members who are discharged from facilities have a primary care follow-up. Secondly, ensuring that there are smooth transitions into and out of skilled nursing facilities or long-term services and supports. Lastly, tailoring transitional care services to our birthing populations as, again, lifting up that birthing individuals. So, pregnant and postpartum, up to 12 months postpartum, are considered high risk for the purposes of transitional care services. How can we tailor these services to support these individuals as they transition from pregnancy to postpartum and also emphasizing that vulnerable period from the time of delivery to that fourth trimester? Next slide please.
Slide 14	Bonnie Kwok – 00:11:46	We have two discussion question slides. This is the first of two. The focus for these questions are really around those priority areas that I've mentioned. Primary care follow-up, skilled nursing facility, long-term care facility and birthing population. We'll start with primary care follow-up in blue. So, knowing that it's important to follow-up with the primary care providers post discharge for both high and lower risk members, how do we ensure that we could share some of these best practices to engage members, primary care providers, and primary care support staff in this follow-up post discharge? I'm going to pause there and really hope that we can hear from you all on your thoughts and recommendations on engagement. Caroline?
Slide 14	Caroline Sanders – 00:13:21	Hi, can you guys hear me?
Slide 14	Bonnie Kwok – 00:13:24	Yes, we can.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Caroline Sanders – 00:13:25	Great. I'll just make a general comment. I didn't see this specifically addressed, but I think obviously language access, language assistance is going to be really important for members. So it's not just the communication between the provider at the hospital and the doctor, the PCP, but actually with the patient to understand what's happening, that they need to call their doctor or that they should be hearing from the doctor, et cetera. So, it'd be nice to have that called out a little bit more in some of these examples just to really put that fine point, that communication is also with the patient in language. It could also be in sign language or whatever that looks like for that patient. But if the patient doesn't understand what follow-up will be happening or they don't know that they should expect a call or that they should call their provider, then that could be a missed opportunity. Thanks.
Slide 14	Palav Babaria – 00:14:47	Caroline, thank you for calling that out explicitly. We agree, I think having it be highlighted in these examples will help it stay centered and we can also take that back. I think as we're looking at the key performance indicators for transitional care services, we absolutely intend to not only stratify some of those indicators by race and ethnicity, but also by primary language, because we recognize there are gaps in the health education and navigation that is really critical on the member side, as you pointed out. Definitely needs to be done in a way that is class compliant and we intend to measure that.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Daniel Calac – 00:15:31	Hi, I can't find my hand emoji for my hand, so I'm just going to jump right in there. So, hi. There it is. I see it now. So I think one of the biggest issues is having some familiarity with the services once they're in their homes. So I know for us it's difficult in a rural area where those services can be, how far they can go out in the community. Many times they do it by zip code, whether it be nursing facility or skilled nursing, PT, hospice, palliative care, any of the services that are going out to the community, even home visits, if it's a zip code, then they usually just wall off those services and they just don't go there. Sorry. I think from that side of it, it's important to know how far and where these services will actually end up going because otherwise they're stuck with no services and that's often the case, especially in some of these rural areas.
Slide 14	Palav Babaria – 00:16:46	Thanks Daniel. I also want to lift up some of the questions in the chat. So Tim, I think your question is studies have shown some effectiveness with early discharge follow-up clinics. Could these specialized clinics be considered a proxy for a PCP follow-up? So I think we've been thinking about this in a few different ways and welcome our advisory group to comment as well, where certainly for high risk members who need that post-discharge seven day follow-up because there are critical time-sensitive pieces that need to be followed up. That key performance indicator is agnostic to the provider type so that some urgent care or specialty care, or whatever the right care is, as long as it's provided within seven days, counts for numerator compliance for that measure.
Slide 14	Palav Babaria – 00:17:33	But I do think we also, in addition to that, recognize that there is clear evidence documenting that long-term engagement with a primary care provider actually has a mortality benefit. Not that that short-term follow-up valuable, it absolutely is, especially for certain patients, but that it's not a substitute for having a primary care provider on an ongoing basis. So I think it's a both end answer to your question, but welcome feedback from our advisory group if we should be thinking about that any differently. Takashi, go ahead and then we'll go to Katherine after that.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Takashi Wada – 00:18:26	Oh, great. Hi. Yeah, so we are piloting some discharge clinic projects with a couple of our hospitals and our preference is always going to be to try to connect back with the primary care provider. There was another comment I think I saw about delegating transitions, but here at IEHP, we're doing this ourselves with our own multidisciplinary teams. So we have a single point of contact, but it's really to an entire team that's made up of a nurses, behavioral health, social worker, pharmacist, then we have a community health worker that's embedded into the hospitals. They're really the ones that are interacting with the member and then trying to connect them back with the PCP, helping to schedule the appointment. Then we follow-up after the scheduled appointment to see if the member actually went and received the care. But because we do have some challenges in certain areas around PCP access and getting that in a timely way, we are piloting, as I said, with a couple hospitals and jointly funding these discharge clinics. So, we'll be tracking that data and seeing if there are any differences in longer term outcomes.
Slide 14	Palav Babaria – 00:19:44	Thank you for sharing and I'll be really curious to see that data as soon as it's available. Katherine.
Slide 14	Katherine Barresi – 00:19:53	Great, thanks. Hello everybody. Sorry my camera is protesting right now, otherwise I'd smile and wave. But just a couple of things. With regards to best practices in that first bucket, I think one of the things we can really think about is leveraging data and systems. So for example, notifying our primary care network via our provider online portal of when their members are admitted and/or discharged and making those reports timely and available.
