CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

CALAIM CHILDREN & YOUTH AND POPULATION HEALTH MANAGEMENT (PHM) ADVISORY GROUP MEETING

Date:	October 29, 2024
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Speakers:

- Palav Babaria
- Mary Giammona
- Laurie Soman
- Amie Miller
- Heyman Oo
- Daniel Calac
- Alex Briscoe
- Michelle Gibbons
- Geoffrey Leung

TRANSCRIPT:

13:34:24—Palav Babaria

As we started digging into this work, discovered that our maternity policy is robust, but has really been layered in over decades, often leading to parts of policy that really need to be updated and modernized given advances in clinical medicine and new Medi-Cal benefits and the Medi-Cal transformation happening right now.

13:34:39—Palav Babaria

As well as really building out

13:34:41—Palav Babaria

parts of our model as a result of the 12-month postpartum expansion and not really having sort of well-defined services or clinical pathways for some of those areas.

13:34:51—Palav Babaria

So we're really excited today to check in with all of you and share what we have learned through extensive stakeholder engagement, which I'll cover

13:35:00—Palav Babaria

And sort of what some of the problems are that we are aiming to solve with our birthing care pathway report, which we intend to publicly release later this calendar year.

13:35:10—Palav Babaria

So a little bit just for those of you who are newer to this topic around the state of maternal health in California.

13:35:16—Palav Babaria

While we have one of the lowest mortality ratios, our mortality, maternal related mortality has been rising significantly over the last 15 years, especially during the COVID public health emergency, and the vast majority of these deaths are preventable.

13:35:30—Palav Babaria

I think we can all acknowledge for any of us who either had personal experience or read about some of the devastating maternity related losses that individuals in our state have experienced that

13:35:43—Palav Babaria

such a loss is obviously not just affecting the life of the mother or the birthing individual who's passed away, but really is devastating for the entire family and especially the newborn who is often left behind.

13:35:54—Palav Babaria

We also know that we have deep disparities in our state. So currently, Black pregnant people in California are more than three times more likely to die in pregnancy.

13:36:05—Palav Babaria

or postpartum compared to the right peers and eight times more likely when deaths from pregnancy related cardiovascular disease are considered. We also know that we have payer disparities where individuals on Medi-Cal are almost twice as likely to die than individuals who have other types of insurance.

13:36:25—Palav Babaria

So.

13:36:26—Palav Babaria

without being a Debbie Downer, we are going to go into sort of what we have heard and some of the areas that we are exploring. And as always, we've been open chat. So really invite all of our panelists and attendees to really take, you know.

13:36:42—Palav Babaria

liberal use of the chat to share your ideas, thoughts, and feedback, and then we'll also be pausing for discussion questions.

13:36:48—Palav Babaria

So we can go to the next slide.

13:36:52—Palav Babaria

We can keep going.

13:36:54—Palav Babaria

One more.

13:36:58—Palav Babaria

So we really wanted to cover sort of, you know, again, why are we here? What are we trying to achieve? So the explicit goal is really starting from conception through 12 months postpartum and looking at what are all of the holistic services and the experience that we want our members to have that ultimately will result in reduced maternal morbidity and mortality and closing the racial and ethnic disparities that we have in maternity.

13:37:22—Palav Babaria

in our state. We really want to achieve the six goals outlined here, which are core to our Medi-Cal program. So one, making sure that all of our members have access to all of the services that we have covered for a long time in California. We know that currently those

services, depending on what zip code you live in or what part of the state you're in, may or may not be as equally accessible to all of our members.

13:37:47—Palav Babaria

We also know that there's a lot of work to be done on making sure that our members can access risk appropriate care, again, depending on what part of the state our members live in, making sure that they are being screened and provided the full complement of services they need, and especially for those individuals who need higher levels of care or have more complex needs that that access is

13:38:09—Palav Babaria

easy and support it and people are not forced to make trade- offs between caring for their children, keeping their jobs and getting the maternity care that they need.

13:38:18—Palav Babaria

You'll hear a little bit more about what we learned through our member engagement, but one of the most significant and

13:38:25—Palav Babaria

consistent themes was that

13:38:28—Palav Babaria

Not all of our Medi-Cal members feel respected and heard throughout their pregnancy and postpartum journeys. And we really want to achieve that that is a never event and that everyone is consistently having the most supported, thoughtful experience possible.

13:38:43—Palav Babaria

We also learned a lot through our work that while we have a lot of benefits and services on the books, including new benefits like doulas and community health workers and dyadic services.

13:38:54—Palav Babaria

Many, not most of our members are not aware of all of these benefits that are available to them.

13:38:59—Palav Babaria

We also heard resoundingly throughout all of our stakeholder engagement that the rising toll that behavioral health conditions, both mental health and substance use

related disorders are taking on pregnant and postpartum individuals and really needing robust services and a robust network to care for those individuals and their families.

13:39:19—Palav Babaria

And then we also heard a lot about our fragmented data systems and data silos and really how we need to improve data exchange and partnerships in that domain to make sure that people can get whole person care.

13:39:33—Palav Babaria

And go to the next slide.

13:39:37—Palav Babaria

So the report, we are aiming to publish it before the end of the calendar year, so sometime in December, it will be publicly posted. It's going to have a lot more details on that sort of vision that I just outlined and then provide a lot more information on the stakeholder engagement and what we heard, which we'll be previewing with you today. And then it's going to sort of talk through policies that we are

13:40:01—Palav Babaria

definitely implementing some of those are in progress right now or are being planned to be launched fairly shortly, as well as additional policies that we may explore. The things that are falling into the may explore bucket as opposed to definitely doing bucket are largely because some of the policy changes that we are exploring require additional financial investments from the state or statutory changes or are more complicated and

13:40:26—Palav Babaria

So we'll definitely need partnerships across state departments and maybe contingent on budget authorizations.

13:40:33—Palav Babaria

we can keep going.

13:40:37—Palav Babaria

So to dig into sort of how we've landed where we are today, as mentioned, we started this journey in 2023, knowing that our policy and existing landscape in the maternity services sector is pretty vast and broad and wanting to capture all of it so that we are not just piecemeal solving this problem, but really overhauling our entire maternity policy.

13:41:00—Palav Babaria

to drive towards future state.

13:41:02—Palav Babaria

So we did a landscape assessment of all of those existing policies and initiatives, some of which date back more than 50 years.