Slide 14	Katherine Barresi – 00:20:16	So in addition to systematic ways, there's also incentivized ways. Where the health plans have quality improvement plans that include post-discharge follow-up to incentivize primary care for readily and proactively prioritizing their members and their patients for timely discharge and follow-up is also two other best practices, other than direct managed care level intervention, I think is one thing to call out.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Katherine Barresi – 00:20:41	Secondly, with regards to the bucket of the skilled facilities and those transitions, a huge component to this is buy-in and engagement with the facilities, their level of education and understanding as part of a continuum picture and not just a siloed business model per se, that I think that they're part of a broader puzzle for patients and getting their buy-in with regards to either having staff embedded, making these same reports available via an online portal, and holding joint accountability for the discharge planning and it not just being an interim place until they become custodial or something like that, as well as a screening place for members that qualify for enhanced care management.
Slide 14	Katherine Barresi – 00:21:25	With regards to the third bucket for the birthing population, what has been shown time over time is that mom and baby have appointments on the books before they leave the hospital. So, it is crucial that when babies deliver that either managed care plans or systems teams and people have bidirectional information sharing so that way the appointments are scheduled before they actually leave the hospital.
Slide 14	Katherine Barresi – 00:21:49	So, those are just some best pieces that I really wanted to call out. The other two components are when we think about transitioning settings, I also think that we need to think about folks moving in and out of substance use residential treatment as a type of transition and a type of vulnerability, especially since those with SMI and SUD are part of the ECM population of focus. Just wanted to call that out.
Slide 14	Katherine Barresi – 00:22:13	Then lastly, as part of our NCQA health plan accreditation, transitions of care, as you know, is a component of a pop health strategy within NCQA accreditation. So wanting to put it out there to the department to think about plans that have robust TOC processes or TCS processes in place, whether deeming or aligning those KPIs would be super helpful.
Slide 14	Bonnie Kwok – 00:22:39	That's really helpful, Katherine. I just have a clarifying question for your suggestion around the appointment scheduling prior to discharge, especially for the birthing population. I'm curious if you have recommendations on following up on whether members have made it to their provider follow-up visits post discharge and how you're tracking that.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Katherine Barresi – 00:23:11	So there's a couple of different ways and models in which partnership is doing this today, but in terms of tracking the appointments, whether it's actual chart review, case review, claims review, data review, it depends on the moment in time that you're measuring and what you're looking back at to validate that. So that's, I think, thing one. Thing two, with regards to the real-time appointment making, I will say it also depends on the model. So for example, if you're contracting with a hospital system that has an embedded clinic within it, that's a lot easier, and that's a different way of tracking that information versus let's say a standalone hospital center, like a tertiary care center where somebody is returning back to a rural area and an FQHC.
Slide 14	Katherine Barresi – 00:23:51	So I'd say that Bonnie, in that there's many ways of tracking that. I don't think that there's a right or a wrong way. The other thing that I would add to this, especially for the birthing population, is that the who in providing the TCS is equally as important as those follow-up appointments. We've had models and different programs in the past here at our health plan where we've had health plan embedded staff, where we've had pilot programs with hospital staff, where we've had primary care staff embedded in hospitals. We've played with all of these different approaches and it really just depends on the population and the community and the hospital, to be frank.
Slide 14	Bonnie Kwok – 00:24:35	Thanks Katherine. Geoff.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Geoff Leung – 00:24:38	Thank you. Just going back to the first bucket, thinking about the required follow-up for high and low risk members, and I think this goes along the theme of the multidisciplinary teams that we've been hearing. One question I have is as we're starting to broaden the elements that we're addressing and move upstream and think about social determinants of health, I wonder if it always needs to be a primary care provider to help with that follow-up. We're seeing that more and more the issues that we're actually trying to address are actually not necessarily those things that fall within the wheelhouse of a typical primary care provider. So just as we think about moving upstream, would it make sense to broaden that group that can help with the follow-up so that it doesn't always have to be a primary care provider, especially if we have a shortage there. Yeah. Thank you.
Slide 14	Palav Babaria – 00:25:32	Thank you so much Geoff for lifting up that feedback. Absolutely, if others of you have thoughts as we think about whole person care, and I saw some comments in the chat from Kim Lewis as well, really thinking about the role of the enhanced care managers or other community supports or other teams and interventions to address the social drivers of health is critical, so we can work to lift up some of those best practices.
Slide 14	Palav Babaria – 00:25:56	I will reiterate though that the evidence that the need to have a primary care provider is well documented in the evidence that supports this, that drives a mortality benefit and is also a disparity that we are actively trying to address. So in California, Medi-Cal members are less likely to have a continuity relationship with a primary care provider than commercially insured populations. That is a disparity gap that we as a department are actively trying to close. So there's definitely additional support that is required and needed, but we do not see it as a replacement for needing a PCP who at the end of the day is the one that will ensure certain preventative services are provided to that member.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Bonnie Kwok – 00:26:40	Just to add on or address Kim's question in the chat about additional clarity on who's responsible for follow-up with a member and delegation, sub delegation to plans in the role of physician groups. She also talked about warm handoffs to assist with these follow-up appointments rather than having that expectation of follow-up, just be the sole responsibility of the member, and said, is that the role of ECM? Yes, that is definitely the role of enhanced care management. I don't think I mentioned it in today's discussion, but if a member is enrolled in ECM or CCM, that ECM or CCM lead care manager will be their transitional care services manager as well, seeing them through this transitional period and will help them address a lot of the social drivers of health concerns like transportation, childcare, et cetera. That is the role of that TCS lead care manager. That's why we want to make sure that members are screened to see if they are eligible for ECM, CCM and community support services.