13:41:09—Palav Babaria

We interviewed state leaders, providers, community-based organizations, associations, health plans, and advocates to really understand what are the biggest problems that they are facing in their day-to-day work across the state. And as you can imagine, that varies highly depending on what part of the state you're in, especially for some of the rural parts of our state.

13:41:29—Palav Babaria

We then had three work groups, one focused on clinical care, really multidisciplinary teams, including doulas, midwives, OBGYNs, primary care providers.

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As well as social drivers of health work group, which was really focused around all of the other social services that are critical for birthing individuals such as WIC,

13:41:51—Palav Babaria

CalFresh, housing, shelter support, et cetera. And then we also had a dedicated postpartum sub work group, as mentioned earlier, the sub work group was really starting to figure out, you know, we last year, two years ago now, expanded our Medi-Cal coverage to go through a full 12 months postpartum and really defining, you know, what is supposed to happen in that 12 months before we used to only cover services up to 60 days and what is

13:42:15—Palav Babaria

that care model need to look like?

13:42:18—Palav Babaria

And then most importantly, I think, which we'll do a deeper dive on, we engage Medi-Cal members directly.

13:42:24—Palav Babaria

I think as many of you are tracking, we are really trying to make sure that we are centering Medi-Cal members and their voices and experiences and needs in all of our policy design work. So we did a multi-month journey to really understand

13:42:38—Palav Babaria

what are members experiences like and what are their priorities for this transformation.

13:42:43—Palav Babaria

we can go to the next slide.

13:42:47—Palav Babaria

So as mentioned, this is a little bit more detail on what each of those work groups did. The work groups have met multiple times in the last 18 to 24 months. The clinical care work group included representation from all of the entities listed here. I'm not going to read them all out for you. And we're really focused on sort of what is the clinical care that an individual needs from conception all the way through 12 months postpartum

13:43:12—Palav Babaria

cross setting. So that includes what happens in the hospital, in the birthing center, happens in provider offices, or other community settings, but really focused on the clinical services.

13:43:22—Palav Babaria

the social drivers of Health Group, as mentioned, really focused on all of the SDOH needs of our members, including services provided by public health, tribal social service partners, food and diaper banks, and a lot of issues related to housing came up, which we will get to.

13:43:40—Palav Babaria

And then the postpartum one was really focusing again on that expansion period and sort of looking at from the time of delivery all the way through 12 months postpartum, what are the needs of our members and what are the policy gaps?

13:43:53—Palav Babaria

We can go to the next slide.

13:43:57—Palav Babaria

So as mentioned, I think the member engagement is probably one of the most robust that we've done for a dedicated DHCS project.

13:44:05—Palav Babaria

We did deep dive member interviews with six members who were pregnant or postpartum.

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And then we had a series of member voice work groups that were comprised of 20 members who met several times

13:44:38—Palav Babaria

last in the in the spring of 2024. And we're also joined by senior DHCS leadership so that we could hear directly from our members and what their needs and experiences were.

13:44:48—Palav Babaria

We can go to the next slide.

13:44:53—Palav Babaria

The report when it is published, will include a lot more information about what we heard from all of our stakeholders and the member engagement. Obviously, we will be protecting their confidentiality

13:45:04—Palav Babaria

as we had promised to do when we did these interviews, but wanted to take the time to walk through the six sort of major themes that we heard from our members and talk a little bit about how it has affected our thinking and policy development.

13:45:16—Palav Babaria

So you'll see the themes on the left, I think, have a lot of commonalities. The number one theme that we heard consistently across all the members was that

13:45:26—Palav Babaria

feeling respected and heard by their healthcare providers was critical to their perinatal experiences. We had both positive and negative experiences that members shared of how being disrespected and not supported through their journey really affected their health and health outcomes and the converse of when they had very supportive interactions.

13:45:46—Palav Babaria

We also heard that some of our members experienced discrimination in their healthcare encounters

13:45:52—Palav Babaria

sort of agnostic of what phase it was in the perinatal period and the postpartum period. And many of our members really felt connected to their health care providers when they received racially and culturally concordant care.

13:46:04—Palav Babaria

We also heard from our members that there were a lot of loops that weren't closed and balls that were dropped that often when there was sort of screening tests that were done or referrals that were supposed to be made and those results were not communicated to members or the

13:46:20—Palav Babaria

referrals never happened or even just navigating sort of things that the member needed after the birth, such as high quality breast pumps. And there were barriers and issues to getting those. It just engendered a lot of mistrust in the healthcare delivery system and its ability to meet our members needs.

13:46:36—Palav Babaria

On the right side are themes that we heard from our members, and I would say I think those three we also heard consistently from both our clinical and our social drivers of health work groups. So many Medi-Cal members felt like we have a lot of services, but they are fragmented and the onus was on them, often with a brand new newborn baby at home to independently navigate and coordinate all the aspects of their perinatal care, which was often

13:47:01—Palav Babaria

and overwhelming. We also heard consistently that members who needed mental health or substance use support found it difficult to find those services, or if they did eventually find those services, often the individuals did not have experience or comfort levels caring for pregnant or postpartum individuals.

13:47:20—Palav Babaria

And then one of the resounding pieces that came out, especially from the focus groups of numbers, is that many members

13:47:27—Palav Babaria

are not aware of what Medi-Cal covers. And so it was shocking to some of our members that doula services or breast pumps or things like ECM are actually a part of their medical benefits.

13:47:40—Palav Babaria

we can go to the next slide.

13:47:44—Palav Babaria

We also have met with a lot of different partners and have been really trying to coordinate across state partners as well to make sure that our policies and what we are hearing are aligned and synergistic and integrated with other existing efforts because we recognize the problems as we'll walk through in the subsequent slides are enormous.

13:48:05—Palav Babaria

and deep and it really is going to take strong partnerships and a unified vision for us to make a dent and meet the needs of our members.

13:48:13—Palav Babaria

I can go to the next slide.

13:48:14—Palav Babaria

So before we dig into sort of what we heard and what the focus areas are for our report, I'm going to pause there and just invite our advisory group

13:48:24—Palav Babaria

members, are there any questions or thoughts you all have just on the process and who we've engaged and how that I can help clarify before we dig into the policies and focus areas?