Slide 14	Bonnie Kwok – 00:28:04	I think that we've just really broadened the discussion beyond the first bucket of primary care follow-up. We also have skilled nursing facility and long-term care transitions as well. How can members be best supported to have timely discharges and thrive in the community? And what are the most critical supports for members and how can plans of facilities ensure that those are in place before they are discharged? So really any of these categories we would appreciate additional feedback on.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Kim Lewis – 00:29:09	Yeah, just thought I'd make an oral comment on this. So I think one of the keys to these facility related transitions or levels of care transitions is really planning in advance for discharge from the day of admission. To me, that is the critical way that this happens. It's not like this person's ready who's picking them up day of, or how do we get them where they're going without any communication. It's really saying on day one when you're there, this all needs to start. So there's a very smooth transition and clarity around who needs to be following up and doing what because that's not really what happens. It really generally is just sprung on people. Hospital discharges are like, somebody needs to come now and get them. So I do feel like that's really the key to this is really early and often reminders of where that process starts and when it starts rather than waiting for the time of discharge.
Slide 14	Bonnie Kwok – 00:30:07	Thanks, Kim.
Slide 14	Amy Salerno – 00:30:13	I just want to bring up a comment in the chat that's somewhat related to this SNF and skilled nursing facility. Long-term care too is the to consider that there be staff embedded in the transitional care settings. For example, the SNF or long-term care, this is by Heather Summers, and how the handoffs occur from ECM to PHM when appropriate in the primary care follow-up to identify champions within the office. So I think really elevating the partnership between MCPs and long-term care facilities. I think that was talked about earlier and then there was another chat just asking the question about how do you do that. So just raising those two comments in the chat if advisory group members would like to comment on the thoughts on those partnerships and the best way to do that.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Geoff Leung – 00:31:58	Thank you. I have a comment and question that I think relates to that second and third bucket. I'm thinking from a public health perspective with the goal to have MCPs and LHJs work more closely together. I wonder if there are opportunities in that second and third bucket, for instance, with the birthing individuals, a number of LHJs have MCAH programs that could dovetail and support this type of work and as well as public health nursing programs that could help the second bucket. So I wonder how you've thought about that and if there are mechanisms through which public health might either be able to support that work or even be reimbursed for that work. So, just a thought. Thank you.
Slide 14	Bonnie Kwok – 00:32:51	Thanks Geoff. That's something that we're definitely working on, encouraging and trying to bridge the work that both LHJs and managed care plans are doing, for example, through the comprehensive perinatal services program, black infant health programs, home visiting programs such as the nurse family partnerships. So thank you for lifting that up. We are in active discussions on how we can partner together rather than work in silos and help these members have access to those services. So, thank you for raising that.
Slides 14-16	Bonnie Kwok – 00:33:41	I'm going to transition to our next set of discussion questions and really welcome follow-up if you have additional thoughts via email as well, and we can drop that in the chat. If you can forward two slides. We've had some discussion already about referral pathways to enhanced care management, complex care management and community supports. We've heard from discharging facilities that sometimes it is challenging to identify which members are enrolled in these programs. So, we'd love to hear from you all, how are members currently engaged in the referral and enrollment and screening process for ECM, CCM or community supports, and how is this information shared between plans and discharging facilities about members' eligibility? Are there any practices that you can share with us?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Tangerine Brigham – 00:35:06	Hi, this is Tangerine Brigham. Can I ask a clarification? When you're talking about the discharging facilities, you're talking about facilities that might not be affiliated with our delivery system. Is that correct? Because our health plan does have access to our EHR and does have this information. So if you could just clarify that, that'd be great.
Slide 16	Bonnie Kwok – 00:35:33	It's both. I think it works for both. If you can speak to both, that would be great, Tangerine.
Slide 16	Tangerine Brigham – 00:35:42	Yeah. Well, for our own facilities, we receive a file from our Medi-Cal managed care member health plan on a monthly basis. That information is provided and updated to our EHR so that information is available. But also because our health plan has access to our EHR, they're able to see if a patient has a primary care visit scheduled post discharge. If they are not, we have a system where our health plan has the contact information for our wellness centers and our specialty clinics to help schedule those visits. I will tell you that information, however, is not available for someone who might be discharged from a non AHS, Alameda Health System, facility.
Slide 16	Tangerine Brigham – 00:36:51	So I do agree that that is a challenge because we may not all share the same EHR, but one of the things we can probably think about doing is many of us are on Epic, at least in the Bay Area, and trying to see whether or not Epic Care might be a mechanism to provide that information. We haven't had those conversations yet, but you're shaking your head like I should have had them a month ago or two months ago.
Slide 16	Palav Babaria – 00:37:28	We know you'll get right on it, Tangerine. One follow-up question on that, so the information you're receiving from the plan, does that include non AHS assigned members? If a member is hospitalized at an AHS facility that you're discharging back to their community-based primary care, how are you all screening for ECM, CCM and community supports eligibility for those individuals?
Slide 16	Tangerine Brigham – 00:37:52	It's a great question, Palav. I don't know, I'll have to check with Hannah and team on that one.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Palav Babaria – 00:38:04	Yeah, and I'll also lift up just, Geoff before we go to you, Tim's comment in the chat about considering that members may refuse services for a good reason. Absolutely. So I think this is why in all of our assumptions we're not going to get to 100% penetration rate for ECM and complex care management and community supports because there will always be individuals who refuse and that is absolutely their choice in their right early feedback though from the data we do have has shown that we have widely disparities and differing rates of acceptance of these programs. They differ from, not who's eligible, but who is accepting these services by race, by ethnicity, by primary language, and by plan and geography and even by outreach.
Slide 16	Palav Babaria – 00:38:49	So, often that refusal is more reflection of how outreach is done, how it is culturally and linguistically concordant, what trust the person who's doing the outreach has with that member. So separately in our ECM and community supports work, there's a lot of lessons learned about how you can decrease refusal rates and really increase engagement with our members. That is definitely one of the things we'll be driving for in this work stream as well.
Slide 16	Amy Salerno – 00:39:20	Phebe, I think maybe you were... Unless Geoff, I don't know whether your hand is newly up. I'm sorry, Geoff, did you have another comment?
Slide 16	Geoff Leung – 00:39:33	I don't have another comment. Sorry. You can take my hand down.
Slide 16	Amy Salerno – 00:39:36	Okay. Then Phebe, I don't know if you want to go next and then I have a comment in the chat to add after you.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Phebe Bell – 00:39:44	Yeah, and I was late getting on the call, so I am positive I missed some critical context. But from what I've heard, we run a ECM program in our behavioral health department and behavioral director. So I'm more understanding from the point of view of getting referrals and how that's working on that end. I would just highlight a couple of challenges that we've run into. The bulk of our successful ECM work is where our team finds people and engages them and then generates a referral versus a referral coming from the plan. At this point, they have very little insight on a person by person basis around needs, particularly people experiencing homelessness, people who have complex needs, they typically haven't had the information to be able to see that from their end and then generate referrals.
Slide 16	Phebe Bell – 00:40:38	Then I'd say the second issue is there are a number of multi-county or statewide ECM providers that just put their hat in the ring everywhere and really don't have an on the ground presence. So the active engagement piece of it, particularly in an embedded sense of being a part of community and knowing resources and where to find people who might be using what services and whatnot isn't really there. So I think sometimes outreach people and spend a lot of time with them and then find out they've been assigned to somebody else that they've never met with or don't know. So managing that piece of what does it look like to sign up to be an ECM provider versus actually being that provider and being present in the community and having boots on the ground as it were, like actual humans doing the work in that community or county.
Slide 16	Bonnie Kwok – 00:41:32	That makes sense Phebe. Making sure that ECM provider that's communicated to the plan and then back to the provider knowing who's really taking the lead and taking ownership in the care for the individual. Does that fit into what you were sharing?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Phebe Bell – 00:42:00	Yes, definitely. Then I think some of it's just a little bit of a work in progress or whatever as data sharing happens better and as plans get more insight into the complex needs of people that are their beneficiaries, there'll be better capacity to make good referrals and not just rely on referrals coming up from the community level or whatever. So, that part is hopeful down the road.
Slide 16	Bonnie Kwok – 00:42:26	Thank you. Takashi. Are we short on time Amy?
Slide 16	Amy Salerno – 00:42:33	No, I was just going to raise up from the chat real quick. Yvette Wilcock added in a question/suggestion about the possibility for the ECM enrollment and eligibility information to be shared during the utilization review process as a way to increase identification of members who might qualify for these services. As a suggestion in the chat, I just wanted to raise that up. Then Takashi.
Slide 16	Takashi Wada – 00:43:09	Yeah, sure. Just real quick, we do have ECM enrollment on our provider portal and we are enhancing our health information exchange. We use Manifest MedEx to help us with a little bit more data sharing, uploading care plans and things like that so that they're accessible.
Slide 16	Takashi Wada – 00:43:30	But I would like to also echo Phebe's comment around having people with local knowledge of resources like physically in person. So we've had a lot more success in terms of ECM acceptance when the member is obviously in the hospital. If we can get to them with a community health worker in person before discharge and explain what ECM is, I think that's the point at which they would be most likely to accept those services. We haven't had as much luck with some of our other vendors that are virtual that don't know some of the local resources or they're just cold calling off of a list. So I would definitely agree with somebody boots on the ground, knowledgeable about resources, making that connection in hospital. Then hopefully handing off to the same team, but handing off to another ECM team is fine, but making that connection in person.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Bonnie Kwok – 00:44:28	Thanks Takashi. Really lifting up those main tenants that we try to emphasize in enhanced care management where it's in person and providing that continuity. I think Katherine for the last comment and then we are moving on to community reinvestment. Katherine.
Slide 16	Katherine Barresi – 00:44:52	Sure. Thanks Bonnie. Just one quick comment, and I don't think that this is necessarily an artifact of the existing policies or processes or innovation. I think the ECM benefit targets nine different populations of focus for both adults and children. So you're talking about 18 different populations with discharge planners that are quickly at the bedside just trying to move heads out of beds. So I don't think it's had the time yet to really permeate into common practice so that they are readily identifying this is a partnership person or this one belongs to Contra Costa Health Plan, or this belongs to Alameda Alliance or San Francisco. They definitely qualify for enhanced care management, it's not socialized yet. I just think that we need to be honest about that and I think that we need to know that as getting to the social workers at the bedside and the case managers at the bedside, it is a forever education process, forever. So programs and benefits and that provider space and holding education for them it's never just a one and done. So, I echo that it's going to be a forever education piece.