13:48:41—Palav Babaria

Mary, see your hands up. Go ahead.

13:48:44—Mary Giammona

Thank you so much. Hi, Paula.

13:48:47—Mary Giammona

How did you select the members, especially the six members you did the deep dive with and then the 20 in the focus group where they

13:48:56—Mary Giammona

specifically different people of color were they uh did you have them in different geographic areas? Were they recommended by different advocacy groups? I'm very interested in how you selected them.

13:49:11—Palav Babaria

Great question. And the short answer is yes to all of the above. And the report will have many more details, but globally, we actually worked with both our clinical and SDOH work groups to sort of get the message out that we were recruiting members and they would be compensated for their time. And so all of the partners, some of whom are on this call who participated in that process really helped get the word out through their

13:49:36—Palav Babaria

community-based organizations and networks and partners. And we received actually more than 400 member applications to participate in this project, which I will tell you

13:49:48—Palav Babaria

was shocking because we did not expect that level of

13:49:54—Palav Babaria

engagement and outreach. And I think the two major takeaways were that one, clearly partnering with trusted partners who are working in communities and we're sitting on our work groups was a very successful recruitment strategy because we could not have gotten that response if it was just DHCS reaching out directly. And that too, clearly this is a topic that really resonates with our members. And I think having

13:50:17—Palav Babaria

personally sat into some of those focus groups and meetings. The degree of vulnerability and honesty that all of the members brought to those groups was really humbling. Unfortunately, the member engagement piece of this work was grant funded and I should have caught out at the front, we are very, very grateful to the Lucille Packard Foundation and the California Healthcare Foundation for funding all of this.

13:50:42—Palav Babaria

work that has supported the engagement, policy development, and eventually the publication of the report. And so we had not anticipated that member response and had a cap on sort of the amount of funding we had to pay for member participation. So what drove the sort of six interviews, six journaling, and then the focus groups was largely the funding in hindsight, having planned for sort of

13:51:05—Palav Babaria

more member participation would have been helpful. We just didn't anticipate the response. And so we will take that into account for future presentations. And then, yes, once we got the 400 applications, we really intentionally selected a diversity of opinions. And so we wanted to make sure that we specifically had Black, American Indian, Alaska Native, and Pacific Islander voices represented because those are the

13:51:30—Palav Babaria

groups that we're really focused on for our birth equity population of focus and closing racial and ethnic disparities, we also intentionally selected members from different parts of the state so that we could get the urban, rural, you know, perspective, as well as different plan models that we could understand, you know, are there differences depending on if you're in an area with multiple health care plans versus a COS model versus a single

13:51:54—Palav Babaria

plan and then also trying to select for people of different ages, because depending on what you know

13:52:00—Palav Babaria

what age you're in and what is this your first pregnancy? Is it a subsequent pregnancy? As well as different parts in their pregnancy journey. So having some individuals who are postpartum, some who were still pregnant and including those who had had miscarriages or abortions as well, so that we could get a diversity of experiences.

13:52:19—Mary Giammona

Great, thank you.

13:52:19—Palav Babaria

Great question.

13:52:24—Palav Babaria

Any other questions on the process?

13:52:32—Palav Babaria

Okay. Well, let's get into the focus areas because I know that is why you all are here.

13:52:39—Palav Babaria

So we can go to the next slide.

13:52:44—Palav Babaria

So I think what we're going to go through is for each of the focus areas, really want to walk through like, what is the problem statement that we heard as an amalgamation of all of the stakeholder engagement, both from our partners, work groups, and members especially, and then talking through at a high level what types of policy interventions we are exploring. Obviously, many more details will come out in the published

13:53:09—Palav Babaria

report, but I will try to get through a few slides and then pause for our advisory group to weigh in on, you know, are the policy things that we are contemplating, do they resonate with you? Is there something sort of obviously missing? And then we will get through all of those.

13:53:24—Palav Babaria

The other caveat that I will say is today's discussion is really focused on what can we do within our existing constructs. So this is really with authority that the department already has or funding that we already have today within the report, there will be sort of a section on additional opportunities, but because those are really budget or legislatively contingent.

13:53:49—Palav Babaria

we aren't going to be getting into those today. But if there is something at the very end, we'll have a discussion question of like, is there something that's on your wish list that we didn't cover today, we are happy to take that feedback.

13:53:59—Palav Babaria

And incorporate it to the degree possible in our final report.

13:54:05—Palav Babaria

Okay, let's go to the next slide.

13:54:07—Palav Babaria

So we're going to go through these eight buckets, which really I think collectively reflect all of the themes that we heard, really thinking about provider access and managed care plan oversight and monitoring around maternity care services, behavioral health needs, risk stratification and assessment, Medi-Cal maternity care payment opportunities, care management and social drivers of health.

13:54:32—Palav Babaria

perinatal care for justice involved individuals, data and quality, and state partnerships.

13:54:38—Palav Babaria

We can go to the next slide.

13:54:41—Palav Babaria

So I think within the provider access and FCP oversight and monitoring, the big

13:54:48—Palav Babaria

themes that we heard from our stakeholdering is that in current state, there's really a limited racial and ethnic diversity of maternity care providers. This is not just limited to OBGYNs, but across the team-based care spectrum. So applying to nursing, midwives, other ancillary support team members serving in provider offices or in hospitals or in birthing centers.

13:55:13—Palav Babaria

And we really heard from our members that having greater diversity and having a choice of providers that

13:55:20—Palav Babaria

better meet their cultural and linguistic needs is a major goal of our Medi-Cal members.

13:55:25—Palav Babaria

We also heard that there is significant confusion, both among managed care plans and providers on sort of what does Medi- Cal cover? How does provider enrollment work? How does the contracting work and reimbursement specifically for midwifery care, home births, lactation, and doula services. I will add some color commentary here. I think, you know, obviously some of these benefits like doula services are new.

13:55:50—Palav Babaria

And they're still being worked out. Others have the opposite problem. Our lactation, APL, and contract language, we discovered was written in the 1990s, and I think we can all acknowledge that what has happened in the lactation space and what the clinical models are for lactation look very different today than they did over 30 years ago.

13:56:10—Palav Babaria

We also heard consistently that obtaining breast pumps, especially if sort of higher quality or hospital grade breast pumps are needed, was a major barrier for Medi-Cal members.