Slide 16	Palav Babaria – 00:46:07	Katherine, can I just ask one follow-up question? Everything you're describing makes sense. Have you seen any differences between the low risk versus high risk members for TCS given that the high risk ones have a dedicated care manager, has screening and uptake of ECM and CCM and community support's been different in that high risk group or is it a universal problem?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Katherine Barresi – 00:46:28	No, I think again, it comes down to the relationships. So in a low risk one where it's just we're making it available, very little uptake engagement or true robust activity. But in that high risk populations, the hospital discharge planners where we have extended length of care meetings weekly with all of our 50 plus hospitals and talking about our members who are having difficulties getting home or their next level of care, it's in the forming of those relationships with the hospital staff where we began to crosspollinate resources, ideas, what's working. More importantly, to what Takashi said and what Phebe echoed, we've had pilots in the past going back into 2016 even. We got an award from you guys in the Department of Public Health with regards to our embedded model where we had planned staff assigned in hospitals talking to members.
Slide 16	Katherine Barresi – 00:47:21	There is something to be said for talking to somebody at the bedside and being there with them at their kitchen table when they go home. So working with the hospitals to better readily identify, we've talked about enhanced care management, we talk about community supports, but until they see it actually working for the patient and the patient's not coming back, that's where the validity is coming in. They're like, oh, well that thing actually worked. We should call partnership again. We should call Joe again, we should call Susie again. So right now I think it's still very much conceptual and given the different layers and options, I think it's just a lot.
Slide 16	Palav Babaria – 00:48:02	Thank you.
Slide 16	Bonnie Kwok – 00:48:10	Thank you. I think we should transition to the next topic, but Al, sorry if you don't mind dropping your question in the chat, I'll be happy to respond to that. I've also dropped our email address if you have additional thoughts, please reach out to us. Thanks.
Slide 17	Palav Babaria – 00:48:41	Great. I know there's probably a lot more discussion to be had, and really appreciate all of the comments that have been coming in through the chat and we'll definitely take that back and really excited about the potential of leveraging CHWs in some of the space as well as lifted up by several of our panelists.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Palav Babaria – 00:48:57	So now we're going to pivot and give you all a preview of the community reinvestment policy. Really again, we're at the start of this journey for the community reinvestment policy. So a lot more details to come, but your early feedback will be much appreciated. We can go to the next slide.
Slide 18	Palav Babaria – 00:49:16	So a few just reminders and context before we dig in. As I think all of you are tracking under the new 2024 managed care plan contracts, MCPs and their fully delegated subcontractors, this plan to plan delegation, who have a profit, so positive net income, are going to be required to allocate 5% to 7.5% of their profits towards investment in local communities. We are working on finalizing the APL and we'll be releasing that through our normal public comment process in quarter two of 2024. This is one of many stakeholder engagements that we'll be doing to really start to get all of your feedback before the APL release. We can go to the next slide.
Slide 19	Palav Babaria – 00:50:02	Thank you. So to dig in a little bit more, anyone who has a positive net income, so if you are not making a profit, this does not apply to you, will be required. If their profit is equal to or less than 7.5% of their contract revenues, then they have to allocate 5% of their profit to the community reinvestment. If their annual net income or profit is greater than 7.5% of contract revenues, then those plans have to allocate 7.5% of their annual debt income to community reinvestment. Then as mentioned earlier, this also applies to fully delegated subcontractors as well. We can go to the next slide.
Slide 20	Palav Babaria – 00:50:45	In addition to that base 5% to 7.5% profit investment in community reinvestment, those plans that are not meeting DHCS's quality expectations have to dedicate an additional 7.5% of their net income to community reinvestment. So the way we are defining that is we tier annually after we got the EQRO validated quality scores on our managed care accountability set. We assign health plans into tiers based off of how many MCAS measures they failed to hit the DHCS target, which is currently the national 50th percentile.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Palav Babaria – 00:51:22	So, those plans in tier two and tier three annually would be subject to this additional 7.5% community reinvestment. Again, this only applies if there's positive net income or profit for that plan. The 7.5% would be added to the other 5% to 7.5% allocation. So, plans who are not meeting their quality targets could have up to 15% of their net profit be reinvested in the community reinvestment policy. Then for those plans that are subject to this quality based additional reinvestment, the entire pot of their community reinvestment would need to be focused on those activities that directly improve quality of care for members, which is why they were in this tier to begin with. Go to the next slide.
Slide 21	Palav Babaria – 00:52:17	So before we move on, we'll open it up to our panelists. Are there any high level questions about these two buckets of the base 5% to 7.5% profit allocation or the additional quality component for those plans who don't meet the quality targets? Before we get into what the actual community reinvestment looks like. Tangerine, we'll start with you.
Slide 21	Tangerine Brigham – 00:52:38	I put my question in the chat. So what's the relationship between the tangible net equity requirement and this provision? When I think of a positive net income, I think of the rates that the state provides, the health plans is the state in developing its rates, either assuming that there is either sufficient tangible net equity that enables the health plans to be able to do this? Because there seems to be conflicting policy initiatives around rate reductions, but then on this side, the assumption that there's profit and therefore it can be reinvested in the community.
Slide 21	Palav Babaria – 00:53:36	Great question, and I'm going to phone a friend and see if any of our finance colleagues are on the call because they own the fiscal pieces of this policy. What I do know from the quality perspective is that all of our plans do filings with us, and there are, not all, but many plans who do post a profit at the plan level every single year. So that is really the profit we're talking about. So it's not at the provider level, it is at the health plan level. Yes, there are plans who are maintaining profit every year, but any of our CRDD colleagues on today?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Erica Johnson – 00:54:07	Hi Palav, Erica Johnson with CRDD. Thank you for the question. So we are currently working through the details of how we're going to be defining what net income is included within that. So we'll have more guidance related to that within the APL, but we are really looking at it to just be based on the plan financial reports that are provided to us either, quarterly or annually. So we're going to be leveraging those reports in order to determine what net income would be subject to the requirements of the community reinvestment obligations. Hopefully that helps answer your question.
Slide 21	Tangerine Brigham – 00:54:42	Yeah, thank you very much.
Slide 21	Erica Johnson – 00:54:44	Yeah.
Slide 21	Palav Babaria – 00:54:49	Any other questions on this section? Geoff, go ahead.
Slide 21	Geoff Leung – 00:55:02	Thank you. I know we might get into this a little bit later, but I am wondering, I see, first of all, I think I really appreciate the upstream approach to looking at community investment to helping improve measures. One question I have is if things are linked too closely to clinical quality measures, could that limit the types of things that people are thinking about? Can we think of a broader set of measures as we think about community transformation in addition to clinical indicators that might also be a proxy for improvement in community health or wellness, if that makes sense? So again, with the emphasis on the clinical quality indicators, it may limit the types of community investments that you're able to do. So just thank you for that.
Slide 2	Palav Babaria – 00:55:52	No, thank you for lifting that up. I think we'll get into that more because there are other avoiding duplication factors that we will need to take into consideration with this policy as well. So let's go into the next slide. I think folks are headed that anyway.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Palav Babaria – 00:56:08	So we wanted to walk through the departments for high level guiding principles that we really want to anchor all of the policy decisions in. So first and foremost is really making sure that all community reinvestment activities are targeting health equity and actively reducing health disparities and addressing social determinants of health for Medi-Cal populations.
Slide 22	Palav Babaria – 00:56:31	The second guiding principle is really for those MCPs that do not meet the minimum quality performance standards that these activities are specifically linked to improving healthcare quality. Geoff, I think as we get into the discussion, we can talk about where do we want collectively to target that? Is that more upstream? Is it downstream? Is it a mixture of those? And that there's flexibility, but we do want to tie all of these investments very directly to both equity and quality.
Slide 22	Palav Babaria – 00:56:59	The third guiding principle, which many of our plans do today, but this would make it a statewide expectation, is that how these community investments are made are directly informed by and engaged with the local community that they're designed to benefit. So these are not decisions made in a vacuum, but that the community advisory committees that are now required that every plan is supposed to have as a part of the new contracts are actively looking at the recommendations and advising on where the community reinvestment goes. Then you all are tracking from our previous meetings the new population needs assessment process that we'll be launching, where managed care plans are partnering with local health jurisdictions on their community health assessment process. We also expect that these investments tie back to that local community health assessment process and improvement plan that comes out of that. So that at the end of the day, the investments are really guided and centered by what the community's needs are as defined by the community.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Palav Babaria – 00:58:03	Then the fourth guiding principle, which is really again from a fiscal and avoiding duplication process is that the community reinvestment activities cannot be duplicative of Title 19 and 21 funded services. So anything that is already covered by the Medi-Cal program, essentially, this cannot be used to supplement or expand that. That still needs to be covered by Medi-Cal. This really covers activities that are not separately covered by Medi-Cal. Then CPS can't claim existing investments towards the community reinvestment obligations, but can use funds to build upon ongoing investments as they submit their plans moving forward.
Slide 23	Palav Babaria – 00:58:47	Then these are the five buckets of categories that the department has envisioned of what would count towards community reinvestment. So the first bucket is really cultivating neighborhoods and built environments, so thinking about the physical infrastructure of communities and neighborhoods, housing, improving clinics, neighborhood revitalization, parks and green spaces. The second bucket is really cultivating a healthcare workforce, which we recognize is really critical. Again, many plans are already operating in this space. But thinking about training programs and pipeline programs to address workforce shortages, providing additional staffing and support to healthcare providers and other entities and paying for that staffing. The third bucket is cultivating wellbeing for priority populations. So this is really, again, to lift up and double down on the critical populations that the current Cali initiatives are designed to support. So thinking about our foster and other child welfare involved children and youth justice involved populations, maternal child populations and individuals experiencing homelessness and thinking about additional support that is not currently covered via CalAIM programs or the Medi-Cal program that these priority populations need.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Palav Babaria – 01:00:03	The fourth bucket is cultivating local communities, so thinking more broadly about community improvement, so initiatives like educational initiatives, employment and training programs, wellness initiatives to address social isolation. Then the last bucket is going to be more specifically focused on the health outcomes, both reducing healthcare disparities as well as improving quality outcomes. Again, these are not services that are explicitly provided by Medi-Cal, but all of the other things that need to happen to achieve high quality equitable care. That last bucket, number five, is where those plans that have to do the additional 7.5% investment because of the quality piece and failing to achieve quality targets where their efforts would be focused.
Slide 23	Palav Babaria – 01:00:52	So this is really high level we recognize, I think feedback on if you have any questions or concerns about the guiding principles or these buckets or just ideas about what would you like to see in these buckets. I think to call out the explicit tension is how specific do you think the department should get in describing what is in these buckets and providing more guidance to the plans versus leaving it a little bit higher as it is here and flexible knowing that plans will be submitting their investment plans to the department for review and approval once the policy is implemented. You can go to the next slide, so maybe we can pull down the slides for the discussion piece and if folks want to weigh in on what you think.