13:56:21—Palav Babaria

And then especially in our member focus groups, but also with the provider groups, many were often unaware of all of the services that Medi-Cal currently covers today for birthing and postpartum individuals.

13:56:35—Palav Babaria

And then members especially expressed a need for smoother hospital discharges after birth, and that's sort of coming into the hospital, going through a labor and delivery or a C-section, and then being sent home often without support with a brand new newborn and not having all of their needs met was a major

13:56:54—Palav Babaria

just area of opportunity and where a lot of the gaps happened.

13:56:57—Palav Babaria

So I think within this

13:57:00—Palav Babaria

realm, we are looking at ways of how can we use existing workforce programs that we have, such as our loan repayment programs, to improve sort of diversity and promote building out the maternity workforce. Right now, our loan repayment programs are mostly focused on physicians, but there are other efforts across the state to really look at the workforce.

13:57:22—Palav Babaria

We also recognize the need to have sort of more clarification and education on existing policies and benefits so that we

13:57:32—Palav Babaria

can make it more clear, you know, what are our reimbursement and provider enrollment pathways and policies for midwifery care, home births, lactation, and doula services, and how do we educate

13:57:44—Palav Babaria

all providers and members on those entitlements so that they can access them.

13:57:49—Palav Babaria

We also recognize the opportunity to really strengthen how we

13:57:53—Palav Babaria

monitor and oversee our Medi-Cal managed care plans and providing these services. Some of what we learned is depending on how maternity services are delegated by managed care plans, that can sometimes affect a member's ability to access the full suite of services and really looking into that delegation and making sure that services are available the way they're supposed to be is a critical policy opportunity.

13:58:17—Palav Babaria

We also heard loud and clear from members and are looking at how we can strengthen access to midwives and doulas across the state. We know there's variability depending on what county members are in to access those and thinking about how we do our network.

13:58:31—Palav Babaria

adequacy and monitoring and oversight is an opportunity there, as well as sort of updating our lactation APL and looking at how breast pumps are authorized and provided to members.

13:58:44—Palav Babaria

And then we also heard from members sort of transportation and other benefits, which can be a part of that member engagement.

13:58:52—Palav Babaria

We can go to the next slide.

01:00:00—Palav Babaria

The next theme is really around behavioral health. So I am assuming that most of these findings are probably not going to be shocking to any of us on the call, but we consistently heard that

13:59:08—Palav Babaria

Medi-Cal members who are pregnant, postpartum face challenges in accessing timely behavioral health care.

13:59:14—Palav Babaria

And this spans the spectrum. It was not just on the county behavioral health side, but also on the significant non-specialty mental health services side as well. And that it was hard finding a provider who takes Medi-Cal. And then often when individuals would wait, sometimes weeks or months to see a provider who would take Medi-Cal, those providers didn't always feel comfortable taking care of someone who is pregnant or postpartum, especially if they need

13:59:39—Palav Babaria

medications or prescriptions. And so it's both sort of access writ large, but then also specifically access to individuals who have the skills and experience to support someone who is pregnant or postpartum.

13:59:52—Palav Babaria

We also heard a lot about just rising rates, not surprisingly, of substance use disorders in pregnancy and that the critical role that this plays also in maternal suicides, especially in the postpartum period, and a lot of confusion about how pregnant or postpartum members can receive residential SUD treatment.

14:00:13—Palav Babaria

And then there were a lot of through lines around trauma, really thinking about adverse childhood experiences, intimate partner violence, community violence, racism, and discrimination.

14:00:24—Palav Babaria

Many of which disproportionately affect people who are pregnant or postpartum, and then how

14:00:31—Palav Babaria

the healthcare delivery system both screens for, supports, and addresses trauma, which was not sort of the norm or consistently happening for our members across the spectrum.

14:00:44—Palav Babaria

And so within this realm, some of the things that we are looking at is, again, going back to our network adequacy and access standards and contract oversight, both for Medi-Cal managed care plans as well as for county behavioral health plans to ensure that pregnant and postpartum members have access to qualified providers and really reinforcing those contract

14:01:08—Palav Babaria

We also are looking at how we can reinforce existing Medi-Cal coverage policy of residential SUD treatment.

14:01:17—Palav Babaria

Because that was identified as sort of an area of confusion, even though we have existing policy on the books.

14:01:23—Palav Babaria

And then also looking at how we can maybe update and better disseminate the substance use disorder perinatal practice guidelines, which the department has already issued. And then as a part of our overall DHCS work on making sure that perinatal services are trauma informed, a lot of that work has been done through our ACEs Aware program, as well as through dyadic services, but more explicitly distilling this in our maternity.

14:01:48—Palav Babaria

pathway are all things that we are looking at.

14:01:51—Palav Babaria

Okay, I'm going to pause there and take any questions before we go on to the next

14:01:56—Palav Babaria

two domains or comments or feedback from our advisory group.

14:02:25—Palav Babaria

Lori, go ahead.

14:02:27—Laurie Soman

Hi, Paula.

14:02:29—Laurie Soman

You may be addressing this later on, but

14:02:34—Laurie Soman

Through the presentation so far, I'm wondering if you could more explicitly address

14:02:40—Laurie Soman

how the department is including or is planning to include

14:02:44—Laurie Soman

existing public health maternal and child health programs that have been in existence for many decades. And as you well know, some of those

14:02:51—Laurie Soman

are already explicitly focusing on these very vulnerable populations.

14:02:56—Laurie Soman

So I know they were involved in part of the, you know, the focus group conversations but

14:03:03—Laurie Soman

In terms of the program infrastructure going forward.

14:03:07—Laurie Soman

What are you thinking?

14:03:09—Palav Babaria

Great question. And I think that is related to, I see in the chat, I think Antoinette asked a question about home visiting as well and referrals to home visiting.

14:03:18—Palav Babaria

I'm going to come back to your question in more detail when we get to the care management and SDOH slide, because we do have some more details there, but I think it's fair to say that we consistently heard there are lots of existing programs in California. They are in deep silos and people on all sides who are serving maternity members are largely unaware of

14:03:19—Laurie Soman

Yeah.

14:03:39—Palav Babaria

programs outside of their own silo and unaware of how to make referrals, how to leverage them. And so a lot of the work that we all collectively need to do and DHCS is

14:03:49—Palav Babaria

contemplating is how do we break down those silos so that all of the existing programs can be leveraged their full potential and that everyone is aware of sort of what are the members needs? How do we connect them to those longstanding programs that do a great job, but just are not being utilized or integrated with the care delivery system to the degree that they should be.