No slide	Palav Babaria – 01:02:07	Cary, go ahead.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No slide	Caroline Sanders – 01:02:10	Thanks, Palav. Yeah, just excited to see more details on the community reinvestment piece and just to see how this is coming together. I think that alignment piece is going to be really important. While we definitely I think want to see how improvements tie back to quality and equity goals at DHCS, we would want to see alignment with the CHIP and the CHA processes, and we also feel like the decision in terms of how to invest the funds really should rest with the governing body of the CHIP and CHAs, the folks that are working on that, not just the managed care plan. So I think really leaning into these regional structures that, and it's another conversation, but hopefully and ideally are co-governed by community and have a strong community voice is where we would love to see some of the conversations going. So just not necessarily, well, maybe it's a question too, if there's anything more you can say about that piece and a comment. Thanks.
No slide	Palav Babaria – 01:03:38	Thank you, Cary. Definitely hearing the recommendation for what the governance structure looks like for community reinvestment, which we'll take back and discuss. Katherine, why don't we go to you next and then Amy.
No slide	Katherine Barresi – 01:03:57	Great, thanks. Just in terms of an initial gut check, we prefer the flexibility just given the broad range of our network and our communities that we're supporting. Just even in this early CHA/CHIP work, I can tell you there's where we would love to have similarities and alignment. If you've seen one community, you've seen one community, so appreciate the flexibility there. The second is just again with regards to timing. When is this policy slated to start?

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VISUAL	SPEAKER – TIME	AUDIO
No slide	Palav Babaria – 01:04:23	It will apply to profits for calendar year 2024, which is the first year that this policy is applicable under the new contracts. Obviously I think we recognize that both the financial summaries as well as quality scores, which will dictate that additional 7.5% in calendar year 2024, there's a lag time so that information doesn't become available until 2025. So we still have some time to plan and more details about the specifics of when in 2025, some of those allocations will be finalized, et cetera, will be forthcoming in the APL and in further policy guidance.
No slide	Katherine Barresi – 01:05:00	Perfect. Thanks.
No slide	Palav Babaria – 01:05:01	Go ahead Amy.
No slide	Amy Scribner – 01:05:06	Thanks. I agree with Katherine. I'm leaving it a little bit broad in the categories. I think that gives you the opportunity for it to be really a local intervention in your local community rather than more broad and statewide. I'll add in, I think it's really great that you've added in the CAC it going through CAC committees through the plans because that's where we have also a lot of community input. We have a lot of community members on our CAC as well as actual MCP members, and so I think they can help inform and make decisions on what makes sense for the local plan.
No slide	Palav Babaria – 01:05:44	Thank you so much, Amy. Geoff, let's go to you.
No slide	Geoff Leung – 01:05:49	Thank you. I wanted to agree that I think these broad categories are wonderful. One area that I wonder if we can also think about as we think about co-governing is if there's a category or if this is already included in cultivating local communities, but something around capacity building or power-sharing or power building. So if one of our goals is to help uplift communities, which category would that fall into where communities feel like they have a stronger voice to be able to-
No slide	Palav Babaria – 01:06:31	Oh no, I think we lost, Geoff, you still there?
No slide	Geoff Leung – 01:06:38	I am. I don't know if you can hear me.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No slide	Palav Babaria – 01:06:41	Yeah, we can hear you now. I think you got muted halfway through.
No slide	Geoff Leung – 01:06:45	Sorry, I'll back up for a moment. First of all, I think the categories, the broad categories are great. One area, I wonder if it falls under cultivating local communities, is there somewhere where we capture increasing voice or building power or helping communities become more engaged and empowered? If that could be either more explicitly described under one of the categories or if we could consider a category like that, since we know that that's definitely related very tightly to the health of communities. Thank you.
No slide	Palav Babaria – 01:07:26	Really helpful comments. Thank you. We'll definitely take that back and figure out where it fits in or if it needs its own category. Other comments or feedback?
No slide	Caroline Sanders – 01:07:45	Sorry, if I can just, prerogatives, I can unmute, but just a plus one to what Geoff said. Not to be repetitive, but when I look at this list, I don't see that community building piece. If we really are cultivating local communities, it's not just about addressing individual wellness, but actually community health and wellness. A big piece of that is making sure that we're investing in community voice. So I just wanted to say a plus one on that, a strong plus one.
No slide	Palav Babaria – 01:08:27	Thank you Cary.
No slide	Al Rowlett – 01:08:40	Can I just speak to Cary? I think that in many areas there is not a structured community voice in that there it's fractured and it's very grassroots and maybe not as sophisticated to sit at the table. To sit at the table, you have to be present in the discussion, which means you really have to understand the background and all kinds of things. So I wonder if there should be some preparation so that we really can engage those who are smaller, organizations who are doing some of the best work to be present in the discussion, to participate and to want to participate and to feel welcome to participate.
No slide	Palav Babaria – 01:09:20	Thank you so much for lifting that up. Your comment in the chat that is really about real community representation and not just agencies and politics representing community. So, thank you. Peter, go ahead.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No slide	Peter Shih – 01:09:48	Hey, good morning everybody. I think this is great. Embedded in all these categories I think should be some ability to create space to talk about best practices so that we don't need to recreate the wheel. We don't know what we don't know. But if we have an opportunity for folks to see what has worked in other states and other countries to bring that into every bucket so that, again, we're not trying to wheel because others have learned how to work this through. I think echoing, if this is really some de novo new work to bring as many voices to the table as possible, I really do agree that that's important.