14:04:10—Laurie Soman

Okay, well, I'll look forward to hearing more. I mean, I'll just say right off the bat, I know I've raised this at other meetings too

14:04:18—Laurie Soman

I'm just concerned if what we're looking at is a move to

14:04:23—Laurie Soman

creating a new maternal and child health structure, but in managed care plans.

14:04:29—Laurie Soman

when we already have a maternal and child health structure with its flaws, absolutely.

14:04:33—Laurie Soman

But we already have a lot of really well-run programs already in the

14:04:39—Laurie Soman

public sector. So to the degree you can address that, that would be great. Thank you.

14:04:43—Palav Babaria

Yeah, no, absolutely, Lori. And I don't know if it's in the slides, but we'll also flag that we as a state received a HRSA strategy planning grant to overhaul maternity cares, the CMQCC is the lead for that, but DHCS Office of Surgeon General, and CDPH are on the

steering committee and the explicit goal of that grant and the work we are doing is exactly what you said, Lori.

14:04:58—Laurie Soman

Right.

14:05:09—Palav Babaria

invent and use system, but break down the silos and integrate our existing system. And so the birthing care pathway work I'm presenting today intends to do that, but that overall HRSA effort, I think is really what's going to bring all of the different pieces of the puzzle together in strong partnership with public health.

14:05:11—Laurie Soman

Right.

14:05:27—Laurie Soman

Okay, great. Thanks. I'll look forward to hearing more.

14:05:31—Palav Babaria

Amy, go ahead.

14:05:32—Amie Miller

Hey, Paula, is there like some data that you've been looking at that you can help us to understand your perspective? I know like the listening tours and how that develops perspectives, but I guess it's kind of inconsistent with some of the experiences I've seen at a local level where we've seen people use sort of a case management benefit to coordinate care. So I was just curious if there was like an underpinning data source that you could point us to to look more deeply at this.

14:05:55—Palav Babaria

Yeah, Amy, do you mean for behavioral health specifically or just in general or

14:05:59—Amie Miller

I'm always interested most in behavioral health, but also data in general.

14:06:04—Palav Babaria

Yeah, we can definitely share that. So we do have some good HEDIS measures that we have looked at. We also looked at all of the public health data that we have through our

maternity dashboards. So I think within the behavioral health space, what is clear is that both our rates of screening for depression, anxiety, and substance use disorders is far lower than it should be.

14:06:29—Palav Babaria

And that when people are screened, sort of then linking them to the effective treatment and getting that intervention in place is lower than it should be, most of that obviously rests on the non- specialty mental health side. On the specialty mental health side, a lot of the

14:06:43—Palav Babaria

sort of information I presented was more anecdotal from the member listening tours. And so I think there is just variation by county as to what services are available. But then we also have really good data from the public health side, especially in the postpartum period of the impact of both SUD and mental health on maternal morbidity and mortality that we've looked at.

14:07:03—Amie Miller

Yeah, we'd really be interested to do a deep dive on those measures, especially calling out people like engaged in substance use care and confirming if we're able to look at a larger data set, their engagement with all of the different systems.

14:07:15—Amie Miller

Because I've sort of seen a lot of great residential providers deeply investing in coordinating care. And we were doing rate setting, the data supported that as well. And we're looking at sort of those dosages. So we'd love to have a deeper dive.

14:07:29—Palav Babaria

Absolutely.

14:07:33—Palav Babaria

Hey, Min, go ahead.

14:07:36—Heyman Oo

Hi, just for the group, the pediatrician and FQHC, the Northern California.

14:07:41—Heyman Oo

This is about behavioral health, but also sort of the general theme that I heard so far throughout your presentation around the confusion and lack of awareness, both from providers and members about the benefits that are available. And I've

14:07:54—Heyman Oo

feel like where we're coming from is not so much an awareness of what's available or covered, but really a bandwidth and the silos are, I didn't know that you existed to provide this service, sort of that connection.

14:08:06—Heyman Oo

Although again, in our smaller county, I think we are very aware of who is providing various services that are covered.

14:08:14—Heyman Oo

But the capacity is not there, right? And so

14:08:18—Heyman Oo

we just have a larger patient population that could benefit from all of these things and

14:08:25—Heyman Oo

it because the programs are closed or a capacity or, you know, those are the delays that we see

14:08:32—Heyman Oo

And so it might be in the larger report of just how that breakdown goes. Obviously, awareness and making sure that

14:08:38—Heyman Oo

members know to ask for these things as well as providers know that they can refer to these things, but then the other piece of

14:08:44—Heyman Oo

who are the service providers that are providing these things and do they actually have the capacity for that load?

14:08:51—Palav Babaria

Yeah, great feedback. And we obviously, we also know

14:08:55—Palav Babaria

one, there's variation across the state. So in talking with our public health colleagues, right, in some areas, for example, home visiting or black infant health programs are very oversubscribed. There are other areas where we are actually leaving slots on the table that are going underutilized. And so how do we solve for that across the state? And then the other piece is with CalAIM, obviously some of these benefits like doulas or community health workers or ECM,

14:09:18—Palav Babaria

don't have enrollment caps like they are entitlements. And so anyone who needs and meets criteria for those services, our managed care plans are required to provide them. And so I think also thinking about how do we leverage some of those scalable benefits that aren't just capped at slots similar to home visiting or other pieces.

14:09:40—Taniel

Taniel, go ahead.

14:09:42—Daniel Calac

Hi, Paula. Thank you. I'm curious

14:09:45—Daniel Calac

I know that it's more kind of a left field component, but there are individuals in terms of substance abuse and their engagement for partners. So in some of the

14:09:57—Daniel Calac

American Indian valuations that are not done here, but maybe in Alaska. I have noticed in some of the descriptions that

14:10:07—Daniel Calac

there have been partners who are very interested in engaging in substance use and behavioral support, but there are limited or no programs for the referral. So wondering if there was anything that came up for partners who were interested in engaging in substance use disorder treatment.

14:10:27—Daniel Calac

To kind of free up some of the stress and the recurrent exposure that some of the mothers were having as well.

14:10:34—Palav Babaria

That is a great point. And I will admit, I don't know that I specifically have heard that angle before, but we certainly heard it from the family angle right of

14:10:42—Palav Babaria

when someone is pregnant or going through the postpartum period that

14:10:46—Palav Babaria

caring for the entire family often is one of the most effective ways to care for that individual. And that obviously includes the partner. So just thank you for raising that. We can definitely take that back.

14:10:58—Palav Babaria

Okay, in the interest of time, I'm going to try to get through maybe a few more slides and then we'll open it up because I don't want to run out of time. So let's go to the next slide.

14:11:09—Palav Babaria

So around risk stratification and assessment, I think we heard, you know, not everyone who is pregnant or postpartum has the same level of needs, either from a medical, social, or behavioral health standpoint. And how do we really dig into that? And so I think two things to lift up here is that one, as a part of our CalAne population health management program, as many of you are tracking.

14:11:33—Palav Babaria

are building our own risk stratification, segmentation and tiering methodology. This is not about OB risk, so this is not designed to define who is a high risk from a maternity clinical standpoint. This is really around who's high risk

14:11:50—Palav Babaria

from a services standpoint where they should get a further assessment and be connected to care management programs or other services and looking at the pregnant and postpartum members is in scope for that work. So we intend to look at that. I think many of you are tracking the Office of Surgeon General's roadmap came out that is proposing a number of sort of screening and stratification tools to DHCS is exploring how to support those.

14:12:13—Palav Babaria

And then one of the big pieces that came out here is that especially for trauma-informed care and intimate partner violence, screening, which is supposed to be done as sort of inconsistent and individuals are not getting the sort of follow-up care support that they need. This is work we've also seen with our ACEs Aware work. So really writ large, thinking about how do we better understand the needs of our members

14:12:35—Palav Babaria

whether they are social, behavioral, or medical, and then really link them to existing services. And I think that touches upon some of what both Daniel, Heyman, and Lori were also talking about, about not building a new system, but identifying needs and actively integrating and connecting with existing services and resources is really critical.

14:12:56—Palav Babaria

We can go to the next slide.

14:12:59—Palav Babaria

The next bucket is really around maternity care payment redesign. So we heard loud and clear that sort of reimbursement rates for providers, both licensed and non-licensed, is not high enough, especially in the maternity space, and that the existing payment models are also very hospital oriented, which pose challenges for

14:13:22—Palav Babaria

freestanding birth centers and midwives, as well as confusion around home births.

14:13:30—Palav Babaria

And also really some of the challenges around clinics providing dyadic services, which we see as a major opportunity to really support

14:13:39—Palav Babaria

individuals in the postpartum period and provide that family- centered care and really avert some of that postpartum morbidity and mortality associated with behavioral health needs. So some of the things we're looking at here, obviously, I think people are tracking, we already through our targeted rate increases that went live in January 2024 and are going to further be increased in 2025, have increased

14:14:03—Palav Babaria

reimbursement rates in Medi-Cal for all maternity providers and associated codes. So I think that piece

14:14:10—Palav Babaria

will really help address some of number one. We also have been looking at our existing value-based payment programs, such as the quality incentive pool program for district and public hospitals and have added some maternity measures on that that already went into effect in 2024 and then continue to really intend to focus on strengthening implementation of dyadic services. And I see Alex put some info in the chat. Thank you, Alex, for calling

14:14:36—Palav Babaria

out the TA Center because there is still a lot of scaling of that, which is going to be critical to this work. And then we're also developing some of the billing and reimbursement guidance are things we're contemplating because some of these pieces such as paying for home births are existing policy. There just isn't a lot of clarity and visibility around that.

14:14:56—Palav Babaria

that we are exploring.

14:14:58—Palav Babaria

We can keep going to the next slide.

14:15:01—Palav Babaria

So I think the care management and social drivers of health, Lori, hopefully this answers some of your questions. So I think in general, we heard loud and clear that the ECM birth equity population of focus and community supports are relatively new and how they can be optimized and used for pregnant and postpartum individuals. People have requested more clarity and more TA on that.

14:15:24—Palav Babaria

We also heard that some members are unaware

14:15:27—Palav Babaria

of what ECM and community supports are and how they can serve them. And then we also heard that while there are existing networks for ECM and community supports, they don't always have the sort of expertise to really serve perinatal populations, especially we heard consistently across both work groups that housing is an increasing crisis for pregnant and postpartum.

14:15:53—Palav Babaria

individuals and housing

14:15:55—Palav Babaria

community supports providers and ECM providers serving the populations of focus who are experiencing homelessness.

14:16:02—Palav Babaria

don't always know what to do with someone who is pregnant or postpartum or has a newborn and really having a network that can get to that level of nuance is really critical.

14:16:12—Palav Babaria

So within the space, you know, I think some of the things that we are looking at are how do we make our TA more robust to really focus on this subpopulation within our existing CalAIM programs? How do we help build out networks that can sort of bring in some of those CBOs and public health programs and other social services partners who really have existing strengths and programming around pregnant and postpartum individuals and families?

14:16:37—Palav Babaria

And again, I think to some of the earlier comments, this can then become a sustainable source of funding to scale those programs where the limitation is really capacity and not having enough staff or spots. And then really going back and contemplating, you know, is there further guidance or clarification that is needed to really describe how ECM and community supports can and should work for this population?

14:17:01—Palav Babaria

We can go to the next slide.

14:17:05—Palav Babaria

The next theme that we also really heard a lot about, especially given all of DHCS's work and the Justice Involved initiative, is sort of, you know, how are we making sure we are taking into account the individual needs of people who are pregnant or postpartum who are incarcerated in our state or going through release. And obviously there is significant intersection here between that population

14:17:27—Palav Babaria

And sort of substance use and mental health needs, just given who is incarcerated in our state. And as individuals are released, sort of especially during pregnancy, sort of how medications and post-release services and how that handoff occurs. So we heard a lot about just, you know, especially from our justice involved and behavioral health providers that this is sort of an area where a lot of different

14:17:52—Palav Babaria

clinical and behavioral health and social needs intersect.

14:17:55—Palav Babaria

And how we can work to address those.