No slide	Peter Shih – 01:10:38	I think sometimes when there's selective voices, then it's an echo chamber and people have group think and another voice is so important to add another perspective. To truly achieve this equitable inclusive access to everything, we need to really be humble and open to differences in opinion and perspective. I think that we need to create a safety to have people share their voice and that just because a trained clinician or you're an executive doesn't mean that your voice is stronger than someone who's actually receiving the services or helping someone receive those services.
No slide	Palav Babaria – 01:11:30	Thanks, Peter. Do you have suggestions for how that can be accomplished in the policy side or do you see that as more of a technical assistance and implementation and learning collaborative need for the policy?
No slide	Peter Shih – 01:11:46	Yeah, I think it's all the above to a certain extent. When you look at a board of an FQ, sorry, federally qualified health center, if you look at a board of medical center or board of a health plan, there's a need to have community leaders and also patients in the conversation. So someone with the lived experience of coming up as a vulnerable population and someone who actually has received the services, they can speak to that.

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VISUAL	SPEAKER – TIME	AUDIO
No slide	Peter Shih – 01:12:25	But if they're talking about strategic or operational tactical things, then the patient or the community member should be trained to understand what levers they really do have to make a difference. I think to be sharing with them the data and the transparency of how everything connects and what operational changes are required and what the funding stream is important so that they understand how the machinery works. So I think it's a little bit of all the above that you mentioned. I think it's really important for everyone to recognize that we don't know what's around the corner, very few people can see around the corner. So the more data that we have and the more lived experience and actual patient experience that we share helps better inform the decision making that everyone's leaning into.
No slide	Palav Babaria – 01:13:28	Thanks, Peter. Any other comments on high level preview of the policy?
Slide 25	Palav Babaria – 01:14:07	Okay, I think we can pull our slides up and maybe go to next steps. So I think we touched on a lot of this, but just to lift up, we are actively trying to make sure that the PNA and community health assessment policy, that the new requirements for the community advisory committee is in the 2024 manage care contracts and the community reinvestment policy are synergistic and aligned and that these policies aren't working in silos. So lots more to come. Tangerine, saw your comment that having some visual or map about how these pieces fit together would be helpful. So we can definitely take that back as well. You can go to the next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 26	Palav Babaria – 01:14:53	So things that are coming up, there will be a formal all plan letter that is released about community reinvestment. So that will go through the normal process at DHCS. So a draft APL will be released, which will be open for public comment, and then a final APL will be issued. Once calendar year 2024 is complete, there will be a calculation of what the funding obligation is for each managed care plan based off of both the quality scores as well as their profits for that calendar year. Then all plans will be required to submit a specific community reinvestment plan submission, which DHCS will review and approve. Then once that plan is approved, then the actual implementation of those funds being actually invested in the community can commence.
Slide 26	Palav Babaria – 01:15:41	So there is a little bit of a lag time, obviously, because the data from 2024 will not come in until 2025. Then plans will need to be put together, reviewed and approved. So, we anticipate that the actual funding will start in calendar year 2026 for calendar year 2024 financial profits and quality scores. Go to the next slide.
Slide 27	Palav Babaria – 01:16:09	So I think that is our last slide on community reinvestment. Any other final thoughts on any of our topics today? Cary, go ahead.
Slide 27	Caroline Sanders – 01:16:22	Thanks, Palav. Sorry, just not to be disjointed, but I neglected to comment in the previous conversation on the transitional care piece that I also think as a use case it would be really important to call out homeless populations and how that transitional care is happening with those populations. It's come to our attention that in some cases where homeless folks are discharged from a hospital, people may be reporting discharged at home, which is not accurate and would make follow-up really difficult. So I just want to call out that particular population and how we do that follow-up care and those connections afterwards really, really matters and maybe deserves a little bit more of attention or use case. Thanks.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Palav Babaria – 01:17:34	Thanks Cary. Super critical. So, appreciate you lifting that up. Go to the next slide. One more. So we'll send out all these slides. The entire recording and materials from our meeting today will be posted within a few weeks on our population health management website. Just really want to thank and appreciate all of our advisory group members who joined and then all of you who've attended and really generated a very robust and helpful chat that we will definitely be digesting and using to inform our work in both of these areas. Bonnie, any final words?
No slide	Bonnie Kwok – 01:18:18	I was going to reply in the chat, but just to lift up two quick things. We are working to standardize the authorization and referral process for ECM, for enhanced care management. I think that that's something that John brought up. Someone else, I think it was Beth Hernandez, who raised the question about a small number of individuals accounting for a large number of readmissions. Yes, I don't have the numbers at hand, but that is in line with what we're seeing as well. That's something that we're definitely focusing on across all populations to focus, but particularly for the population of focus for avoidable hospitalizations and ED visits. But thank you for joining us and providing this helpful feedback. I'll pass it to Palav to close us out. If there's anything in particular, particularly for the birthing population, which we didn't do a deeper dive on, if there are certain components of transitional care services that you think we need to make sure that should be specifically called out in our TCS policies, please do let us know. We'd love to hear from you. I'll head it back to Palav. Thanks.
No slide	Palav Babaria – 01:19:43	Thanks Bonnie. I will lift up, Kim has asked in our chat to the panelists any updates on the PHM service, so the PHM service is still going, and we will tee that up for one of our upcoming meetings to share more about the timeline for implementation and progress to date with all of you. So thank you for lifting that up. We certainly have not forgotten it and are furiously working on it behind the scenes. Great. Well, thank you all so much. Hope everyone has a lovely week and we look forward to seeing you next time.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No slide	Geoff Leung – 01:20:18	Thank you.