14:17:58—Palav Babaria

And so within this, we are

14:18:02—Palav Babaria

woven a lot of this stuff into our justice involved policy, but really making sure that as we launch the pre- release services, that there is specific services that are going to support pregnant and postpartum individuals. And then on the post-release side, how do we make sure that we have an ECM network that is not just sort of doing general justice involved ECM, but can really meet the

14:18:24—Palav Babaria

prenatal or postpartum related needs that a member may have, which is going to be very different than non- pregnant members.

14:18:34—Palav Babaria

Okay, let's stop there actually for comments and then we'll go to the last two sections.

14:18:49—Palav Babaria

Anyone on our advisory committee have any thoughts or feedback on those buckets or other things that we should be looking at?

14:19:18—Palav Babaria

seeing some really great feedback in the chat around how to leverage doulas in addition to ECM. So thank you all for those thoughts.

14:19:27—Alex Briscoe

Can you just say really quickly, could a doula be an ECM provider as well?

14:19:31—Alex Briscoe

Is that possible?

14:19:35—Palav Babaria

There is nothing in our current policy guide that dictates who, like what specific qualifications are required to be an ECM provider.

14:19:45—Palav Babaria

There's no licensing requirement. So as long as they provide services.

14:19:49—Palav Babaria

yes, theoretically, a doula

14:19:50—Palav Babaria

could be the CM provider. Obviously, there are

14:19:54—Palav Babaria

the individual services cannot be double billed. So if a service is rendered once, it cannot be reimbursed by both ECM and under the doula benefit because of double dipping sort of prohibitions. But otherwise, yes.

14:20:09—Palav Babaria

It's the short answer.

14:20:10—Alex Briscoe

Thank you.

14:20:17—Palav Babaria

Okay, let's get through the end. I know we have 10 minutes left. So I think the other big pieces, and this gets to Amy, I think some of what you were asking earlier too, is we heard loud and clear that in current state.

14:20:31—Palav Babaria

there's a lot of assessments and documentation and screenings that are done for pregnant and postpartum individuals by multiple programs, and they are all

14:20:41—Palav Babaria

For the most part, sit in silos. So that includes WIC,

14:20:44—Palav Babaria

CPSP, prenatal visits, postpartum visits, behavioral health care visits, the hospital and delivery to the point where

14:20:52—Palav Babaria

In each of those settings.

14:20:54—Palav Babaria

whoever is interfacing with and caring for the member is largely completely unaware of what screenings and services and diagnoses have happened in other settings. And as you can imagine, it becomes really risky for the member that people are not tracking what their housing status is or who their care manager is or what their complex medical conditions are in the pregnancy. And so really thinking through how do we break down

14:21:19—Palav Babaria

not just the data silos that sort of a meta level, but even just individual care plans where everyone who's actually caring for that member during pregnancy journey knows what the care plans are and who's doing what, and especially the silos between the sort of social services and the health care services within pregnancy and postpartum become really important.

14:21:39—Palav Babaria

The other problem that we heard is really just data sharing across public benefits and programs. So how do we really leverage paid family leave, WIC, CalFresh, and Medi-Cal, and then all the associated Medi-Cal benefits in a more streamlined way? And we also heard this from our members that sometimes they just turn down benefits because it's yet another appointment to go to or figure out how to fill out the form and how to survey.

14:22:03—Palav Babaria

access those services. So how do we redesign those processes in a way that is easier for the member and more one-stop shopping rather than the member having to attend 20 different appointments to get all the benefits that they are entitled to.

14:22:17—Palav Babaria

And then around data and sort of quality measurement, I think we all recognize and know that the existing MCAS and HEDIS measures that we have around prenatal and postpartum care, they really just say, did a visit happen or not? They don't tell us about the quality of that visit. They don't tell us, you know, especially given things like cardiovascular morbidity and mortality are among the leading causes of death for Black postpartum.

14:22:41—Palav Babaria

individuals in California like

14:22:43—Palav Babaria

do they have hypertension? Are we controlling that hypertension? How are the actual needs being met? And so how can we break down silos, especially between sort of public health.

14:22:53—Palav Babaria

data that is available through our statewide maternal morbidity and mortality review processes and the healthcare delivery side to have a more comprehensive picture.

14:23:03—Palav Babaria

Go to the next slide.

14:23:06—Palav Babaria

And then on state agency partnerships, I think this goes back to also some of the comments that have been made earlier in the meeting is that

14:23:07—Alex Briscoe

Thank you.

14:23:14—Palav Babaria

We have many, if not most of our healthcare agency state departments have programming and existing services

14:23:23—Palav Babaria

focus on maternity care, but the same silos that exist locally have also existed at a state level and really thinking through instead of building a whole new system, how do we really create a coordinated system of care that breaks down the silos at the state level is

really something we are working to solve, not just through this initiative, but through that overall HRSA grant that I mentioned, as well as the Office of Surgeon General's

14:23:47—Palav Babaria

roadmap. Home visiting here is also called out specifically because, again, we don't want to reinvent the wheel. There's abundant evidence for the high impact of home visiting on pregnant and postpartum individuals and their families. But how do we really create a more coordinated approach where all of the existing slots we have are being utilized, where we have shortages that we can help support scale?

14:24:11—Palav Babaria

those slots and that the referral pathways and coordination is happening at the local level.

14:24:18—Palav Babaria

You can go to the next slide.

14:24:21—Palav Babaria

So we'll drop these questions in the chat so that folks have them for reference and then we can open it up to just comment. So one, just

14:24:31—Palav Babaria

you know, from the problem statements we've identified and the stakeholder engagement that we've done, are there any sort of major problems that we completely missed that you all want to call to our attention? And then are there any specific policies or focus areas that you haven't heard that we should be calling out?

14:24:51—Palav Babaria

And if you have any ideas for how we should all engage you. And then we really look forward to sort of reconnecting with everyone after the report is published. We'll be doing an all- commer webinar because we know this is complicated and it's only going to work if we are all working to integrate our currently fragmented system.

14:25:10—Palav Babaria

Which is going to require everyone on this call.

14:25:13—Palav Babaria

Okay, so maybe we can take down the slides so we can see people and I will open it up to our advisory group if you have any comments. And then otherwise we can take some questions from the chat or Q&A.

14:25:22—Peter Shih

Thank you for the presentation. I was wondering if

14:25:27—Peter Shih

We've talked about food insecurity for

14:25:31—Peter Shih

this population because in San Mateo we've had

14:25:35—Peter Shih

clients ask for more food as part of their services that we deliver to them. So I just wanted to highlight that.

14:25:42—Palav Babaria

Thanks for bringing that up. And yeah, I was remiss. I think I talked about housing and transport and other things, but yes, food insecurity absolutely came up

14:25:51—Palav Babaria

in both of our work groups, as well as sort of our member voice work. And I think some of the observations were that we know

14:25:58—Palav Babaria

the uptake of WIC, for example, is not 100%, right? So there are people who could be getting additional support and extra services that we're sort of leaving on the table. Same with CalFresh and how do we optimize existing benefits, recognizing that even if those are optimized, there may be additional needs that we have to figure out how to meet.

14:26:21—Palav Babaria

Antoinette, let's go to you next.

14:26:24—Antionette Dozier

Thank you. Thank you for the presentation. I'm wondering.

14:26:29—Antionette Dozier

Have you started to explore

14:26:32—Antionette Dozier

um you know pathways to

14:26:36—Antionette Dozier

direct linkages to services and supports, especially when there's a concern about the health and safety of baby. We know that a lot of

14:26:46—Antionette Dozier

referrals to child welfare come from the health community and especially Medi-Cal provider

14:26:53—Antionette Dozier

OBGYNs and pediatricians.

14:26:56—Antionette Dozier

And one thing that we've heard from doctors is, you know, what is the alternative to reporting? What do I have to

14:27:02—Antionette Dozier

refer them to directly connect them to and

14:27:04—Antionette Dozier

I know that there's a lot of work at the state level as CDSS is doing on moving from mandatory reporting to a mandatory supporting model and what that

14:27:14—Antionette Dozier

that cohort of services are and just wondering if you guys are engaged and at the table of that and thinking through how you can import that work into sort of the pathways of services and supports

14:27:26—Antionette Dozier

for birthing

14:27:29—Palav Babaria

Thank you so much for that really critical call out. And yes, I think that sort of as we heard about like the

14:27:37—Palav Babaria

trauma-informed care and sometimes the trauma that going through the healthcare delivery system insights and individuals who are trying to seek care, many of those themes did come up. So we have been starting to have those conversations with social services. So more to come on that front, but thank you for the call out.

14:27:55—Palav Babaria

Michelle, let's go to you next and then Jeffrey.

14:27:57—Michelle Gibbons

Yeah, thanks, Paul, for the presentation. And I'm just going to apologize because I missed some of the earlier parts. So if the slides have been sent out or will be sent out, that would be really helpful. One thing that I just wanted to mention is that I think conceptually these things make sense. The devil will be in the details. And one of the things I would encourage the department to really think strongly about is not recreating the wheel or taking

14:28:21—Michelle Gibbons

what is working well and moving it into like just the managed care space because it makes that really challenging to continue to do the great work. For example, you know, with home visiting, I think a lot of the challenges with home visiting has been the lack of funding and sustainable funding for home visiting programs, which has led local health departments to have to really kind of temper the participation, right, in terms of how many families can participate in those programs.

14:28:47—Michelle Gibbons

And then even some of the strict policies in those programs already. So for example, you know, the CDSS home visiting has more models that you can choose from than what CDPH home visiting programs allow. And then there's very strict requirements on the staffing models that you use for those home visiting programs. And so it makes it really challenging, whereas some of our folks

14:29:09—Michelle Gibbons

know that like second time moms, for example, don't fall within the nurse family partnership model, but they are actually still a population that needs to be supported. And because they don't fall in a model, then it becomes more challenging. So really.

14:29:24—Michelle Gibbons

how things have been is like, if you have this model, you can do this. If you don't have this model.

14:29:28—Michelle Gibbons

then you'd have to stand up a whole separate model, which is very resource intensive. And so I would encourage the department to really think about what flexibilities can be given to those entities that are already administering some of these programs

14:29:41—Michelle Gibbons

And how could you structure it in a way that doesn't necessarily push this all into managed care and say, hey, managed care, now you have to figure out who to partner with, but instead starts with the expertise and builds that into the framework. Because I do worry about

14:29:54—Michelle Gibbons

those that have the closest touch who have been showing great outcomes, who know the populations.

14:30:00—Michelle Gibbons

being left out of being able to continue those services because they can't do it based on a rate or a new structure of reporting. And then on the data piece, I just want to mention that

14:30:11—Michelle Gibbons

All of these data supports or things like to make the data more robust is super meaningful and helpful.

14:30:17—Michelle Gibbons

I do want to remind folks that like from a local health department framework

14:30:22—Michelle Gibbons

we don't have some of the same tools that maybe healthcare has. And so if this is going to require like new investments in technology, I would just ask that there would be support to help local health departments and other entities get up to speed on those things.

14:30:37—Palav Babaria

really helpful feedback. Thank you, Michelle. Jeffrey, let's go to you.

14:31:01—Geoffrey Leung

are dedicated to MCAH programs. However, kind of trying to fold groups into that structure is challenging. And being able to call out sort of very explicitly maybe some of those other statewide programs, you know, whether it's in another state agency that already exists that we want to partner together might be helpful in describing that structure. I did want to mention WIC data sharing.

14:31:26—Geoffrey Leung

which I know is a thorny issue, may not fall completely within the scope of this discussion.

14:31:32—Geoffrey Leung

But just wondering if there's an opportunity for either a recommended approach or advocacy since California is such a powerhouse, but that continues to be a big challenge. And if there's a statewide approach where we can even temporarily sort of navigate some of the WIC data sharing, that might be promising.

14:31:53—Geoffrey Leung

And then finally, I think what's really the most exciting for me is that opportunity between social services and healthcare delivery. So Ed would love to hear some of these same conversations from the other state agencies. So excited about this topic. Thank you.

14:32:12—Palav Babaria

Thank you so much on as always we have run out of time. So please keep a lookout for the report. We'll obviously have a full all-commer webinar after it is published. And we recognize, right, like a single report is not going to actually get this work done. It will hopefully provide a roadmap and a policy framework for how we get there, but there's a lot of work and conversations we will all collectively need to have

14:32:35—Palav Babaria

to figure out how to actually implement and move the needle on this across our state. But just really appreciate everyone's feedback and commitment to improving care for this population.

14:32:46—Palav Babaria

Thank you all so much for joining and we will post everything and share everything on our website.